

Controlling Other Humans

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One of many peculiar things about being a psychiatrist is that we're often asked to bring another person's problem behaviors under control. The list of these unwanted behaviors can seem endless and it's very rarely the person exhibiting the impulse problems that's asking for help in controlling them. We'd love to see research aimed at discovering the percentage of psychiatric patients who, at the heart of it, have been brought to the office or hospital because of problems with behavioral control. The results would likely be stunning.

Dennis the Menace: By H. Ketcham



"Don't blame me! It's YOUR job to make me behave!"

Sometimes the unwanted behaviors are aggressive in nature, as when a nursing home patient starts hitting the other residents. The problem behaviors can be sexual, like the group home resident who masturbates openly or makes crude sexual advances towards staff members. Compulsive behaviors like repetitive hand washing or hoarding a house full of useless junk may be brought to us for correction. Drug and alcohol abuse are frequent target behaviors that we are asked to somehow impact.

People seen in State Hospital systems have generally, by definition, shown some potential for dangerousness towards self or others. There are the manics who can't stop talking or spending or sexing. The schizophrenics banging themselves on the head to make the voices stop. The self-mutilators. The screamers. The fire setters. The biters. The

wanderers. The stealers. And that most common and overlapping of all the patient groups - the people who just won't take their medications as we tell them to. All manner of problematic behaviors are cause for psychiatric attention, and the implicit demand is always "make him stop it!"

This sets up a strange situation for the psychiatrist. The patients who are engaging in the problem behaviors may not see them as a problem at all. They may minimize the problems or even deny that they exist. Others may be blamed for overreacting. Or the patient may acknowledge having a behavioral problem but insist that they have no control over the behavior whatsoever. So the person that we are, in theory, to be allied with in correcting the problem behavior may have no interest in our assistance. More frequently they may resent our offers of help and directly oppose any attempt to make them change.

Nobody ever told us it would be like this

Most of us entering the field of psychiatry are quite unprepared for this insistence that we bring other people's behaviors under control. Motivations may differ but the majority of people entering the mental health field would say that they do this work to help relieve human suffering or to help people to have better lives. If, when interviewing for a residency position in psychiatry, we inform the interviewer that we want to become a psychiatrist in order to have as much power and control over the lives of other people as possible the results may be unsatisfactory.

Compounding matters is the fact that very few of us are ever given any specific training about how to control other people. The subject just doesn't come up in our education as psychiatrists (if there was a single lecture devoted to this topic during a comprehensive four year residency program it escapes recollection). Instead we're taught to view the person's problem behaviors as a symptom of an underlying illness such as mania or psychosis, then try to treat that illness. Increasingly these treatments involve rearranging the person's brain chemistry. Since we only have fifteen minutes or less with the patient there it is often little time to do much else. When our "chemical imbalance" corrections are unsuccessful we may conclude that the person has a "character disorder", is an "Axis II patient" or "has antisocial tendencies".

Making matters worse is the universal tendency to assume that the individual's problem behaviors are directly related to the skill and competency of the psychiatrist who is charged with controlling them. We shrink are well aware that we always develop reputations and even labels in our communities. We may be caricatured as weak or ineffective psychiatrists, pill-pushers, good listeners, or clever strategists and much of this is determined by the sorts of things our patients do after they visit with us. How our patients behave is closely related to the professional reputations that we develop, whether we like it or not.

This whole business of influencing other peoples' conduct can get pretty frustrating. Many of us throw up our hands in desperation, asking "how can they expect me to control this guy in a few minutes when I can't even make myself exercise regularly". It doesn't seem fair and it probably isn't.

Do we really have to do this?

Most of us psychiatrists are pretty liberal at heart. We like to think of ourselves as people who respect the rights of others and would never dream of trying to control them. The fact that setting oneself up as someone who removes or reduces symptoms is - in itself - pretty controlling underneath it all usually escapes our awareness. Helping other people may be the highest level of controlling others but it's still control. One only has to think of how he or she feels in the dentist's chair to be reminded of the connection between being helped and feeling powerless.

So when patients are brought to a psychiatrist with the hope that some behavior or another will be brought under control a number of responses and emotions might arise in us. But our knee-jerk reaction is usually to reach for our prescription pads.

