THE PSYCHIATRIST, CIRCA 2015: “FROM SHRINK TO PILL-PUSHER”


DOI: 10.1177/0003065115585169

In 2008, Mojtabai and Olfson reported that there was a significant decline in the number of psychiatrists specializing in psychotherapy, along with an increase of those specializing in pharmacotherapy. Since then, this trend undoubtedly continued, with many physicians (both family practitioners and psychiatrists) providing psychotropic medications to their patients (Olfson et al. 2014). Why has this shift occurred? Is it simply the result of greater insurance reimbursements for providing medications rather than “talk therapy”? (Harris 2011). Are there other reasons? Why has psychiatry prioritized the biomedical model and devalued the biopsychosocial model as first explicated by George Engel? (1977, 1980).

On page 172 of a 315-page volume with various religious imagery, Shrinks: The Untold Story of Psychiatry, Jeffrey A. Lieberman, Lawrence C. Kolb Professor and chair of psychiatry at Columbia University College of Physicians and Surgeons and former president of the American Psychiatric Association, states that “psychiatry’s dramatic transformation from a profession of shrinks to a profession of pill-pushers came through sheer serendipity” (p. 172). That Lieberman considers psychopharmacology the Holy Grail of psychiatric treatment is indicated by assertions such as this: “the mind-boggling effectiveness of psychiatric drugs began to transform the fundamental nature of psychiatry and elevate its professional status. The black sheep of medicine could rejoin the flock because it finally had medicine” (p. 189).

In this volume, Lieberman describes the historical arc of the profession of psychiatry, from its status as “stepchild of medicine” to the
“triumph of pluralism”: DSM-5. The book is divided into three parts: “The Story of Diagnosis,” “The Story of Treatment,” and “Psychiatry Reborn.” Except for a section titled “Toward a Pluralistic Psychiatry” (pp. 284–291), the volume strikes me as unidimensional. Lieberman evinces a seeming lack of appreciation for the complexities of both mental life and therapeutic interventions. For example, at the end of his introduction, he states: “The modern psychiatrist now possesses the tools to lead any person out of a maze of mental chaos into a place of clarity, care, and recovery. The world needs a compassionate and scientific psychiatry and I’m here to tell you, with little public fanfare, that such a psychiatry has arrived at last” (p. 12).

There is an evident irony in this statement, of course, because the book has received a great deal of public fanfare since its recent publication. More irony is to be found in the fact that both of Lieberman’s major case examples are clearly clinical failures, despite his triumphant exuberance concerning the power of psychotropic medication and the quick symptomatic improvement of one of these patients.

In the introduction Lieberman describes the case of Elena, a young woman with schizophrenia who had not improved despite a variety of interventions, which he disparages. The young woman was hospitalized, improved quickly with medication, and was discharged, but then refused to continue treatment as an outpatient, despite the fact that Lieberman “implored [the parents] to continue with Elena’s medical care” (p. 9). The second example concerns a severely psychotic woman, a Mrs. Kim, whose family felt such great shame that they kept her hidden and refused Lieberman’s offer of treatment. “I told them quite bluntly,” writes Lieberman, “that their decision to withhold treatment was both cruel and immoral . . .” (p. 294).

Any mental health professional (psychiatrist or not) will recognize quickly that the central problem in both situations is a result of the treating clinician’s failure to establish a sufficiently powerful therapeutic bond with both the patient and the family, to consider the individual psychologies of all of them, and to take into account the forces emanating from the family’s social milieu. Without this bond and effort at understanding, treatment is doomed to fail, no matter how great the power of the medication or the authority of the physician.

Indeed, Glen Gabbard (2014) has recently commented that “the core of psychodynamic psychiatry is to look at each individual as a
person with highly individual, even idiosyncratic features. This core principle of good psychiatric practice, and even good medical practice, may be obscured by our progress in so many areas of ‘hard science’ in our field.”

