When the System Finally Admits It Has No Exit Plan

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A Morning That Stops You

Sometimes you wake up to bad news, and sometimes you wake up to good news. And then there are those mornings when you wake up, pour a strong cup of coffee, and encounter something that arrests you mid-sip, not because it is entirely new, but because it names something you have sensed for a very long time but rarely see stated so directly.

This morning was one of those mornings.

A colleague I respect deeply, someone I would describe as an activist in the best sense of the word, committed to truth, integrity, and not selling out, clinical psychologist Dr. Laura Haynes, PhD, sent me a simple note and asked whether I had seen a particular article. I had not, and as I read through it, I found myself experiencing a mixture of recognition and disbelief, not because the ideas were unfamiliar, but because they were being expressed with a clarity that is often missing from mainstream conversations.

What struck me most was the sense that something long deferred was finally being acknowledged.

How Did I Miss This?

The article, titled ***"Proposed Guidelines Expose Psychiatry's Catastrophic Diagnosing and Drugging Failure,"*** was published by AbleChild, an organization I had been aware of only in passing. That in itself gave me pause. After decades in the field, it is not often that I encounter a body of work that feels both relevant and under-recognized in my own reading.

AbleChild was founded in 2001 by Sheila Matthews and Patricia Weathers, not as clinicians or academics, but as parents responding to what they experienced in their own families. Their children had been drawn into psychiatric diagnosis and medication under circumstances that did not sit well with them, and rather than accept those experiences quietly, they began asking questions that were not easily answered.

Over time, those questions became the foundation of an organization that has consistently challenged prevailing assumptions about diagnosis, prescribing practices, and the role of informed consent. Their work has not been universally welcomed, but that is often the case when a system is asked to examine itself more closely than it is accustomed to doing.

The Question That Changes Everything

What gives their argument its force is not simply criticism, but a reframing of the clinical conversation itself. Much of modern psychiatry has focused on the initiation of treatment, on identifying symptoms, matching them to diagnostic categories, and selecting interventions that are thought to reduce those symptoms. That process, when done carefully, can be helpful.

But it is incomplete.

What AbleChild emphasizes, and what becomes difficult to ignore once it is seen, is that the arc of treatment has too often been defined by its beginning, with far less attention given to its trajectory or its conclusion. The question is not only whether a medication can be started, but whether there is a coherent understanding of how it will be evaluated over time and how it will be brought to an end when appropriate.

That is not a peripheral concern.

It is central to responsible care.

Planes Without Landing Gear

When viewed through that lens, the current moment begins to feel strangely paradoxical. Psychiatry is now developing structured approaches to deprescribing, carefully considered methods for helping patients discontinue medications that they may have been taking for extended periods. There is, unquestionably, value in that effort.

At the same time, it raises an uncomfortable parallel. It is as if we are watching a field work out how to land planes that have already been in the air for years.

Imagine settling into a flight to somewhere you've been looking forward to. The takeoff is smooth, almost reassuring, the ascent confident, everything unfolding exactly as it should. And then, sometime after you've reached cruising altitude, the pilot comes over the intercom, calm and professional:

"Ladies and gentlemen, we need to inform you that, due to earlier design decisions, this aircraft was not equipped with a complete landing system. We are currently working on a solution and will keep you informed as we proceed."

There's a brief silence.

The kind where you're not quite sure whether to laugh… or start doing the math.

Because the flight up was smooth.
The climb was confident.
And the landing… seems to have been reclassified as an in-flight experiment.

The Late Arrival of Exit Plans

AbleChild's proposed "Exit Plan" is notable not for its radicalism but for its simplicity. It calls for ruling out medical causes before diagnosing, for being transparent about what is known and what remains uncertain, for offering non-pharmacological alternatives, and for establishing clear expectations about duration, risks, and follow-up.

In many ways, it reads like a restatement of principles that should already be embedded in good clinical practice. That it needs to be stated so explicitly suggests that those principles have not been consistently applied.

The development of deprescribing guidelines, while important, underscores the same point. It is a response to a need that has existed for a long time, and its emergence now invites reflection on why that need was not more fully anticipated earlier in the evolution of treatment practices.

The System Behind the Practice

Any honest assessment must take into account the environment in which psychiatry is actually practiced. Clinicians are working within systems that prioritize efficiency, often under significant time constraints, and with expectations that encourage rapid assessment and intervention. In such settings, medication becomes the most readily deployable tool, not necessarily because it is always the best option, but because it is the most compatible with the structure of care delivery. When time is compressed and complexity is high, the most efficient solution can begin to look like the most appropriate one.

Guidelines that emphasize pharmacological approaches early in treatment further reinforce this pattern. Over time, this creates a model that is highly effective at initiating care but far less developed in managing its long-term course. The result is a form of practice that can feel increasingly procedural, where deeply human experiences are translated quickly into diagnostic categories and matched with interventions that fit the system more easily than the individual.

It is important to say clearly that this is not, in most cases, a story of individual bad actors. Many of the physicians working within this system are thoughtful, well-intentioned, and deeply committed to their patients. But they are also operating within a structure that places them in difficult binds, where time is limited, expectations are high, and the range of acceptable responses is quietly shaped by forces outside the consulting room.

Over time, those forces begin to matter more than we might like to admit. Insurance frameworks, reimbursement models, pharmaceutical influence, and institutional priorities all exert pressure, not always overtly, but consistently. What is rewarded is what is efficient, what is billable, what aligns with established pathways. What is less supported is the slower, more nuanced, more exploratory work that does not lend itself easily to standardization.

