Addendum

to my Submission to the Senate Select Committee (Mental Health) entitled "*From Freud to Fraud – Prophets to Profits*" (submitted 24th September)

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20th October 2005

Dear Senators,

The Australian Medical Association's (AMA) submission to the Senate Select Committee on Mental Health was brought to my attention following the submission of my own document ("*From Freud to Fraud…etc*" submitted 24th September 2005). Given that the AMA represents one of the (many!) "peak" health groups that will in all likelihood sway your thinking (by virtue of their "peakness"), I would like to offer my own (inimitable) view of their submission in the form of this *addendum* to my original submission. I do this in order to perhaps balance the gravitas implied by their impressive rhetoric.

1. What really lurks in the hearts of men (& women)?

In my original submission, I noted the following parapraxis (unconscious "slip") in the letter of the president of the *Australian Psychological Association*. I repeat it here;

> An interesting example of unconscious processes is actually to be found in the covering letter of the submission by the "Australian Psychological Society" (written Professor Lyn Littlefield OAM FAPS and dated May 19, 2005). The last line of (substantive) paragraph 3 states that the Society can;
>
> *"…assist in the burden of mental health in Australia."*
>
> What did they MEAN to say? This;
>
> *"…assist in (easing?) the burden of mental* ***illness*** *in Australia".*
>
> Typo?? (as will be claimed). I think not. This is "parapraxis" (unconscious slip) at its best! How many people have read and checked this letter without spotting the unconscious agenda at work here? As Freud said:
>
> *"He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips;* ***betrayal oozes out of him at every pore****."*

Well, how does the AMA "betray" (in a Freudian sense) its deeper, unconscious motivations and ambivalences? In the following manner (on page 2, bullet point 6):

> *"****The ongoing neglect of mental health prevention must cease*** *[their "bolded" emphasis]. There is just as much potential to improve patient outcomes through health prevention, early intervention….health care."*

Once again, what did they really mean to say? This;

> *"****The ongoing neglect of mental illness prevention must cease*** *[their "bolded" emphasis]. There is just as much potential to improve patient outcomes through mental illness prevention, early intervention….."* yada, yada, yada…

Honestly, you couldn't wish for a better (second) example of the fact that we are;

1. Incredibly complex creatures largely unaware of the ambivalences and motivations that we (and our proofreaders!) harbor, no matter how "intelligent" we are presumed to be, and also;
2. No one has someone else's interests COMPLETELY at heart. "Altruism" therefore, has to be legislated into our lives – hence the need for governments and legal systems (and things like money).

Now, am I just playing party games here? I hope not. What I hope to demonstrate is a fundamental feature of the behavioral determinism that ALL the other submissions before you will completely ignore. It is this; we do not "live" in our cerebral cortex under the complete control of our behaviors. This is an illusion – a fantasy that even the most expensively besuited psychiatrists, psychologists and GPs suffer from. Amazing isn't it? And scary. We are not governed by the actions of simple reflexes or a couple of brain molecules (serotonin and dopamine seem to be the current flavor of the month!). We are *not* "master" of our own psychological "house". Furthermore, every time someone has to check that the gas is off a dozen times, or repeatedly that the front door is locked, or if they hijack every relationship they get into, or get horrible depressed in a crummy marriage – they prove this deceptively simple fact. Our pain (and behavioral motivations) run very deep indeed and further, we ignore them at great peril to everyone's mental health.

One consequence of all this is that the vast majority of psychiatrists, GPs, psychologists, "counselors", "therapists", social workers, "psychiatric" nurses (etc, etc) are kidding themselves (and you) when they pretend to know anything about what drives our *normal* moods, desires and behaviors, let alone how to fix things when the mind falters. This is because these groups – while paying scant lip service to unconscious determinants of psychopathology - only deal with "surface" phenomena in their clinical practices, namely "symptoms". Moreover, they deal with these phenomena as quickly and efficiently (read; "profitably") as possible. Even worse, these professionals (unconsciously) fear the possibility that lurking within the recesses of their <u>own</u> minds lie forces beyond their comprehension AND control. This has to be denied in themselves, and by extension, others. Hence the profound antipathy towards all psychoanalysts (and to a lesser degree psychologists), whether they be Freudians, Jungians or Lacanians, as discussed at length in my original submission.