Lieberman appears to consider individual and social factors unimportant. Although faulting psychoanalysis for its old parent-blaming theories, he does not seem to recognize that he himself blames both the Kim family and Elena’s family for the failure of his recommended treatment plan. He seems oblivious to the possibility that the failure might be found in his own service delivery system: “Elena had responded to her initial treatment well, and I believe that had she continued with the prescribed aftercare plan, she too would have had a good recovery and resumed her education and previous lifestyle” (p. 25).

Lieberman does not examine why some patients with severe mental illness continue their use of antipsychotics and others do not. For example, Lieberman’s friend Elyn Saks, whose symptoms are described in the book (pp. 178–179), has written in this journal that she considers herself to be a patient “with psychosis who has benefited enormously from psychoanalytic treatment, four or five times a week for over three decades” (Saks and Evans 2011, p. 59). Kay Redfield Jamison (1992), to whom Lieberman also refers to as a “dear friend” (p. 311), has also written about the value of psychotherapy in the treatment of bipolar illness. Despite this, the value of psychotherapy is virtually effaced in Lieberman’s description of their treatments. In fact, his clinical descriptions of these four cases (Saks, Jamison, Elena, and Mrs. Kim) lend themselves to a testable hypothesis: Do psychotic patients do better when their treatment with psychotropic medications is accompanied with psychotherapy, or not? And if they do, should the psychotherapy be provided by the prescribing psychiatrist or by another mental health professional? In a brief search of the literature I could not find a study asking these questions.

It is unfortunate that Lieberman’s account of the history of psychiatry is populated by “good guys” and “bad guys.” Lieberman’s two major heroes are John Feighner and Robert Spitzer, powerful proponents of systematic diagnostic systems, which led to development of the categorical system in psychiatry. Feighner, whom Lieberman met when he was a psychiatric resident, proposed the famous Feighner Criteria, which introduced American psychiatry to the Kraepelinian system of diagnosis and
became incorporated into DSM-III, the creation of which was due to Spitzer’s full-time efforts. Against these white hats, of course, psychodynamic practitioners play the bad guys who tried to lead an unsuspecting public “down the garden path” (p. 49). I will shortly discuss the one section of the book in which Lieberman recognizes the complexity of mental life and mental health approaches. Elsewhere, throughout the bulk of the volume, the only important goal of the psychiatrist seems to be to make the correct diagnosis and provide the right medication.

Lieberman begins his story with a long discussion of Wilhelm Reich and his Orgone theory. But by beginning with Reich, Lieberman has created a straw man that allows him to denounce psychoanalytic and psychodynamic theories and techniques. Reich, it must be said, was an important early contributor to psychoanalytic theory and treatment. Yet by the 1940s and 1950s his later work had been discredited, not least by psychoanalysts. By stressing Reich’s connection to Freud, this long opening discussion sets the stage for a negative portrayal of the psychodynamic contribution to treating mental health problems, including the gratuitous comment that Freud was psychiatry’s greatest hero and most calamitous rogue (p. 39). In chapter 2 Lieberman disparages Freud’s early Wednesday night meetings with colleagues as a “Coffee Klatch” (p. 49) and a clique (p. 51). In fact, one may wonder at the anti-Semitic innuendo in Lieberman’s account of Freud and his followers. He uses Freud’s Yiddish/Hebrew name for no apparent reason when he introduces him as “Sigmund Schlomo Freud” (p. 39). Were he aiming for historical accuracy, he might have used Freud’s given name which was Sigismund Schlomo Freud. More significantly, however, Lieberman declares that psychoanalysis was mainly a procedure by Jews for Jewish patients: in his view it became “a unique phenomenon in the annals of medicine: a scientifically ungrounded theory, adapted for the specific psychic needs of a minority ethnic group” (pp. 69–70).

