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Pills for the Soul: When Psychiatry Forgets to Listen to Suffering

Pastillas para el alma: cuando la psiquiatría olvida escuchar el sufrimiento

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RESUMEN

El modelo de atención en salud mental ha girado de manera preocupante hacia la farmacología en las últimas décadas, relegando la psicoterapia y la comprensión del sufrimiento humano a un plano secundario. Esta tendencia medicaliza respuestas humanas normativas y empobrece la calidad del cuidado. Se decide realizar este artículo con el objetivo de analizar de forma crítica la prescripción excesiva de psicofármacos, la subutilización de la psicoterapia basada en evidencia y las consecuencias humanas de ignorar la dimensión experiencial del sufrimiento psíquico. En su desarrollo, se examinan las fuerzas impulsoras de la sobremedicalización, se contrasta la evidencia de tratamientos psicológicos frente a farmacológicos y se explora el impacto clínico y existencial de desatender la narrativa del sufrimiento. Se concluye que el abuso de psicofármacos y la desatención a la psicoterapia representan una iatrogenia social que deshumaniza el cuidado, por lo que es urgente un reequilibrio hacia prácticas que prioricen la escucha, la relación terapéutica y la comprensión del dolor como experiencia significativa, utilizando la farmacología con mesura y sabiduría.

ABSTRACT

The mental health care model has turned worryingly towards pharmacology in recent decades, relegating psychotherapy and the understanding of human suffering to a secondary plane. This tendency medicalizes normative human responses and impoverishes the quality of care. It was decided to write this article with the aim of critically analyzing the excessive prescription of psychotropic drugs, the underutilization of evidence-based psychotherapy, and the human consequences of ignoring the experiential dimension of psychic suffering. In its development, the driving forces of overmedicalization are examined, the evidence of psychological versus pharmacological treatments is contrasted, and the clinical and existential impact of neglecting the narrative of suffering is explored. It is concluded that the abuse of psychotropic drugs and the neglect of psychotherapy represent a social iatrogenesis that dehumanizes care, so there is an urgent need for a rebalancing towards practices that prioritize listening, the therapeutic relationship and the understanding of pain as a meaningful experience, using pharmacology with moderation and wisdom.

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Imagine a woman in her thirties who comes to therapy carrying a profound sadness. Her marriage has been crumbling for years, she feels trapped in a meaningless job, and loneliness has become her constant companion. Two decades ago, a therapist would have explored these existential cracks with her. Today, all too often, after a consultation of barely ten minutes, she leaves with a prescription for a selective serotonin reuptake inhibitor (SSRI). The pill might lessen the weight of her pain, but what do we do with the pain itself? With her story? With the vital, concrete, and pressing reasons that keep her on the verge of constant tears?

This scenario is repeated daily in therapists' offices around the world, revealing a profound shift in how we understand and address psychological distress. We have dangerously confused symptomatic relief with healing, and neurochemistry with life story. This article stems from a clinical and ethical concern: as a psychiatrist, I observe how we medicalize human suffering on an epidemic scale, while neglecting the tools that could best help people make sense of their pain and transform their lives. This is not an abstract debate, but rather an issue that determines the quality of recovery for millions of people.

Therefore, the objective of this article is to critically assess the over-prescription of psychotropic drugs, the underutilization of evidence-based psychotherapy, and the human consequences of ignoring the experiential dimension of psychological suffering.

If we look at the prescription figures for antidepressants and anxiolytics over the last two decades, the upward trend is alarming. Their consumption has skyrocketed far beyond any plausible increase in the prevalence of serious mental disorders. [1] Why is this? Part of the answer lies in a powerful narrative, promoted for years by the pharmaceutical industry, that convinced us that problems like depression were, in essence, a "chemical imbalance" in the brain, something as physical as diabetes. [2] This idea, although simplistic from a scientific perspective and now strongly challenged, took deep root: it offered a quick explanation, absolved us of blame ("it's my brain, not me"), and promised an immediate solution. [3]

The fundamental problem is that this medicalization of distress has been encroaching on areas that previously belonged to the realm of normal human experience. Emotions such as sadness over a loss, anxiety in the face of uncertainty, or exhaustion resulting from an unbalanced life have been progressively reclassified as symptoms of disorders amenable to pharmacological treatment. [4] This phenomenon is exacerbated by a structural reality: consultations

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have become shorter, healthcare systems prioritize immediate solutions, and, in terms of time and administrative cost, prescribing medication is much cheaper than offering an hour of psychotherapy per week. The result is a care model that, by design, rewards prescribing and penalizes listening.