This highlights a fundamental problem facing your committee; to whom should you listen?! Whomever you listen to, make no mistake – we know next to nothing about the workings of the mind (with its 10 billion connections) when it is **healthy**, let alone when something goes **wrong**! To use an analogy, the current use of drugs such as Prozac and books (bibles?) such as the DSMIV, are the equivalent of using leeches to cure cancer. The anthropologists of the future will have a field day looking back and laughing at our current pretensions! This brings me to the main failing of the AMA's document.

2. The "Medical Model" of Mental Health is Fundamentally (and Fatally) Flawed

Otherwise, why would be in the mess in which we currently find ourselves with regards mental health? As the AMA document states, the incidence of mental illness has increased alarmingly in the last few years (Pg 5, section 2.2). The majority of this (as also cited on page 5 of their document) comprises "depression" and "anxiety". Why has this happened? Is it because all of a sudden we have all developed abnormal brain genes?! Hardly! Is it because someone is draining our brains of serotonin. I don't think so! It is because of the insane world we live in and the absence of the life skills and support structures necessary to deal with it. This is where we should be concentrating our attention. I suspect though, that we will all dodge dealing with the rubric of aligning our lifestyles more closely with those that match our innate needs. More about this later.

Part of the problem is that we all (doctors included) hate listening to people complaining. Why? It takes a lot of work to listen to this, *and* it's a lot of work to deal with (temporally, emotionally, verbally and financially). However, since time immemorial, community groups have found ways of dealing with life pains using strategies such as;

- Religion & other rituals
- Extended families & social networks
- Music, dancing, art & literature

Most of us now however, live lives nearly totally deficient in all of the above elements. This comes about simply because of the times we happen to live in. The vacuum (and psychological symptoms) left by the absence of the above "meaning-giving" activities has, in this day and age, been filled by psychotropic drugs. Why? They are quick, and they are cheap. And they seemed like a good idea at the time! As did lobotomies, once upon a time. As were barbiturates 50 years ago. As were benzodiazepines 20 years ago. As is prozac now. See the pattern? We are always playing catch up with our ignorance *and* arrogance. Moreover, we are largely in denial with regards both this ignorance and hubris.

The current situation of over-reliance on drugs as the "answer" has also occurred because psychiatrists;

- wanted to be seen as scientific (as opposed to psycho-babbling shamans),
- (understandably) want to minimize all the whining ("pain") patients were engaging in, and by extension;
- hope themselves to avoid having to think about life, death, sex, love, hate, aggression, conflict, relationships, and all the other "messy" things that no one wants to think about in this emotionally autistic, post-modern world we live in. Even worse;
- no one wants to think about the alternative to drugs, namely, suffering life's pains and learning from them.

Thus, the reality is this;

> *By overly <u>pathologizing</u> normal feelings (viz, sadness ="depression", fear ="anxiety" etc), a psychiatric and pharmacological industry has been created that is now self-perpetuating and rather self-deluded. Worse still, aside from their iatrogenic effects, the use of psychotropic "quick" fixes actually <u>impairs</u> normal psychical developmental processes and thus personal growth, <u>particularly</u> in the young.*

A scarier possibility is that the stunting of personal growth through massive widespread use of psychotropic drugs might actually translate into a stunted *societal* growth. After all, pain is one of the processes that provokes introspection, answer-seeking and (ultimately) adaptive growth (of people and communities). We are thus actually in the midst of a huge social "experiment" with regards drugs and mental illness, the consequences of which the committee is trying to grapple with, namely, ever increasing rates of depression and anxiety. Even more alarming is the AMA cited statistic that childhood mental illness is likely to increase by 50% in the next 15 years (Pg 31, Section 7.5). For these reasons – and many others – the medical model of dealing with what is actually existential pain is to be viewed with deep (but not paranoic!) suspicion.

