The Future of Psychiatry

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The author reviews the vicissitudes of psychiatry's history over the past 50 years and urges the profession to abandon false boundaries between mind and brain and to make a commitment to the scientific validation of prevailing theories of the etiology of psychiatric disorders. He argues that the separation of psychiatry and neurology is no longer justified. He calls instead for a carefully conceived new career path leading to specialization in clinical neuroscience and further urges that psychiatric training programs be restructured to focus on the critical examination of problem solving and validation methods.

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Over the past 50 years, many articles and lectures and several largely unsuccessful commissions have attempted to deal with psychiatry's identity as an independent specialty. Perhaps because, as the late Mayer Gross claimed, the dysphorics are overrepresented, at least among academic psychiatrists, we believe that we are the only ones whose claim for unique competence is challenged by other disciplines. The facts, however, do not support our contention. The optometrists want an increasingly large share of the ophthalmologists' practice; podiatrists have invaded the territory that once belonged to orthopedists; gynecology, after it was almost eliminated by the discovery of antibiotics and the abdominal surgeons who wanted to cut out the same organs, is busily concentrating on problems of fertility; obstetrics is threatened by the midwives, who are ready to re-enter the delivery room; dentists and otorhinolaryngologists are locked in a deadly battle over the maxilla; hematologists and oncologists are after the same blood. And so it goes on, and it must go on. As science and technology advance, complex tasks are simplified and are gradually taken over by emerging new professions.

Undoubtedly, we were not passive bystanders either. Starting in the late 1930s, when neurosciences were still in their infancy, we discovered to our great relief that psychology and the social sciences contributed far more toward the understanding of our patients than did neurology. The decision to disaffiliate ourselves from neurology, however, set a historical precedent: we became the first medical specialty without ties to any organ or organ system.

One by-product of our nearly exclusive reliance on psychosocial explanatory theories was that we rid ourselves of problems that did not fit our newly found identity. We abandoned the epileptics, the demented, the developmentally disabled, and the retarded (1) and asked the police to take care of the alcoholics, the substance abusers, and the delinquents. We displayed great compassion by embracing the existentially unhappy and were ready to treat problems such as low self-esteem, failure to achieve one's creative potential, and chronic inability to trust. Soon we reached out again and enrolled a large group of people who were described by their friends, families, or employers as obnoxious, irritating, or uncooperative. Although by substituting such terms as passive-aggressive, narcissistic, and passive-dependent for less endearing ones such as pain-in-the-neck and s.o.b. we made a substantial contribution to good manners, we totally confused ourselves and the public about the meaning of mental illness.

Encouraged by the warm reception of the upper middle class and our growing influence, we performed the acrobatic act known as "Look, mom, no hands," explaining to the world that anybody, well almost anybody, could understand psychiatric disorders. All

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that was required was a bit of intuition and an appreciation of the oppressive forces operating in our families and society at large. Having convinced ourselves that cure could be achieved only with intensive psychotherapy, which regrettably few people could afford, we decided that overcoming social and economic inequities must receive the highest priority. We should take legitimate pride in our successful campaign, which improved access to psychiatric care for the poor and disenfranchised. Unfortunately, however, the method chosen to achieve this otherwise noble goal—the establishment of community mental health centers—further legitimized the separation between psychiatric care and general health care.

This Weltanschauung, as it turned out, was in perfect tune with the spirit of the early 1960s and led to one of the oddest alliances yet conceived: that among clinical psychiatry, community psychiatry, and psychoanalysis. Together we wrote a splendid script on the psychological society. We were so successful that our ranks were gradually swollen by an increasingly varied group which, in addition to health professionals, social workers, and psychologists, included streetologists, faith healers, and experts in both dressed-up and naked encounter groups, all of whom declared their undying commitment to promote the mental health of people in the United States (2). Crowning our spectacular achievement were two savvy political decisions: we abolished double specialty boards in psychiatry and neurology and concluded that internship was an unnecessary preparatory step for specialty training in psychiatry. These decisions, based on an extraordinary lack of foresight, were very costly. During this phase of our history, while we managed almost totally to demolish traditional asylums, we paradoxically made our specialty an asylum for physicians who were running away from medicine.