Think of all of the medications that are now used in attempts to bring just aggressive behaviors under control. Antipsychotic medications are a mainstay. Mood stabilizing drugs including, lithium, Depakote, and a variety of new antiseizure medications are commonly employed. Stimulants like Ritalin and amphetamines receive lots of play, especially among the young. Antidepressants such as Prozac and its chemical cousins, minor tranquilizers like Valium and Ativan, and even blood pressure drugs like Inderal are tried sometimes. It's hard to think of a psychiatric medication that isn't used in our attempts to bring pesky behaviors under control.

When one drug doesn't work we simply add another. A popular drug combination for aggressive patients these days is the "B 52": Haldol, Benadryl, and Ativan all injected at the same time, from the same syringe. Some of us have even received phone calls requesting permission to use this knock-down combination on patients before they've even reached the hospital.

Clearly, if we give any person enough sedatives their aggressive behaviors - or all behaviors for that matter - will cease. They will eventually become so sleepy or confused or incapable of purposeful activity that nasty behaviors will go away for a little while. But when does "correcting a chemical imbalance" cross the line into "chemical restraint"?

An astounding reduction in the use of physical restraints

Our field has made some progress in the field of behavioral control. We rarely use the tools of our past - leather restraints, straight jackets, or corporal punishment - anymore.

An amazing development took place a couple of years ago. The federal government agency that sets the rules for hospital reimbursements mandated that any time a patient is put into a seclusion room or subjected to physical restraints they have to be assessed, face to face, by a psychiatrist within one hour. The subsequent drop in the use of seclusion and restraints nationwide has been astounding. Patients who previously could not be managed without being tied down in restraint beds or locked up in rooms by themselves were somehow manageable now without those strategies. Simply requiring a psychiatrist to drive in to the hospital rather than just calling in a telephone order for seclusion or physical restraints has apparently produced unimagined therapeutic benefits for these problem patients.

So tying patients up or putting them into locked rooms are no longer in vogue. Many times people just don't behave nicely when we try to drug their problems away. Even when the drugs do work it often takes weeks for their effects to really kick in so we have to think of something to do in the meantime. And we can rarely convince these people to take the drugs outside of expensive hospital settings anyway. What other options do we have?

Should we use honey or find a big stick?

Psychiatrists and other mental health professionals often turn next to a crude form of behaviorism. Since we can't directly punish people anymore we do the next best thing. We find something that the patient likes or values, then take it away if behaviors don't improve. "If you don't stop threatening people you will not have the freedom to leave the hospital". "If you don't attend three chemical dependency groups per week you won't be granted a weekend pass home". Or "if you have one more positive urine test for marijuana you will lose your subsidized apartment and have to live in a shelter". The varieties on the theme are endless. This is one area where mental health professionals can really use their creativity.

In most cases the professionals are just doing the best that they can to help a person bring his behaviors within acceptable societal standards. But anyone who has taken some introductory psychology courses will recall that this "negative reinforcement" approach is ultimately doomed to fail. Negative reinforcement only works as long as the negative reinforcers are present and available. Give a man a cattle prod and he can make another person behave pretty well - but only for as long as he is standing there with the cattle prod.

Sooner or later the individual is left to control his own behaviors. Some are left feeling more angry and rebellious than they were in the beginning. Others don't seem to "learn from experience". Ultimately, we often teach people that it is dangerous for them to want or value things. For as soon as they do somebody might try to attach a hook to it. It's pretty hard to help chronically ill people to move towards recovery until they can find something – anything - outside of themselves that they can love and enjoy. Whenever we

make it unsafe to do that we're decreasing their chance of recovering.

Sometimes the negative consequences that we threaten patients with aren't so "negative" from their perspectives. "If you don't start taking your medications regularly you'll have to go back to the State Hospital" doesn't have much sting if the State Hospital is seen as far better than any other living option that the person has available to them. Putting people on one to one observation to make them stop cutting themselves isn't that bad for people who cannot tolerate being alone. You can't always tell going in what sort of "consequences" other people will actually find rewarding.

Obviously, we need to come up with some better strategies if we are really going to have a long term impact on peoples' problem behaviors. One good place to start might be by examining the nature of our relationships with our patients.

Who's the boss?

We physicians are accustomed to being in charge. We don't write on a sheet that says "Doctor's Requests". The form says "Doctor's Orders". Staff members that don't follow these written orders can get into trouble or even lose their jobs. This clear "chain of command" is sometimes necessary in organizations, especially military ones. But it can ultimately give the psychiatrist the impression that everyone, including their patients, should follow their orders. We are quite unprepared for the fact that over half of our patients don't even take our medications the way we prescribe them, much less give up their problem behaviors when we tell them to.