Does this mean however, that we should go back to priests and dancing around Stonehenge? Hardly – unless you are into that sort of thing! But, things have to swing in the direction of more meaningful 'liturgies' than chanting the word 'serotonin' in a quasi-religious trance. But there is no doubt about it, drugs and a brief perfunctory chat in the GP/psychiatrist's office are a quick and

cheap way to get people out of the clinician's office and back at work. The long-term consequences of this are not precisely known, but are likely to be quite damaging.

How does the medical/psychiatric profession deal with the above criticisms that, after all, they have been hearing for many years? Well, they can call the critics 'kooks'. This strategy can be quite effective – after all, they are the ones with the degrees on the wall. Another strategy is discussed in the next section.

3. Arrogance

There is of course no shortage of arrogance within the medical profession. Otherwise, why would doctors assume the aristocratic right to make you wait 50 minutes in a dingy waiting room while reading 10-year-old *New Ideas*?! The power over life and death will promote such attitudes (and passive-aggressivity) in people.

There is also ample evidence of arrogance in the AMA submission. Some examples;

Pg2, line 13; "*We know what has to be done. Governments are running out of excuses"*

My Comment:
Really? The AMA's "*Compendium of Recommendations*" (Pg 37) contains – on close inspection – an extraordinarily vague list of "Motherhood Statements" and repeated grabs for cash (a bigger "slice of the pie" is the phrase they use, despite Mental Health already receiving about 20% (9.9+4.5+5.4) of health care expenditure (Table 4)). There are no concrete suggestions or detailed plans on how to achieve their wish list. Just a lot of words and phrases such as "*focus*", "*reconsider*", "*empower*", "*undertake*", be "*forward looking*", "*acknowledge*", "*address*", "*widen the focus*", "*strengthen*", "*redress*" etc, etc. Each one of these recommendations could be met with the question **"how, precisely??"** So, do they really "know what has to be done"? Or, do they just know the problems? Problems they have not been able to fix up to this point….I am strongly of the opinion that throwing more money the way of the GPs and shrinks is **not** the answer.

Pg 10, line 26; "*the GP is the key to treatment for most people with mental disorders*"

My Comment:
Says who? They are certainly the first person many people turn to when they can't sleep or are plagued by anxiety. Many people have no one else to turn to. But does this make GPs the "key" to treatment. I don't think so. The poor GP (whom the AMA represents) has no idea of how to help these poor people, other than given them pills and send them to shrinks, who then send them back to GPs (and the cycle continues). Yet (and here is the rub), the incidence of depression and anxiety-based disorders is doubling every 10 years or so. Why? Not because of a lack of money! Alternatives to the GP-shrink model MUST be found. Simply increasing the number of GPs and shrinks (or paying them more) will not solve the problem.

Pg 17, "*Naïve Belief That Community Care would be Cheaper*"

My Comment:
And the AMA stood by while allowing the mentally ill to be thrown into the street to lead lives of utter degradation before ultimately being thrown into jail. Was the AMA also being "naïve"? If not – what were they? The word 'culpable' comes to mind…

Pg 18, line 36; "*..increased administrative officers..*" are to blame.

My Comment:
The favorite whipping boy; administrators. Too many administrators is the (rather tired) claim here, and furthermore, according to the AMA, we have administrators that "do not have a proper understanding". Perhaps the AMA could give the precise factual bases for these claims.

Pg 20, line 32; "*Commonwealth and State governments (put) patients ahead of their turf wars*".

My Comment:
This is an insulting statement.

Pg 26, line 7; "*...psychologists…to work under supervision of private psychiatrists..*".

My Comment:
Why? This is highly insulting to psychologists who correctly see themselves as mental health practitioners *in their own right*. Actually, this is the only reference to psychologists in the whole 47-page document! Now THAT is what I call a turf war! What is wrong with the GP/shrinks working *side-by-side* with psychologists?

