Introduction

"THEY" ARE "US"

Almost thirty years ago, a patient on the psychiatry inpatient unit where I had just started working approached me as if we were lifelong friends. He was tall, skinny, unshaven, dressed in threadbare jeans and a pale blue hospital pajama shirt. His hair was long and matted, and it was clearly some time since he had bathed. I assumed my best psychiatrist manner – unthreatening, warm but not familiar, and firm – and prepared to tell him that I was not actually his doctor, that we had never met, and that my colleague Dr. Buckingham would be looking after him.

He started speaking before I could deliver my blurb.

"David Goldbloom! I heard you had gone to medical school. How amazing to see you here. Do you remember me?"

There was something about the man's deep, slow voice, with an Ottawa valley drawl, that was familiar. But I couldn't recognize or place him.

"It's Andrew. Andrew Balkos. We played squash together at university."

His voice, height, and smile coalesced immediately into an older, gaunt phantom of the muscular twenty-something squash player who had won a healthy number of games off me during round-robins in university. We had been part of a group of young men who played sports and socialized before we all headed off to further education or our first serious jobs. We were a confident bunch in those days, encouraged by our education, our youth, and our health to think we would attain whatever life goals we set ourselves. I hadn't known him particularly well, but I now recalled that he had dropped out of school – no one said why – and that I was short a squash partner as a result.

Usually when I run into old school friends, we discuss work, family, travel. Andrew told me that he had been admitted from the emergency room the previous night. He explained that he had been struggling with mental illness for years, and this was not the first time he had been hospitalized.

I made the right noises about Dr. Buckingham being a good psychiatrist and about the treatments available in the hospital, but my brain was in overdrive. It was hard to reconcile this emaciated, unkempt individual who looked easily fifteen years older than me with the virile young man with whom I had competed for corner drop shots ten years earlier.

It was clear from our discussion that whatever psychiatric disorder Andrew was suffering from had completely changed his life course. He told me that he was estranged from his family and had never married. He had dropped out of school and done odd jobs, but within a few years he started to experience the paranoia and hallucinations that continued to haunt him, despite his intermittent efforts to quiet them with medication and talk therapy. Currently he was living in a rooming house a few blocks away, surviving on public assistance. His only social contact was with the other inhabitants of the rooming house and a social worker assigned to him after his most recent hospitalization.

I told him how sorry I was to hear about his illness and wished him well in his treatment. I couldn't think of what else to say. What I

didn't tell him was how sorry I was that a decade earlier I had not been attuned to whatever struggle he was having, that I was oblivious. Back then, I knew nothing about mental illness.

Andrew told me that knowing I worked in the hospital as a psychiatrist would help him to trust Dr. Buckingham and his recommendations for treatment, something that had been difficult for him during past hospitalizations. I didn't comment at the time but have wondered in retrospect why our meeting – our first in more than ten years – had this impact on him. I know that he stayed until Dr. Buckingham thought he was ready for discharge and accepted both medication and referrals for outpatient therapy.

My hypothesis, looking back, is that his knowledge of me as a person rather than simply as a psychiatrist helped him to trust me and to think differently about psychiatrists in general, including Dr. Buckingham. I also believe the fact that I had known him before his illness made a difference. I hadn't known him well, just in the way young men know each other when they share similar backgrounds, goals, and an enjoyment of sports. We had been equals once in terms of our potential, and he knew that to me he was more than just a patient with a psychiatric disorder. I wonder if his experience of knowing and being known by me in a way not limited to his illness spread to his relationships with his doctor, nurses, and social worker, allowing him to trust.

Andrew left the hospital two weeks later, and I have neither seen nor heard from him since. But that brief encounter at the beginning of my clinical career would be an enduring reminder that "they" are "us."

WHEN I BEGAN A career in psychiatry in 1982, five years after Andrew and I had played squash together, I was naïve about what my choice would mean. I didn't realize then that I was entering the most misunderstood – and mistrusted – specialty in medicine. Coming from a family of physicians and inspired by my father-in-law, who was a psychiatrist, I assumed that everyone saw psychiatry the way I did: as the

branch of medicine that offered its most complex diagnoses, its most profound relationships with patients, and its most dazzling frontiers for scientific discovery. Given my youth and relative inexperience, it was arguably a natural mistake.