A wonderful strategic therapist named Jay Haley tells the story of an idealistic young psychiatrist who was put in charge of a ward for people with schizophrenia. The Doctor quickly noticed that most of his new patients were either lying on bed or sitting in the smoking room all day so he decided to remedy the situation. He mandated that everyone must leave the ward for several hours of fresh air and exercise each day. The results were predictable.

Patients were causing all sorts of problems. Some wandered away. Others walked into traffic. Some lay spread-eagled outside the door. One gentleman simply walked until he reached the nearest tree, then stood with his nose against it as though unable to figure out how to get around it. While the psychiatrist's intentions were good, he didn't realize that these people were just not going to tolerate being in a relationship in which he would tell them what to do and they would obey.

People with severe mental illnesses are among the most difficult humans to "control". Many of them have tons of experience with people that have tried to control them, from parents to a variety of previous professionals. They are often masters at evading control through the use of symptoms that we conceptualize as "unconscious" or "just a part of their illness". And since they may experience the loss of control in relationships as though it were a life or death matter they're often willing to play for much higher stakes than their treaters.

A few simple strategies

In truth, in all but the most tightly regimented situations (like locked, fully staffed hospital wards), the patient himself must decide whether or not they will do what we ask of them. It's often surprising for them to hear their psychiatrist acknowledge that simple fact though. Explaining to patients that they are really in a very powerful position, that they are holding nearly all of the cards and that you are ultimately powerless to control them, can set up a whole new type of relationship. At the very least, acknowledging that you can't control someone makes it hard for them to directly oppose you.

So finding ways to *deny* that one is in control is an important part of controlling people. The exceptions come in situations when the professional must immediately take direct control of a situation, as in the case where a patient is actually hitting someone or engaging in behaviors that are acutely dangerous. In those settings it's often best to take control in a very firm and direct manner. It's amazing how many people will stop whatever they're doing if you simply yell "stop that right now" in a tone that shows that you mean business.

Good therapists learn to look at problem behaviors and ask "what is in it for the patient? ... what happens after the behavior? ...what sorts of hidden rewards may be involved? ...what circumstances trigger the behavior?" Sometimes the secret is to find out what the patient really wants, whether it be attention, a feeling of powerfulness, an escape from a monotonous existence, or whatever. Then the key becomes finding some way for the person to get these things without having to act in "symptomatic" ways. This approach was often presented to students as "*don't get mad - get curious*".

The systematic examination of the circumstances in which problem behaviors occur - and the experiences that the patient has around those behaviors - has been operationalized in a lovely form of therapy called "Dialectical Behavioral Therapy" (DBT). It was developed by Marsha Linehan as a way to help people with Borderline Personality Disorder. "Borderlines", as they are affectionately known in the trade, have given the psychiatric profession fits for decades. They are typically impulsive, have little capacity for tolerating being alone, and frequently engage in dramatic self-destructive behaviors such as wrist cutting or minor overdoses as a way to exert control in their relationships. When psychiatrists treat these people we've usually favored the "Borderline Cocktail"- a mixture usually consisting of one or more members of each of the classes of psychotropic medications - but rarely with satisfying results.

In the DBT approach there is a recognition up front that the therapist cannot control the patient's behavior. When bad behaviors - or the impulses to engage in them - do arise the focus is on understanding their causes and effects. Patients are asked to recall all of the events leading up to the behaviors. How they felt at the time, what they were doing, how their day had gone up 'til then, and so on. Diary cards, journaling, and direct reports to the therapist are all used. The events that happened after the behaviors receive similar

scrutiny. Peers supporting each other in their efforts to gain better self-control is another important component of the therapy.

It's not within the scope of this article to provide all of the details of the treatment approach but it's fair to say that DBT has had a dramatic impact on our mental health systems. For the first time there is a solid, readily available treatment for these women (and the clients generally are women - often women who have been subjected to various forms of abuse). Not only has it changed the way we treat these people - it's changed the way we think about them. The term "Borderline" doesn't have quite the pejorative connotation that it had just a decade ago.

Of course any treatment has more appeal if it fits in with the way that we already see things and this is the case with DBT. The daring few that struggled through the vagaries of "**An emerging model of mental illness**" may recall the presentation of a "dual emotional processor hypothesis". In the framework of that metaphor DBT can be seen as a method of shifting the balance from an "*Amygdala*"- based mode of processing emotions (with its impulsivity, dysphoria, anxiety, and propensity for substance abuse) towards a more "*Hippocampus*"-centered type of emotional processing.