Pg 27, line 19; "*The report states, very lamely...*".

My Comment:
There is nothing "lame" about the statement being cited from the *National Mental Health Report* (2004). It is accurate and dispassionate, as it should be. Presumably (and unlike the AMA) this is because it takes an objective stance, free of vested interest.

Pg 33, line 24; "*Our organization was puzzled by the use of the term iatrogenesis in the context of mental health*".

AND

Pg 36, line 10; "*With a lack of adequate evidence concerning the safety of use of modern antidepressant medication in young people and adolescents. These incidents should serve as a warning*"

My Comment:
Yes, indeed. Actually, there are a few warnings here. Yes, there are young people currently committing suicide because they have been incorrectly prescribed antidepressants by psychiatrists mindlessly believing the SSRI dogma. Yes, there are many Australian primary school children being given amphetamines because of PARENTAL failings, with god only knows what long-term effects we are yet to discover! BUT – and here is the real warning – how can this latter statement of "warning" (pg 36) be reconciled with the previous statement regarding puzzlement at the charge of "iatrogenesis" (pg 33). ANSWER; these statements **cannot** be reconciled as they are self-contradictory. The implication of this is that the AMA (and FRANZCP) is being highly disingenuous in claiming a lack of iatrogenesis in their dealings with the mentally ill. Actually, the word "disingenuous" may be way too kind….

Pg 36, line 42; "*...lethargy on the part of politicians...*"

My Comment:
This is insulting to the committee. They should apologize.

Pg 36, line 55; "*...community leaders (should) wake up to their responsibilities...*"

My Comment:
This is also insulting to the committee and others. They should apologize.

Pg 38, line 39; "*Acknowledge the key role of Psychiatrists and General Practitioners in private practice in the provision of services to the mentally ill….*"

My Comment:

Of course – as long as we can also acknowledge their role in allowing the current rates of mental health illness to soar unchecked. They will (predictably) counter this charge with claims of; "not enough money!" - which is a cop-out. Do oncologists or dermatologists or any other specialty keep crying poor? Further, why is money seen as the solution to all problems? The problem lies in the treatment paradigm itself, which I now discuss.

4. The "Medical Model" Revisited

Whenever a person fronts with a psychological disorder to a GP or psychiatrist the (current) medical model is not actually being applied. What is the "medical model"? This is my understanding of it;

> ***Step 1***. *Unrecoverable Disturbance in Homeostatic Processes* (ie. infection that immune system cannot overcome)
>
> ***Step 2***. *Visit doctor and describe symptoms* (fever, etc)
>
> ***Step 3.*** *Interpret symptoms, identify cause and intervene in a manner that reverses the underlying disturbance.* ("You have an infection. Let's give you some antibiotics")
>
> ***Step 4.*** *Allow recovery, educate patient and withdraw treatment.*
> (Bugs killed. Stop antibiotics. "Next time, don't go skinny dipping in the arctic").

Now, can you see where psychiatry fails? It does not fit the 'medical model' because;

- Symptoms are **not** interpreted. They are described in a grandiloquent manner ("repetition compulsion disorder with manic features and histrionic schizotypal features arising from trauma-induced decompensation exacerbated by comorbidity…" yada, yada, yada….). This is meaningless (DSMVI) gobbledygook.
- Surface causes are glossed over. "Oh, your mother died? Take these pills". Moreover, **deeper** causes ("why were you so attached to mummy?") are **never** entertained in a GP or psychiatrist's office. Why? They don't know what to ask or say.
- The treatments **do not** reverse the underlying disturbance. They are masked by chemicals found by drug companies – usually at random – to have the effects of removing symptoms.
- Recovery is **rarely** achieved. The diseases are more often than not deemed chronic and incurable. This has the effect of inviting the patients to become a permanent patient!
- Education with a view to prevention is not carried out in the psychiatrist office and even less so in that of the harried GP. Once again, they are not trained to empower people to take control of their lives in the longer term.

The negative consequences of this flawed approach are not just for the patient. It also impacts on the psychiatric profession itself. How? Read on.