There is a body of thought that attempts to describe how systems drift in this way. Andrew Łobaczewski wrote about what he called ***Political Ponerology***, the study of how pathological dynamics can emerge within otherwise functional systems. More recently, voices like Michael Rectenwald have described how institutional incentives, including corporate and financial pressures, can shape behavior in ways that gradually move organizations away from their stated purpose.

One does not have to adopt all of their conclusions to recognize the pattern they are pointing to.

Because when incentives consistently reward speed over depth, intervention over understanding, and continuation over reflection, the system itself begins to take on a momentum that is difficult for any individual practitioner to resist. In that environment, even good clinicians can find themselves participating in patterns that, over time, produce outcomes that do not fully align with their original intent.

That is not a comfortable observation.

But it is an honest one.

And if we are serious about improving care, it is one we cannot afford to ignore

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What a PhD Actually Means

In discussing these issues, it is worth clarifying the perspective from which I speak. I am not a physician, and I do not claim to be. I am, however, a PhD in psychology, which is fundamentally a research degree. That training involves not only familiarity with clinical theory, but a rigorous engagement with experimental design, statistical reasoning, and the critical evaluation of evidence.

It also requires contributing to the literature through publishing, a process that I have been engaged in since my graduate work and have continued through articles and books over the course of my career. That background does not confer authority in every domain, nor does it place me in the lineage of Sigmund Freud or Carl Jung, but it does mean that I have been trained to analyze claims carefully and to question them when they do not align with either evidence or experience.

Combined with more than four decades of clinical work, that training provides a vantage point from which certain patterns become difficult to overlook.

Patterns You Cannot Unsee

Among those patterns is the cyclical nature of medication trends and the gradual narrowing of prescribing practices around a limited set of familiar options. Clinicians, often acting in good faith, develop preferences based on what they have seen work in their own experience, and over time those preferences can become default approaches applied across a wide range of patients whose underlying conditions may be quite different. What begins as clinical familiarity can slowly harden into habit, and habit, when left unexamined, can begin to substitute for individualized care.

The consequences of this are not always immediately apparent, particularly in the short-term view where symptom suppression may be interpreted as improvement. But over time, especially in longitudinal work, a different picture begins to emerge. I have encountered adolescents placed on powerful medications for behavioral concerns rather than clearly defined psychiatric conditions, and I have watched as the downstream effects unfold. In some cases, the physiological changes are striking. I have seen young people placed on antipsychotic medications who, within a matter of months, gained so much weight that I could barely recognize them. Alongside that, there are often shifts in affect, motivation, and overall vitality that are harder to quantify but no less significant.

At the same time, I have worked with individuals who arrive in treatment taking multiple medications simultaneously, layered over time as each new symptom or side effect is addressed with an additional prescription. What presents clinically is not a clear diagnostic picture, but a complex pharmacological overlay that can obscure rather than clarify what is actually going on. In these situations, the work often involves not only addressing the underlying psychological or emotional issues, but carefully and methodically disentangling the effects of those medications in order to understand who the person is beneath them.

What becomes particularly evident is how profoundly this layering can affect a person's ability to engage in therapy. When individuals are significantly numbed, whether emotionally, cognitively, or physically, the very capacities that therapy depends upon—reflection, emotional access, relational presence—are diminished. But as those medications are responsibly tapered, as those layers are gradually rolled off, there is often a noticeable shift. The person begins to return. Affect comes back online. Engagement in therapy deepens. They become more present, more connected, and more capable of doing the work that had previously been out of reach.

These experiences are not isolated anomalies encountered in rare cases. They represent a recurring pattern that, once seen clearly, is difficult to unsee.

When Critique Becomes Difficult

It would be reassuring if such observations were consistently met with open dialogue, but that has not always been my experience. There have been occasions when raising these concerns has led to pressure to moderate language, reconsider conclusions, or withdraw written material. While such responses may be motivated by a desire to maintain professional standards, they also raise questions about the extent to which the field is willing to engage with critical self-examination.

A discipline that is confident in its foundations should, in principle, be able to tolerate scrutiny.

Indeed, it should welcome it.

Voices That Would Not Stay Silent

The concerns being raised here are not new, nor are they limited to any one perspective. Peter Gøtzsche, Peter Breggin, Robert Whitaker, Joanna Moncrieff, Mark Horowitz, and Josef Witt-Doerring, among others, have been articulating similar critiques for years, often at considerable professional cost. Their work reflects a sustained effort to bring greater clarity and accountability to a complex and evolving field.

The Core of the Matter

At its heart, this discussion is not about rejecting psychiatry or dismissing the value of medication. It is about restoring coherence to the process of care. That includes being transparent about the limits of current knowledge, exploring alternatives where appropriate, and ensuring that any intervention is embedded within a clearly articulated plan that extends from initiation through evaluation to conclusion.

Such an approach does not complicate care unnecessarily.

It strengthens it.

A Final Reflection

It is often said that it is never too late to correct course, and there is some truth in that. At the same time, the lived experiences of many patients remind us that delays in addressing systemic issues carry real costs. Those costs are not abstract; they are reflected in disrupted lives, diminished functioning, and the long process of recovery that follows.

In that context, the persistence of organizations like AbleChild and its founders, Sheila Matthews and Patricia Weathers, takes on added significance. Their work represents a sustained effort to bring attention to questions that have too often been sidelined.

For me, encountering their argument in this form prompted a simple but powerful reaction, one that reflects both recognition and a measure of humility.

How did I miss this?

Because it is not only relevant.

It is, in many respects, exactly right.

And it returns us to a question that should have guided the process from the beginning, a question that remains as essential now as it was then.

What is the plan?