Using tasks that place demands on the "*Hippocampus*" system, such as self-reflection, seeking cause and effect relationships, and considering alternative strategies for responding to painful emotions all serve to strengthen the neural connections in that system. The finding that people who have been sexually abused often have significant shrinking of their hippocampi lends further support to this idea.

Even the most ardent supporters of a DBT approach will tell you that it doesn't work for everybody. Some people won't embrace it. Some people can't use it because of cognitive limitations. A certain amount of capacity for self-reflection and abstract thought makes success in that model much more likely. So we still need other ways to help people gain control of their behavior.

Sometimes it can help to make problem behaviors what we call "ego dystonic". This basically means doing something to change the way a person thinks about his problem - to make his usual way of seeing things uncomfortable for him.

An inpatient who prided himself on threatening, sometimes even striking, the nursing staff was felt to relish the fear that he saw in the eyes of these people who otherwise seemed to be in control of him. Some repeated comments along the line of "where I come from real men don't hit women" and "only cowards pick on people that are weaker than them" eventually seemed to help him to change. It was harder for him to feel strong and powerful when his threats were repeatedly framed as evidence of cowardice and weakness.

Whenever something troubles someone or motivates him to misbehave it can be helpful to get the problem out in the light of day and poke a little fun at it. It turns out that, for a lot of humans, their rebellious nature is one of the things that they secretly like best about

themselves. Acknowledging their difficulty accepting control from others, even genuinely admiring them for it and being able to share a laugh about it, can go a long way to detoxifying and reducing problem behaviors.



"What's the next best medicine?"

Trying to treat people without the use of humor seems inconceivable to some of us. Laughter has all sorts of wonderful physiological effects. If we could put the biochemical effects of a good laugh into pill form we'd have people lined up for blocks to get our medicine. Sharing a laugh with someone also has important effects on our relationships. It's harder to get angry or rebellious with people that we can laugh with. And if the target is ourselves or the mental health profession (and what richer source of material could we possibly hope for?) that ultimately makes it easier for the patient to start to laugh at themselves too, or at least to take their problems a little less seriously.

There are many other ways to gently gain at least some degree of control in a relationship. Asking people to do small, simple things at your request - things that they'd look silly opposing - can be helpful. "Could you sit in that chair please?" "Can you speak a little louder?" Even "How was lunch today"? Any of these little things can help to establish a relationship where the therapist gradually gains some control.

The relationship can be balanced by respectful requests for permission to do the things that we ordinarily do. Some of us will never pick up a pen to write during a session without first asking if it's OK with the patient. After all, it's not that we want to be in a relationship in which we're in charge all of the time. The goal is to be in an equal,

“symmetrical” relationship with the patient. One in which each person has some reasonable degree of control over what happens between them.

The terms of address that we use for our patients are often overlooked, but can readily lead to relationship problems. If we insist on being called “Doctor” but call the patient by their first name that immediately sets up a relationship imbalance. We’re the authority, they are the person who has less control. There’s no better set up for promoting rebelliousness than that. Attending to simple things like this can go a long way towards creating respectful relationships with people and some chance of a meaningful therapeutic alliance.

Some patients who have an adequate ability to reflect on their behaviors and learn about them are surprised to learn that being in an oppositional relationship with an authority figure ultimately decreases, rather than increases, their personal freedom. If they are always defining themselves by the mechanism of “I am that person who is opposed to you” it really doesn’t allow them the room to truly become themselves. Of course many of us shrink are still waiting for the patient who can use that sort of abstract insight. Just because what we say is accurate or true is no guarantee at all that it will be helpful.

Sometimes patients need to be, as we say, “shown the map”. This is a process of giving them an honest appraisal of what their behaviors provide for them, as far as we can tell. They are also told exactly what the behaviors ultimately cost them, whether it be decreased personal freedom, inability to maintain a job or keep an apartment, or the damage to their relationships. It helps a lot if we can truthfully predict the negative consequences that their behaviors will bring to them if they are continued, then point out those very consequences when they occur.

When we psychiatrists try to control the behaviors of our patients we often pay inadequate attention to the words that we use when dealing with them. For example, whenever we have to restrict a person’s liberty rights we owe it to them to explain exactly why we are doing it, for how long, and what will have to happen for things to change. We should be able to use words that fit the situation and are understandable to the patient.



"It's getting much harder for me to distinguish good from evil. All I'm certain about is what's appropriate and what's inappropriate."