5. Who would want to be a psychiatrist (when other specialties actually make a difference)?

Look, medical students doing their hospital placements, and graduates doing their hospital residencies see at first hand how psychiatry works. They are not stupid. They can see that the DSMIV is a semantic labyrinth that is actually "systematized delusion". They can see that patients are placed – if not in physical straight jackets – then restrained with chemical ones. They also know that talk is just as good as pills and that therefore talk is the more dignified option. In short, I suspect that the average medical graduate does not think that psychiatry is a morally defensible approach that maintains the dignity of the patient before them. This is why their numbers are falling. It is not – as the AMA and college would have you believe – because they are not paid

enough! Leaving aside the issue of how much they are actually being paid (I wonder if they'll tell you?), is the AMA saying that greed is the most important motivation in entering a given specialty? No – it is how attractive the specialty is with regards its meaningfulness and authenticity with regards helping people. I suspect therefore that the specialty of psychiatry will collapse under the weight of its own lack of authenticity and disappear within the next 30-50 years. This raises an important question.

6. What will replace the current psychiatric model?

Ideally (and idealistically), we would seek to lessen the burden of mental illness by constructing for people life styles that are *sensible* and that meet their physical **and** ('spiritual') *inner needs*. However, I don't think that the Senate Committee is likely to recommend that we dissemble society, stop chasing dollars, abandon instant gratification and return to small tribal groups at harmony with fellow members and the environment, etc, etc. Not likely! In addition, no one dares talk about spiritual needs, even in its most generic sense! Consequently, are we in a position to ditch pills? No - not yet. Nevertheless, we must move in a direction that both recognizes the mad world we currently live in and encourages individuals to seek meaningful solutions to psychic pain through understanding and self-knowledge. In this manner, we might then allow personal growth while minimizing the use of pills, particularly in a chronic manner. Simple eh? No. And (despite what my pretentious writing style might suggest) I don't have ALL the answers! I do however, have one final suggestion.

7. A new way?

Set up a completely new paradigm for the treatment of so called mental illness. There are just too many competing ideologies at the moment. This is understandable given that mental illness and its treatment is a relatively new academic construct. Organic brain diseases such as dementia, mental retardation and schizophrenia will probably always remain within the province of the medical profession. Psychosis is in a bit of grey area. However, for states such as depression, anxiety, eating disorders, borderline personality disorders and addictions, the "patient" should be placed in the **primary** care of a psychologist or (better still) a psychoanalyst. A consultant psychiatrist would also be assigned to act in a **liaison** capacity only.

Now, of course, this suggestion will be howled down by the AMA and college. I strongly put to you however, that at the very least, a **trial** of this approach should be carried out under the auspices of a recognized and respected (and thoroughly independent) University research group. As long as the study is conducted in an ethical manner with appropriate patient safeguards, then what do we have to lose? Not much – and in fact, we might find a better way than drugs and a chat to treat what I see as the problems associated with the current pathologizing of existential pains and crises.

8. A final word

I've wasted enough of your time. However, I can't help finishing without a plea. This is a plea that arises from the fear that after all the submissions, after all the interviews you conduct, after a report is prepared and presented to the government, it will be shelved with nothing actually done to change matters. I earnestly hope that this is not the case. If for no one else's sake than for the children that will be part of the 50% increase in neuropsychiatric disturbances that is predicted to occur in this cohort over the next 15 years (AMA submission, pg 31). The current psychiatric model is designed to pick up the pieces when it is way too late. Early intervention is **desperately** needed as well as better approaches to detection of behavioral disturbances in pre-school and primary school children. Even this stage might be too late, and behavioral problems in the young are very hard to detect. Actually, I think most of the experts that will come before you will attest to the fact that most emotional disturbances are probably hard-wired in the first year or two of life. This suggests that **parenting** and the **early childhood environment** should be the REAL focus of your committee. However, I very much that that this is a can of worms that no one is ready to open.

Regards and good luck in your deliberations.

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