In contrast to this paradigm, psychotherapy, that space precisely dedicated to listening, human connection, and the exploration of meaning, strives to maintain its relevance. It does so, moreover, supported by overwhelming scientific evidence of its efficacy. For moderate depression, for example, psychotherapy demonstrates effectiveness comparable to medication in the short term, and its superiority in preventing long-term relapses is highly significant, as it equips the individual with tools and insights that transcend the duration of pharmacological treatment. [5] In the case of anxiety disorders, psychological approaches are, in fact, the recommended first-line intervention. [6] Therapy does not merely mask symptoms; it addresses their root causes. It helps a person understand why they collapse in the face of certain criticisms, learn to tolerate anxiety without being paralyzed by it, and reconstruct a life narrative in which they do not perceive themselves solely as a victim. Its characteristic "side effect" is not weight gain or sexual dysfunction, but rather the strengthening of self-awareness, autonomy, and the capacity to relate to others.

But the most subtle and profound damage of this imbalance is not measured solely in relapse rates or adverse effects. It is measured in silences. When we transform suffering into a set of symptoms to be eliminated, we rob it of its voice. We deny it its status as a legitimate messenger. Psychological pain, however unbearable, is almost always telling us something: that we are trapped in a toxic relationship, that we have betrayed our values, that we have not grieved a loss, that our way of life is killing our soul. The pill may silence that messenger, may turn off the alarm, but it leaves the fire untouched. Worse still, it convinces the patient that the problem was a fault in their internal wiring, diverting attention from external circumstances—work, family, social—which are often the true sources of suffering. [7]

This dynamic generates a paradoxical dependence. Many patients, after years of medication, feel trapped in a cycle in which trying to reduce the dose triggers anxiety or emotional dysregulation, symptoms that both they and their doctors often attribute to the reappearance of the "underlying illness." However, in numerous cases, what actually manifests is a prolonged and frequently misidentified withdrawal syndrome. [8] In this way, the drug that promised liberation ends up enslaving, while simultaneously

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diminishing the opportunity to address what truly underlies the suffering. Life experience is thus medicalized, and the search for meaning is pathologized.

At this point, the diagnosis is clear, albeit uncomfortable: we have erected a model of mental health care that, in its haste to alleviate suffering, often forgets to heal; that confuses the chemical suppression of suffering with its cure; that conceives of people as mere receptacles of dysfunctional neurotransmitters, and not as authors of fractured biographies crying out to be heard. (9)

It is important to emphasize that this is not about demonizing all psychotropic drugs. In contexts of acute crisis or intense, debilitating suffering, they can represent an indispensable lifeline. (10) The problem arises when they cease to be a specific tool and become the cornerstone of the system, a distortion with profound consequences. In this context, psychotherapy and relational support should not be seen as dispensable complements, but as the fundamental and most effective long-term intervention for the majority of psychological distress.

Therefore, the change we need is both systemic and cultural. We need healthcare systems that fund and value the time spent in psychotherapy as much as the time spent prescribing medication. We need to train doctors and psychologists who can tolerate the uncertainty of suffering, who can listen without rushing to fill the void with a prescription. And, above all, we need to reclaim the value of storytelling. We must return to asking "What hurts?" rather than "What symptoms do you have?" We must understand that behind every diagnosis lies a story of loss, betrayal, failed love, and shattered dreams that deserves to be told and heard.

Psychological suffering is not an evolutionary error that chemistry must correct. It is the signal of a human being struggling to find their place in the world. Our task as clinicians, and as a society, is not only to silence that signal, but to help decipher its message. The use of psychotherapy, beyond its proven effectiveness, brings the therapist closer to the patient without relying solely on medical prescriptions and psychotropic drugs, because neglecting the psychological and social component is iatrogenic. The future of truly compassionate and effective psychiatry and psychology depends on our regaining the courage to sit with others' pain, look them in the eye, and ask them, simply and humbly: "What brings you here?"

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