Mental health professionals seem to be enamored with the word "inappropriate". In hospitals and throughout our systems of care almost any misbehavior is met with the response "that's inappropriate"- as though this should somehow convince the patient to abandon the behavior. In truth most of us wouldn't change the way we behave simply because someone said it was "inappropriate". Some of us would even increase the offending behavior in response to this judgment.

As Mark Twain once said "morals are for those with a full belly". Powerful, emotion-laden statements like "Stop that right now - we won't tolerate hitting people here" or "this is a hospital - if you don't cut that crap out nobody can relax and get better" will often have a better effect than using fancy terms that seem politically or morally correct to us.

Is matching consequences to misbehaviors really impossible?

Strangely, one of the most difficult things to do in the mental health system is to arrange normal and appropriate consequences for bad behaviors. Police, jails, and the courts are sometimes hard to get on board with this. They may excuse a person's behavior as soon as they learn that a diagnosis of mental illness is present.

The status as "mentally ill" can become an immediate trigger to move the person from the criminal justice system into the mental health system, regardless of the behaviors that brought the patient to the court's attention or whether symptoms of mental illness were involved at all. Sparing a person from the *normal consequences* of bad behavior is rarely in their best interests.

Some clients have even come to see their psychiatric illness as a “get out of jail free card”. One gentleman revealed that whenever he is sent to jail he “just says that he is suicidal until he is sent to the hospital”. It sure seems like a lot of people have caught on to his little trick lately. Workers in jails and prisons are often ill-equipped to deal with mental illness and are only too happy to have these confusing clients transferred into the mental health system at the first opportunity.

In other situations our patients are punished severely for relatively minor crimes that were a product of their illness and languish in prisons for years. At any given time we have far more mentally ill people housed in prisons than in psychiatric hospitals. It seems unreasonable to expect that courts will be able to make good decisions about providing fitting legal consequences for our patients unless mental health professionals are able to offer meaningful input into the process. This is one of many situations that call for clear communication between psychiatrists and outside agencies - and one that we all too often come up short in.

One very promising development in the business of providing consequences for bad behaviors is the growth of "Restorative Justice" programs. In fact, this approach, which is borrowed from Native American cultures, seems ideal for many clients who suffer from mental illness.

In restorative justice models there's an emphasis on having the offender meet with the victims that were harmed by the offence. Many mentally ill people lack the capacity to experience *empathy*. Their malfunctioning brains cannot provide them with reliable information about the emotions and perspectives of other people. Corresponding feelings such as guilt or embarrassment may not be attached to their harmful behaviors. A systematic method of teaching the patient exactly how they affected others approximates some of the empathic functions that are often missing as a result of their illness.

Restorative Justice models also do a better job of matching bad behaviors to meaningful consequences. The usual approach to offences by mentally ill people forces an arbitrary decision by the judge: Either the patient spends time sitting in a jail cell or he is transferred to a psychiatric hospital. From the client's perspective there may not be much difference between these facilities and either place may be experienced as preferable to their usual living situation. Restorative Justice allows for a rich spectrum of "sentences" that are intended to restore a balance between the offender and the victim. Clients may have to provide various forms of restitution for losses incurred by the victim or perform services aimed at making their communities better. Both punishment and education for the offender can be provided in this model.

No discussion of controlling the behaviors of other humans would be complete without mention of the fact that there *are* some professionals out there who are quite adept at this art. But effectively controlling patients requires both knowledge of specific techniques and a willingness to deal openly with the fact that exerting control upon other humans is

not always such a bad thing.

Using advanced techniques

Some therapists dare to use “paradoxical techniques” in their efforts to control people. Giving people “permission to be symptomatic” or even predicting that the person will fail in their efforts to do what you want them to can be very useful.

Sometimes patients have been told things like “I know that you mean to take your medication when you leave the hospital but let’s be realistic. You’ve never been able to make yourself take them regularly before and without someone to nag you every day you won’t be able to do it this time either. You’ll probably have to bounce around from hospital to group home to apartment a few more times before you’ll start to be able to manage your own illness”. Seeing someone stay out of psychiatric hospitals for the first time is gratifying, even if they are doing it to “prove that shrink wrong”.

A woman was driving a nursing staff crazy with her simple refusal to open her eyes. Direct commands to open them failed. She physically resisted when a nurse tried to pry them open. We couldn’t have her bumping into things. Being essentially blind left her vulnerable to abuse from the other patients. Instructing her to keep her eyes closed seemed like the best option. She was told that she obviously was not ready to have them open yet (implying, of course, that she would be at some point in the future) so she should just keep them closed until she did feel ready. The first meeting like this seemed to leave her a bit confused. She could not be oppositional by closing her eyes anymore. The second session was the clincher. Repeated instructions to keep her eyes closed were combined with some soft whispers to the nurses. Nobody could keep their eyes shut in those circumstances.

