

## **RESPONSE TO WONG, WYATT AND MIDKIFF**

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Upon reading the abstracts for the articles by Drs. Wong, Wyatt and Midkiff, I thought here we go again—two more articles that attack the pharmaceutical industry and challenge current conceptualizations and classifications of mental illness. In my mind these issues were settled long ago and no longer needed to be debated. As a social worker who has provided mental health services to clients with various disorders I have routinely used the DSM extensively as part of the assessment process and I have frequently referred clients for medications as a crucial means to alleviate the painful and debilitating symptoms that can accompany mental illness. However, these two articles succeeded in challenging me to review these issues once again from a more critical perspective.

Drs. Wong, Wyatt, and Midkiff make several interesting assertions about the pharmaceutical industry and biological psychiatry and illustrate well the symbiotic relationship between these two powerful entities. Indeed both drug makers and psychiatrists have much to gain financially and professionally by promoting the belief that chemical imbalances and other biological dynamics are the cause of mental illness. However, just because they may have a self-promoting interest does not mean that there is not validity to their claims. It does, though, encourage greater scrutiny of the research upon which the claims are based. Drs. Wyatt and Midkiff draw attention to this scrutiny when they describe the Mind Freedom challenge to psychiatry and succeed in exposing the lack of extensive empirical evidence to support the biological basis of mental illness. The formal response by the American Psychiatric Association is indeed unsatisfying and makes me question why I have so readily accepted the causal claims. Is it because that is how I was trained? Or because I have seen the beneficial effects of medication for many people with mental illness? Or because I accept the notion that since medication helps physical illness it likewise must be able to help mental illness?

The general public appears to have likewise accepted the notion that chemical imbalances are at the heart of mental illness. This is perhaps partly in response to drug makers' direct marketing of medications to the public by means of the ubiquitous television and print advertisements touting the benefits of certain drugs to reduce social phobia, depression, and almost everything else that ails us. Bombarded with these messages, people with mental health problems increasingly seek medication as the treatment of choice and appear satisfied with symptom reduction. This may represent an important shift in the way people understand treatment for mental illness: symptom reduction is sufficient. In the fast-paced world of today many patients want a quick fix and do not necessarily want to dedicate the time, energy, and resources to address the possible cognitive, behavioral, interpersonal, and environmental factors that may be contributing to and maintaining their depression, anxiety, etc. Nowhere is this more

readily apparent than with children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). By large margins parents seem to prefer a prescription of Ritalin rather than parenting skills training and behavioral techniques to assist their child. This biochemical focus tends to isolate the problem as a medical issue, fails to address whatever intrapersonal and interpersonal factors may be associated with the ADHD, and disempowers patients and their families in their own efforts to effect change. Drs. Wyatt and Midkiff are right when they suggest that patients feel less responsible and are being shortchanged by the biochemical approach.

Biological psychiatry and the reliance on pharmacological treatments also pose risks to patients in ways that psychotherapeutic approaches do not. All medications have side effects. Dr. Wong documents some of the most striking side effects including extrapyramidal symptoms and the more serious neuroleptic malignant syndrome. But there other significant side effects and unintended consequences of psychotropics. The heightened risk of suicide among adolescents on certain selective serotonin reuptake inhibitor (SSRI) medications is a good example. Many are documented and the most dire may be reflected in “black box warnings” on the medication or in the extensive drug information that may accompany a prescription when it comes from the manufacturer. Of course, since most patients receive prescriptions from the pharmacy and do not have access to the original documentation, they are often simply provided with a summary sheet of the most dangerous potential side effects. This summary sheet is typically stapled to the prescription bag and discarded when the patient gets home—often without having been read. Obviously this raises concerns about how well informed patients are before agreeing to take these powerful drugs.

In the discussion of drug efficacy studies and adverse events, the authors point to the drug manufacturers’ selective presentation of negative outcomes, and they suggest that drug companies exert undue influence at the Food and Drug Administration (FDA). Could this be changing? In May 2005 the National Institute of Mental Health (NIMH) issued a research program announcement soliciting research studies to identify and explore “adverse effects of psychopharmacological medications across the lifespan.” This announcement entitled, “Treatment-Emergent Adverse Effects of Psychotropic Medication” (PA-05-104), seeks research studies to address issues such as side effect burden, the consequences of treatment cessation and non-adherence, etc., but also seeks to identify interventions to prevent and/or mitigate any adverse effects. It appears that while NIMH affirms the usefulness of psychotropic medications, it likewise acknowledges that there may be some negative consequences, and is committed to finding ways to address these negative features in the long term. This may be a positive or negative development—depending on one’s perspective.

How does all of this fit into the evidence-based practice movement within health and mental health services? How do we genuinely know that an intervention is effective? The American Psychological Association—the other APA with a vested interest in this controversy—has a collection of interventions that it endorses as empirically validated based on a set of criteria (APA, 2002). In these criteria the APA makes an important distinction between efficacy as demonstrated in randomized clinical trials and actual

utility in clinical practice. Even more interesting is the fact that the APA clearly states that its evidence-based practice efforts are only concerned with health service based interventions and specifically excludes “organizational, community, or educational applications...” (APA, 2005, p. 4). They also note that just because an intervention may be empirically supported there are many other factors such as the quality of the patient-provider relationship, the provider’s individual competence, issues of diversity, etc. that can affect clinical outcomes and the usefulness of validated treatments. Interestingly, it appears that many of the criticisms that are lodged against the medication efficacy studies apply to non-medication interventions as well.

So where do we go from here? How do we craft a more comprehensive and multi-causal understanding of assessment and treatment? Instead of approaching mental illness from a fundamentally biological or even from a purely psychological perspective, helping professionals need to recognize that humans are complex and that numerous influences including biological, cognitive, behavioral, and social factors affect a person’s mental health and functioning. In order to be truly effective in helping clients, assessment and intervention must consider the person not only as an individual but as an individual functioning within a specific social and environmental context.

A good example of the need for this multi-level approach is the case of a former client who came for treatment of panic disorder. This middle aged woman had suffered with panic attacks and other anxiety for several years. Upon seeking help, she was prescribed medication (an SSRI and a benzodiazepine) and was referred to cognitive-behavioral group therapy. She took the medication as prescribed and participated actively in the group. Within a very short period of time she reported significant reduction of her anxiety symptoms. However some generalized anxiety continued, particularly when she was at home. In discussing this persistent anxiety she noted that she lived in a “dangerous neighborhood” and that she was often anxious at home because of the drug dealing and violence in the street outside her windows. Neither medication nor cognitive behavioral group therapy alone or in combination would remedy this situation. Instead, a community-focused intervention—one that understood the woman within her environmental context—was required. After some consideration of options and prompting, the client became involved with other neighbors and they created a neighborhood watch group in conjunction with the local police. The threats on the street greatly decreased and the woman felt more at peace at home. Treatment was finally successful.

Drs. Wong, Wyatt and Midkiff raise many significant questions about how mental illness is currently understood and treated in the United States. There are many forces and interest groups that profess to know what is best. Clearly vast sums of money and professional territorial dominance are at stake. Sadly, our patients have the most to lose.

## REFERENCES

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