Lieberman is correct in his criticism of early ideas such as the schizophrenogenic mother or the refrigerator mother, and he does grant the importance of Freud’s conceptions of unconscious mental activity. But the major portion of the first two chapters consists of a critique of psychoanalytic ideas, especially during its heyday in the 1940s and 1950s, including the comment that psychoanalysis “conquered academic psychiatry and created an industry of private practice” (p. 78). In a much more neutral way, Lieberman reviews historical figures like Pinel,
Mesmer, and the alienists1 (as psychiatrists who worked in mental hospitals were known).

In chapter 3 Lieberman embarks on a paean to what he calls the “Bible of Psychiatry” (p. 87); he describes how DSM and psychoanalysis “ran parallel for almost a century before colliding in a tectonic battle for the very soul of psychiatry, a battle waged over the definition of mental illness” (p. 88). Such language, typical of the book, certainly does not belong in a work purportedly describing the scientific development of a field, including its academic disputes.

The overriding theme of this chapter is the evolution of the official classification of mental diseases, beginning with the 1840 U.S. Census, which categorized mental illness as a disability for the first time, using the label “insane and idiotic” (p. 89). In 1917 the American Medico-Psychological Association (forerunner of the APA) published The Statistical Manual for the Use of Institutions for the Insane (known as the Standard). In contrast to the lack of consensus in America concerning diagnoses, Emil Kraepelin, born in Germany in 1856, the same year as Freud, developed a classification system, the Compendium der Psychiatrie, that differentiated the psychoses based on patients’ life histories: dementia praecox, manic-depressive insanity, and paranoia. By the 1930s European psychiatry had embraced the Kraepelinian system, in contrast to the domination of Freudianism in American psychiatry.

What is most striking about Lieberman’s account is his seeming lack of appreciation for the ongoing tension, through much of the twentieth century, between a Kraepelinian categorical system of mental disorder and a dimensional system considering normality and pathology to occupy a continuum (Hoffman 2014). Although Lieberman rightly criticizes the variations in approach among different psychoanalytic schools based on their pet theories (pp. 97–98), he does not seem to question the validity or clinical utility of the increasing number of categorical diagnoses that resulted from the ongoing evolution of statistical manuals. For example, in 1943, William Menninger, to help the military evaluate recruits, developed Medical 203, which described 60 disorders. This was an expansion from the 22 disorders in the Standard from 1917. DSM-I, published in

1Lieberman seems to imply that the word alienist was used because psychiatrists were “working [in country madhouses] apart from one’s medical colleagues, separated from mainstream society” (p. 71). In fact, the word is derived from the French les aliénés, the point being that the mad were separated (alienated) from reason (George Makari, personal communication).

What can we infer about the scientific nature of a field with such variation in its taxonomy? Certainly it indicates that the field is in its infancy. Lieberman, who has been intimately involved in the final stages of DSM-5’s development, defends the taxonomy against its critics by insisting “there is no institutional interest in expanding the scope of psychiatry by inventing more disorders or making it easier to qualify for a diagnosis” (p. 281). He seems proud of the fact that the number of diagnoses fell between DSM-IV and DSM-5. The development of the various classifications and iterations of diagnostic systems is discussed in chapters 3 and 4. The account concludes with the standing ovation given to Robert Spitzer when DSM-III was passed after a political battle, which is described in detail (p. 149). In chapter 5 Lieberman describes the desperate measures once taken in trying to aid those suffering from severe mental illness: fever cures, coma therapy, and lobotomies.