My early passion for psychiatry has not changed over the intervening decades, even if my view and understanding of it has: psychiatry remains for me medicine's most intellectually challenging, eclectic, and diverse specialty. It is also the most open to considering different theories of illness, examining explanatory models that bring together the contributions of biology, psychology, culture, and society into a coherent whole. I tell my residents that all their prior education – whether in the sciences, social sciences, or humanities – will be relevant to their work in psychiatry, and that they will need to read voraciously in all those disciplines to keep up in a field where knowledge is constantly expanding and intellectual paradigms evolving.

More selfishly, as a natural extrovert who is incurably curious, I revel in the opportunity that psychiatry gives me to meet new people almost every day of my working life, to hear their stories, and to try to help them. I also love the variety inherent in my work: seeing patients with a range of psychiatric disorders in different settings, teaching students, working with colleagues from various disciplines, participating in research, and speaking publicly about mental illness and its treatment. I am too restless and easily bored to do the same thing every day.

But thirty years later, my naïveté in believing that my passion for psychiatry would be shared uniformly by others is long gone. I now recognize that powerful forces (both inside and outside my specialty) dog public perceptions of psychiatry and psychiatrists, and converge to create an environment of mistrust and skepticism regarding our potential to help people struggling with mental illness.

Some of the damage to public trust, of course, has been perpetrated by psychiatrists themselves. It would be disingenuous not to acknowledge the role that psychiatry's own history – its fads, therapeutic dead ends, and ethical breaches and abuses – has played in creating its

persistently negative image, amplified by the popular culture of movies and television where both patients and psychiatrists are either mocked or vilified. It is also unarguable that modern psychiatry's close relationship with the pharmaceutical industry – a partnership that some characterize as a pact with the devil – has done great harm to the perceived integrity of the research that lends our treatments credibility. No psychiatrist I know wants to return to the era before the 1950s, when there were no effective medications for anxiety, depression, psychosis, and mania; it would be like being nostalgic for the pre-antibiotic era of infections. But as good as the current medications are, they are still not good enough. We need to find new paths for drug development and clinical evaluation where the legitimacy of the results is not compromised by conflict of interest. At the same time, we need more research on the effectiveness of nondrug interventions – psychotherapy, of course, but also interventions relating to housing, employment, income support, and social engagement.

Some of society's ambivalence toward psychiatry stems from its historically and legally assigned ability and responsibility to detain individuals in the hospital against their will, and in certain cases to force treatment upon them. It's not a simple equation, however, between those powers and public fear and mistrust because in most jurisdictions, including my own, the Canadian province of Ontario, all doctors – not only psychiatrists – have those powers, at least for certain periods of time and under certain carefully and legally prescribed circumstances. It fascinates me that a family physician, an obstetrician, or a surgeon can hold patients for up to seventy-two hours in a hospital to allow for psychiatric assessment and decide that a patient is not able to make treatment decisions for himself or herself without prompting any of the public debate or protest that psychiatrists exerting the same powers evoke.

I think that superimposed on people's philosophical concerns over depriving someone of fundamental civil liberties is the fear of the kind of illness that at times warrants some such action. There is no greater

threat to our sense of personal integrity and identity than mental illness. If you break your leg, you're still you. If your brain is broken, are you still you?

Psychiatrists can't win on this one. Some critics argue that psychiatrists don't use their power to detain and treat patients often enough, allowing acutely ill patients to fall through the cracks by waiting until their disorders bring them to the brink of disaster or beyond. Others argue that psychiatrists are simply agents of social control, treating nonconformity and alternative ways of being as illnesses requiring forceful intervention.

Most societies have a long tradition of isolating, shunning, and victimizing people with mental illness. Although this has improved substantially in the last century, it is still acceptable to lampoon them in popular culture, in ways that would no longer be politically correct for any other form of disability.

