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THE LEARNER'S VOICE

Reconceptualizing the Role of the Expert: The Unspoken Hierarchy in Mental Healthcare

Ananya Roy[1]

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We sat in a row on a rusted bench outside a grocery store in downtown Austin, the emerging summer heat beginning to cling to my skin, reminding me of my privilege of the refuge of air conditioning after this encounter. The patient was a 19-year-old male experiencing homelessness and navigating a psychotic disorder. The three of us, the therapist, him, and I, a third-year medical student at the time, sat beside the specialty market, exploring his experiences with his mental health symptoms and antipsychotic side effects. He explained how he did not like taking the medications because they made him drowsy, a potentially dangerous reality for a person experiencing homelessness. On the days he did not take his medication, paranoia and suspicions took over. He had just lost his job as a delivery driver. Encounters like these illuminate systemic time constraints and an inundated mental healthcare system psychiatrists face in providing the full scope of psychiatric care beyond an inquiry of side effects, medication effectiveness, and diagnostic criteria, missing nuances in perceptions of recovery. While pursuing psychiatry, I have witnessed how the current fragmented mental healthcare system prevents psychiatrists from effectively supporting young people and families and fully being equitable partners in interdisciplinary community-based care models. Despite the evident benefits of collaborative care, there is a discrepancy between theoretical multidisciplinary collaboration and the reality of its implementation in the clinical setting — or the community where many need it most.

As a student, I was drawn to psychiatry over other medical specialties because it embraces the complexities and nonlinearity of treatment and the ability to employ more fully holistic approaches to individuals' unique paths to recovery. During medical school, I concurrently pursued my master's in public health (MPH) with a focus on first-episode psychosis (FEP) and transition-age youth, informing my perspective on the role of a psychiatrist on the care team. The primary FEP treatment model in the USA has shifted from an isolated psychiatrist to a multidisciplinary community-based team called *Coordinated Specialty Care* (CSC) [1, 2]. This multimodal care model includes intensive case management, medications, and psychosocial functioning, including employment and education services and family and peer support to achieve symptom remission, prevent relapse, and achieve successful psychosocial integration [3]. Psychiatrists have the unique opportunity to address developmentally normative challenges young people face while partnering with non-psychiatric team members. However, despite increasing collaborative models, I have witnessed a continual emphasis on the authority of physicians and prioritization of drug therapies over other treatment modalities and behavioral interventions, reinforcing the traditional biomedical model of mental disorders.

The social privilege of a physician's license or a string of letters behind a last name immediately designates a power imbalance among patients, providers, and treatment team members. When I first sat in on the adolescent peer support group at the Austin State Hospital, I was taunted by the patients after introducing myself as an aspiring psychiatrist. I was effectively the enemy, a representation of the institution, leading me to confront my perceptions of what it meant to be a physician and the label that holds. The patients taught me about the realities of interfacing with a psychiatrist and having their knowledge of the impact of their medications on their symptoms and quality of life neglected when treatment planning. These sentiments were echoed by treatment team members who would relay valid observations on patients' experiences with medications to providers with minimal consideration. In my discussions with team leads or primary clinicians on CSC teams, who are primarily psychologists, they vocalized frustrations that psychiatrists would often

✉ Ananya Roy
ananyaroy@utexas.edu

[1] Dell Medical School, The University of Texas at Austin, Austin, TX, USA

override the observations of other interdisciplinary team members and overlook their academic or experiential expertise despite medication prescribers having less frequent contact and limited interaction with patients in the community setting. Physicians often assumed the de facto leadership position in multidisciplinary treatment team meetings — not necessarily because they wanted to but because it was the culture in community settings for the physicians to have the final say. These remnants of medical paternalism that linger in psychiatric service provision are vestiges of a historic, antiquated system of healthcare that prioritized medication adherence and clinical outcomes over patients' and team members' voices and perspectives on personal recovery. I have a sense of cognitive dissonance in being privy to these outdated practices and reconciling that reality with what initially drew me to psychiatry. I have learned, however, that within this discomfort with the fact that psychiatry is imperfect emerges an opportunistic hope in what psychiatry can become.

As a future clinician, I hope psychiatry can further acknowledge when to step back and elevate the young person's voice as they navigate the challenges of burgeoning adulthood with a disorder that impacts nearly every aspect of their life. It is not uncommon when a diagnosis directly contradicts a person's perception of their illness or experience. In these situations, it becomes vital to elevate the value of lived experience and reframe how psychiatrists, social workers, psychologists, and peer supporter specialists collaborate in providing care. Peer Support Specialists use their own mental health experiences to validate and support individuals with their mental health recovery and are highly valued by individuals with severe mental health diagnoses [4]. As a future clinician, I plan to recognize the limits of my understanding and perspective and partner equitably with peers, support providers, and the rest of the treatment team to promote our young adult patients' overall health and well-being. I am optimistic that psychiatry will continue to evolve, elevating patients' voices, embracing interdisciplinary collaboration, and finding ways to dismantle authoritative power structures. Experiencing a mental illness can evoke fear and shame and a desire to be heard and understood. My hope for myself and my peers is that we listen to what people say and not try to say it for them.

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Declarations

Ethics Approval This research adheres to confidential standards in accordance with the US Health Insurance Portability and Accountability Act and avoids the use of Protected Health Information in patient stories.

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References

1. Anderson KK, Norman R, MacDougall A, Edwards J, Palaniyappan L, Lau C, et al. Effectiveness of early psychosis intervention: comparison of service users and Nonusers in population-based health administrative data. Am J Psychiatry. 2018;175(5):443–52.
2. Read H, Kohrt BA. The history of Coordinated Specialty Care for early intervention in psychosis in the United States: a review of effectiveness, implementation, and fidelity. Community Ment Health J. 2021;58(5):835–46.
3. Malla A, Lal S, Vracotas NC, Goldberg K, Joober R. Early intervention in psychosis: specialized intervention and early case identification. L'Encéphale. 2010;36(Suppl 3):S38–45.
4. Windell D, Norman R, Malla AK. The personal meaning of recovery among individuals treated for a first episode of psychosis. Psychiatr Serv. 2012;63(6):548–53.