Similar approaches have worked with mute patients. It’s amazing how difficult it is to remain silent when someone is telling you that you really should stay quiet for now, then goes on to talk about you to a nurse in your presence, saying one inaccurate thing about you after another...

This sort of approach is sometimes caricatured as “reverse psychology” but its really more complicated than that. Just telling people to do the opposite of what you want them to do is rarely enough. People need an understandable context for the command to be symptomatic. It requires that the therapist actually believe what he is saying and actually have the person’s best interests at heart.

“Making symptoms heavy” is another simple technique. We make them heavy by attaching things to them.

A musician was on the verge of abandoning her career because of ringing in her ears.

She'd been to a series of specialists on both coasts and a variety of treatments had been tried, without success. The therapist conceptualized the problem differently. Ringing in the ears wasn't the problem. It was the *focus* on the ringing that was making it impossible for her to function. As he learned more about the woman he understood that she had had a difficult relationship with a controlling father and assumed that this pattern of covert rebellion against authority was part of her lack of response to other treatments.

Good therapists will use whatever their patients bring to the table - even rebelliousness. In this case the solution was to instruct her to focus on the ringing. She was put into a position but she had little choice but to agree to rating the severity of her ear ringing - so that we'd have a baseline to know if another "treatment" would work. Having to focus on her symptoms and rate them every fifteen minutes grew so tiresome, and evoked such feelings of rebellion, that she simply stopped paying attention to the ringing in her ears. She went on to a very successful career as a famous musician.

Some are quick to brand many of these sorts of interventions as "manipulation", as though manipulation is something that must be frowned upon. Others feel that when people come to professionals with various behaviors that they cannot or will not control, we should use whatever strategies that we have available to help them.

The real virtuosos of these sorts of strategies are the "Directive Therapists", especially those that have been influenced by the work of an astounding psychiatrist named Milton Erickson. Erickson has been gone for a couple decades now but his work lives on in The **Milton Erickson Society** that's based in Phoenix. Ericksonian therapists use a variety of techniques to help control people's symptomatic behaviors. Hypnosis, unconscious suggestion, hidden directives, "embedded commands", creating special tasks in which people are required to change - no ethical strategy is off limits to these professionals. They are very open about their goals of changing people's behaviors and don't get too caught up in issues of diagnosing or classifying the person they're working with.

Anyone who is in the position of trying to control the behaviors of other humans would do well to familiarize themselves with Milton Erickson. Unfortunately, there is no way to do justice to the beauty and complexity of his work in a paragraph or two. His worldwide association has a nice website on the Internet (<http://www.erickson-foundation.org/>) and runs regular training sessions and conferences. Local Ericksonian societies are present in many large cities. Strangely enough, though, while Erickson himself was a psychiatrist very few young psychiatrists these days have even heard his name much less become familiar with his work.

Where do we stand on the issue of control ?

Of course to pursue any training in the field of controlling the behaviors of another person, psychiatrists must come to terms with their own conflicted feelings about the matter. Sometimes it's more comfortable to deny that anything that we do is at all

involved with controlling others. After all, we're only there to treat people's "chemical imbalances" right? But an honest look at the ways that our patients, their families, and other mental health professionals react to us - and the things that they expect of us - will certainly reveal that the whole issue of psychiatrists controlling people is a little more complicated than that.

Just as asking people to think about themselves and reflect on their behavior can have all sorts of far reaching effects on their brain functioning, asking psychiatrists to start trying to understand their patients again can lead to ripples throughout the profession.

The psychiatric profession is rapidly approaching a state of crisis. The work that we're asking young psychiatrists to do is becoming less and less rewarding on an intellectual level. Seeing people for fifteen minute visits, making a diagnosis using one of the few that we're comfortable with, and writing another prescription for a medication does not demand the best of us. We're not preparing anywhere near enough psychiatrists to fill the demand in our society and the simplistic approach we take to our patients - essentially seeing them as a collection of neurotransmitters - has a lot to do with this.

We should acknowledge that part of being a psychiatrist involves exerting some control over people. And we need to start training our young psychiatrists about the best ways to accomplish these tasks. To do so will ultimately encourage them to see humans as the infinitely complex and mysterious creatures that we really are.