# Preface

The first question raised by a book titled *Alternatives Beyond Psychiatry* is this: Why do we need alternatives? What is wrong with the "care" that mainstream psychiatry provides? While there are many answers to that question, first and foremost we can look at one startling statistic, and that is the rise in the number of people disabled by "mental illness" over the past 50 years.

The modern drug-based paradigm of psychiatric care dates back to 1954, when chlorpromazine was introduced as the first antipsychotic medication. This, or so psychiatry would like us to believe, kicked off a great leap forward in society's care of the "mentally ill." Psychiatric researchers are said to have made great strides in understanding the biological causes of mental disorders and that has led to the development of ever better drugs for treating them. Yet, here is what all this "progress" has wrought: in the United States, the rate of the "disabled mentally ill" has increased nearly six-fold in the past 50 years, from 3.38 people per 1,000 population in 1955 to 19.69 people per 1,000 population in 2003. Since the introduction of Prozac[1] in 1987—this was the first of the second-generation psychiatric drugs said to be so better than the first—the number of so-called disabled mentally ill in the United States has been increasing at the rate of 150,000 people per year, or 410 people newly disabled by "mental illness" every day.

Other countries that have adopted a drug-based paradigm of care, such as the U.K. and Australia, have also reported a great surge in the number of people disabled by mental disorders in the past 50 years. This interesting fact leads to only one conclusion: mainstream psychiatry's paradigm of care has failed. It has not proven to be an approach that helps people struggling with mental distress of some kind—depression, anxiety, mania, psychosis, etc.—

1 Antidepressant, active ingredient fluoxetine, marketed also as Auscap, Deprax, Eufor, Flexetor, Fluohexal, Fluox, Fluoxebell, Fluoxetine, FXT, Lovan, Movox, Oxactin, Plinzene, Psyquial, Sarafem, Veritina, Zactin, etc.; component of Cymbyax

recover and get on with their lives. Instead, it has proven to be an approach that increases the likelihood that such people will become chronically ill.

We desperately need to think of alternatives to that failed paradigm of care. That is a big challenge, and yet the contributions in this timely and much needed book all ultimately point to a common starting point: if we want to help those struggling with their minds, we can start by thinking of them—as the Quakers did when they rebelled against mainstream psychiatry in the late 1700s and early 1800s—as "brethren." Not as people with "broken brains," but simply as people who are suffering. From that conception, a whole world of "care" follows. What does everyone need to stay well? Shelter, food, friendship, and something meaningful to do with his or her time. Any society that provides such care and support, along with a message of hope—that people can recover from whatever mental distress they may be suffering—makes a good start at providing an effective alternative to psychiatry.

There are chapters in this book that tell of such programs. There are proven alternatives to psychiatry, programs that have a track record of helping people get better. And there are reports of ways of coping with madness on an individual level. This book hopefully will encourage many, many other such efforts to take root and flourish.

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