Even within the health-care community, I have been exposed to far too many professionals who regard psychiatric patients, and to a lesser extent those of us who work in the mental health field, with suspicion and even contempt. And my personal experience is sadly reinforced by studies that report health-care professionals, and even some mental health professionals, hold biased and negative perceptions of psychiatric patients.[1]

The most sweeping and potentially powerful force undermining the public's trust in psychiatry derives from the accumulation of misinformation, myths, bias, and stigma about psychiatric disorders and the people who suffer from them (not to mention the people who treat them) propagated by mainstream media. It is easy to recall a negative portrayal of a psychiatric patient or a psychiatrist from film or television (*One Flew Over the Cuckoo's Nest* being the defining image for many generations) but harder to pull out a memory of a positive one. And the positive ones have their own issues. Patients' symptoms are frequently romanticized and minimized in order to elicit the audience's sympathy. The mental health professionals who are viewed with

relative approval are most often nonmedical psychotherapists (in contrast to pill-pushing or sinister psychiatrists), or if they are psychiatrists, they demonstrate their caring for patients by crossing long-established professional boundaries.

The popular media's emphasis on recent razzle-dazzle neuroscience advances in brain imaging and genetics has been a double-edged sword. It reflects the excitement of discovery, but at the expense of spotlighting more mundane interventions that currently have far greater potential for significant and immediate impact on the quality of life and prospects of people with mental illness: housing, employment, social network, and the right level of clinical care available when needed.

The most dangerous consequence of all these forces – those that serve to stigmatize individuals suffering from psychiatric disorders and the health professionals who look after them, and which characterize psychiatric disorders as not real diseases, and psychiatry therefore as not real medicine – is that many people who are suffering are too frightened to see a psychiatrist and to try psychiatric treatments. They are more scared of taking medication, entering psychotherapy, or considering a hospital admission than they are of their own symptoms: the suicidal thoughts, the voices in their heads telling them they are being followed and spied upon, or the fear that the recurrent cardiac palpitations and shortness of breath represent a heart attack rather than a panic attack. By the time they are referred to a psychiatrist, patients may have seen doctors or health-care practitioners who have told them that their struggles are beyond conventional medicine's ability to help them. Or they have been told by relatives and friends, similarly wary, that a psychiatrist is simply a pill pusher, and that they should lean on friends, go to church, go for a run, volunteer – anything other than see a specialist doctor with knowledge of psychiatric disorders.

It is the admittedly ambitious goal of this book to combat this fear and to reassure patients and their families that if they need to see a psychiatrist and pursue treatment, they will be met by a doctor

who has had years of training and supervision; who has been taught to take care of his or her own well-being, and to be aware of professional and personal biases and judgments in order not to inflict these, even inadvertently, on patients. Psychiatrists trained today are taught not only about psychiatry's historical abuses of patients with the goal that they will not be blind to the risks that can characterize patients' and psychiatrists' desperate search for better treatments, but also about the conflicts of interests that have marred and continue to exist within psychiatric research.

This book is not meant to whitewash or oversimplify the state of contemporary psychiatry, which deals with difficult and sometimes frightening disorders and faces problems that need to be confronted. It is meant to provide an honest, informed, and ultimately personal account of both psychiatric disorders and the problems psychiatrists encounter in trying to help sufferers, while also describing the specialty's numerous successes and strengths. In doing so, we hope it will provide prospective patients, their families and friends, and the health professionals who refer them to us with the opportunity to know who psychiatrists are, how we are trained, how we practice, how we cope with the tragedies and horror that are part of all physicians' work, as well as the nature of the scientific evidence that supports our diagnoses and treatment recommendations.

I have been extraordinarily lucky to have as my coauthor Dr. Pier Bryden. We met twenty years ago when Pier was a second-year psychiatry resident and I was a staff psychiatrist providing her with occasional supervision during her training. In the course of writing this book together, Pier and I returned over and over to the centrality of different types of trust: between patient and physician, between psychiatry and society, between researchers and their subjects, and between us and our readers. We agreed that to build trust with our readers, it would be important for me to acknowledge my own biases and judgments about psychiatry, given our shared perception that the traditional image of the therapist/psychiatrist as omniscient but

neutral has not served our profession well, portraying us as uncaring, arrogant, and at some level inhuman.