Unfortunately, Lieberman misses a golden opportunity to discuss in detail the ongoing debates between “lumpers” and “splitters” in the development of the taxonomy of relatively young fields. Such a debate has occurred in botany, for example (Endersby 2009). The outline of what such a discussion might be like can be found in the short section I mentioned earlier, “Toward a Pluralistic Psychiatry.” Lieberman’s discussion here is prompted by the critique of DSM-5 by Tom Insel, Director of the National Institute of Mental Health. Lieberman rightly states that the field of psychiatry “has always fared best when it managed to avoid both extremes of reductionist neurobiology and pure mentalism. . . . the field of psychiatry as a whole has come to realize that the best way to understand and treat mental illness is by simultaneously addressing the mind and the brain” (Insel et al. 2010, p. 286). However this kind of multifaceted conceptualization is absent from the rest of Lieberman’s book, which seems instead to confirm the admonition of Morton Reiser (former chair of psychiatry at Yale) that “we are going from a brainless psychiatry to a mindless psychiatry” (p. 285). The overwhelming thrust of the book is to advocate for psychopharmacology and the psychiatrist’s approach to mental illness as any other medical disorder; only a passing nod goes
to psychotherapy, which may be provided by “allied mental health professionals” (p. 298).

A more open-minded or pluralistic discussion would have included an analysis of the relative value of dimensional and categorical approaches to mental dysfunction. Freud noted that there is no clear-cut demarcation between normality and pathology; the dimensional approach is, of course, inherent in the Research Domain Criteria (RDoC) of the NIMH (Insel et al. 2008).

Instead, Lieberman chooses to focus on the history of psychiatry as a political battle eventuating in the victory of the psychiatrist as psychopharmacologist. And, of course, psychopharmacology requires the availability of reliable symptomatic diagnostic categories. Chapter 6, “Mother’s Little Helper: Medicine at Last,” describes the evolution of psychotropic medications from morphine, to chloral (a nonopiate sleep aid), to meprobamate or Miltown in 1950, which Lieberman considers the first psychopharmaceutical (p. 175). Chlorpromazine, antidepressants, lithium, and other drugs followed, pioneered by first-generation psychopharmacologists like Nathan Kline.

Chapter 7 discusses the beginning of the brain revolution and the development by Aaron Beck of CBT, the only psychotherapy Lieberman seems to value. This is not surprising, as he ignores the scientific advancements made in the study of psychodynamic theory and treatments. To cite just a few recent publications, the official journal of the American Psychiatric Association indicates the activity of psychodynamic researchers, all of whom are ignored by Lieberman (Clarkin 2014; Høglend 2014; Leichsenring et al. 2014; Milrod et al. 2014).

Chapter 8 discusses the evolution of the study and treatment of trauma. In chapter 9 Lieberman describes in tremendous detail the complex public and internal political battles involved in the development of DSM-5. Interestingly, he concludes that “for better or worse, the DSM is not merely a compendium of medical diagnoses. It has become a public document that helps define how we understand ourselves and how we live our lives” (p. 291).

While chapter 10 discusses the future of psychiatry and the importance of destigmatizing mental disorders, one has to wonder whether a compendium of disorders, as presented in the DSM, promotes destigmatization or in fact has the opposite effect. Biomedical psychiatrists like Lieberman believe that by considering mental dysfunction as equivalent
to any other medical disorder, psychiatric conditions will be destigmatized, by both patients and the general public. Yet we can consider Lieberman’s assertion that the DSM “helps define how we understand ourselves” to imply a real difference between medical and psychological dysfunction. Mental function and dysfunction inevitably involve how the individual thinks of him- or herself. Does it help or hinder a patient’s sense of self that he or she has this or that psychiatric diagnosis, or in fact a multitude of diagnoses (comorbidity)? It is hard to imagine a medical disease, other than cancer (Ulrich 2013), where one’s sense of self is so profoundly affected as when one is told that he or she has such and such a psychiatric diagnosis.

Lieberman ends his book saying that “after a long and tumultuous journey, psychiatry has arrived at a pivotal and propitious moment in its evolution—a moment well worth celebrating, but also an opportunity to reflect on the work that still lies ahead” (p. 315).

Jeffrey Lieberman is a distinguished leader in the field of psychiatry. It would have been a real contribution to the field had this volume engaged in self-reflection, rather than displaying an authoritarian approach that does a disservice to the field.

REFERENCES


167 East 67th Street
New York, NY 10065
E-mail: hoffman.leon@gmail.com