I am, as you will read, anything but neutral in my professional and personal lives. I am intermittently insensitive, arrogant, impatient, and an incorrigible performer and teller of tasteless jokes. As you will see, I am very much part of my family in my professional inclinations and behavior. But I hope as a result of what was – at least to my family and friends – an unpredictable career choice that I am a better person, physician, and teacher than I otherwise would have been. It is a choice that has not only satisfied my natural extroversion and curiosity about people but also compelled me to understand better the experiences of individuals suffering from psychiatric disorders and their families. It has also helped me understand myself better, despite my default style of nonreflection. And it has humbled me, forcing me to recognize the limitations of what I am likely to achieve, and what psychiatry as a specialty can achieve, during my professional lifetime.

Over the course of writing this book, events in my own life occurred that changed my thinking about psychiatry and the rest of medicine – and changed me. After much thought and discussion, Pier and I decided to include those events to emphasize the intersection between the lives of psychiatrists and their patients. Introspection on the part of psychiatrists keeps us honest and helps us build trust with our patients. More than any other aspect of the doctor-patient relationship, trust is essential if patients are to ask for and accept our help.

In our effort to make our profession better understood, Pier and I bring you to the front lines of modern psychiatry – the inside of the psychiatric hospital where I work, the largest in Canada: its emergency room, Acute Care Unit (ACU), inpatient units, electroconvulsive therapy suite, and outpatient offices. We introduce you to the nurses, social workers, and other frontline staff, psychiatry residents (qualified medical doctors undergoing an additional five years of training in order to obtain specialist standing in psychiatry), and administrative staff with

whom I work daily to provide care for the more than thirty thousand patients who are seen in my hospital each year.

We address some of psychiatry's most ignominious past practices but balance these with stories of its heroes: men and women who have worked persistently, creatively, and ethically to push forward psychiatry's scientific research, as well as humane and imaginative treatment innovations that have improved the quality of life for patients. Their stories are part of psychiatry's legacy.

We juxtapose some of psychiatry's most exciting neuroscience with less futuristic innovations that have more immediate practical applications: telepsychiatry, housing programs, and evidence-based psychotherapies.

Most important, you will meet my patients. (In our Authors' Note, we describe the patients in this book: some are real and identified with permission, and others are drawn fictitiously from our many years of practice.) Here, they often appear at times when it was my job to persuade them to accept help but when the barriers to their doing so seemed insurmountable. Why would a middle-aged man hearing voices telling him that he is under surveillance by a militant religious group choose to confide his madness to a stranger, albeit one with a medical degree? Why would a woman struggling to care for a baby from the depths of postpartum depression agree to put a pill in her mouth every day despite her fears of poisoning her breast milk? Why would a physician wrestling with an addiction who knows he could lose his license to practice trust a psychiatrist enough to disclose the truth? What allows a fifteen-year-old Indigenous woman who has been sexually assaulted by a family member to tell a doctor what she cannot even tell her parents? Why would any of them ask for help? The answer? These individuals are suffering, and the right psychiatric care can provide understanding, trust, support, and hope.

I have thought of my meeting with Andrew several times in the intervening thirty years. Psychiatry cannot yet answer the essential question of why our lives took such different directions: why I get to

work in a job I love, have a family that supports me, and the physical and mental health to support my activities, while my university squash partner was robbed by psychiatric illness of all those things. As psychiatrists, we have the capacity – and the obligation – to do a better job of explaining our current profession, our understanding of psychiatric disorders, and our treatments; of acknowledging our specialty's past abuses and current mistakes; and of sharing our passion and hope with our patients, their friends and families, public policy makers, potential funders, and the media. It is only by fulfilling that obligation that we will replace fear and suspicion with trust and encourage individuals suffering from psychiatric disorders to seek our help.

This book is our contribution to that process.

Welcome to a week of my life on the front lines of medicine's most misunderstood specialty.