OUR RETURN TO MEDICINE, HAT IN HAND

Finally, in the 1970s, we began to reverse ourselves. The internship program was reinstituted. Training in neurology was encouraged. A few of our leaders even went so far as to declare psychiatry to be a primary care medical specialty. The department of psychiatry at Washington University, which under the leadership of Eli Robins continued to maintain its commitment to nosologic research, suddenly acquired new respectability. Several departments, after apologizing to the residents for taking time away from psychotherapy supervision, started to teach psychopharmacology. Concerted efforts were also made to reconquer lost territory. Our sudden fascination with the aged, the demented, and the developmentally disabled, however, did not engender much enthusiasm. Having serviced them for many years, special educators, psychologists, pediatricians, and a new brand of neurologists called behavioral neurologists became quite rude, insisting that they had legitimate claims to these patients. Alcohol and substance abusers also protested; they informed us that they had finally learned what we had taught them and no longer believed that their problems should be considered the domain of psychiatrists.

Our having come up with many new and not necessarily well-conceptualized theories about the etiology and treatment of psychiatric disorders throughout our relatively short history is not surprising. What is astounding is how little effort has been made to test the validity of our theories and how long we have remained a shelter for bankrupt ideas. Undoubtedly, what appears solely as evidence of our gullibility is also a product of complex sociopolitical interactions. Psychoanalysis in the United States, for example, found a fertile nest in military psychiatry during World War II. The seemingly powerful effect that psychological interventions had on soldiers who, instead of being sent home, were successfully treated for acute stress disorders near the combat zone convinced even the most skeptical of us that the prescription worked. The fact that nobody bothered to determine whether the supportive setting and the expectation for recovery alone could have done the trick is not surprising, inasmuch as randomized clinical trials were not yet in fashion. But other treatments—CO_2 inhalation, insulin coma, psychosurgery, narcoanalysis, electronarcosis, and LSD treatment, for example—continued to survive long after their lack of effectiveness had been convincingly demonstrated. Nor did the dramatic response produced by pharmacotherapy on the bewildering array of manifestations observed in schizophrenia have an unsettling effect on those who prefer to interpret each of the symptoms separately, having persuaded themselves long ago about the psychological origins of this devastating illness.

INTELLECTUAL EQUIVALENT OF DISNEYLAND

Although the unsound reasoning that underlies many of our assumptions about mental illness tends to be justified by the alleged inevitability of the mind–body dualism, nothing is further from the truth. The source of the confusion is that while the "mind" and mental functions constitute a legitimate and convenient conceptual framework to describe certain phenomena about psychiatric illness, it is not an avenue for the generation of biological theories by which we can deduce from the nature of mental defect its etiology and pathogenesis. If, on the other hand, mental illness and the attendant psychological symptoms are not regarded as expressions of as yet undefined disorders of the central nervous system (or another organ system) but disorders of the mind, then one graceful leap will lead us to conclude that the pathological state can be defined only by the symptoms it produces (3). Having extricated the mind, so to speak, we further embellished this rather remarkable spiritual construct

by misusing the term "functional" to mean "psychogenic," when, in medicine, it is intended to convey impaired functioning of a system. In doing so, we created the intellectual equivalent of Disneyland: We can go on our speculative excursions, confident that we will always come back to where we began. We continue to be spellbound by the variety of acute and chronic stresses that impinge on our lives without the distracting thought that characteristics of the organism's processing and responding to such events may be as important as or more important than the so-called specificity of the stress itself.

In other words, even though persistent or progressive deficits in adaptation following stress, including secondary developments of a compensatory nature, may appear as purely psychological phenomena, such changes, by definition, must be the products of altered functioning of the organism. The history of medicine is replete with examples demonstrating that our failure to detect changes in the functioning or structure of organs or organ systems proves only the limitations in our diagnostic methodology and cannot be construed as evidence for the psychological origin of etiology or pathogenesis.

Our failure to appreciate the limits of the data and the nature of the evidence continues to play havoc with us. When it once again became fashionable to think now and then about the brain, we were less interested in the implications of new knowledge than with the application of emerging findings from neurobiologic research to support as yet unproven hypotheses derived from psychoanalysis. The nomination of the unsuspecting corpus callosum as the potential site for the unconscious and attempts to link uncritically what little is known about the neurophysiology of sleep with Freud's theory of dreaming are examples of this kind of endeavor (4). We also seem to forget that our current nosologic system, *DSM-III*, is still on a very narrow foundation. Given that the diagnoses are based primarily on what the patient complains about, how long the patient has been complaining, and how much the patient is complaining, using treatment response alone to prove their existence leads to mischievous conclusions.

We do not have to feel lonely in our disarray, however: our half-sibling and our stepmother, psychology and neurology, respectively, are also engaged in an exercise of self-appraisal. In a 1980 article entitled "Whither Psychology?" Davies and Wetherick (5) lament, "[Ever since psychology became independent of philosophy] at no time has it been clear, even to its practitioners, what constituted the boundaries of the discipline. Within the ranks of psychologists . . . fragmentation into schools occurred. On the whole, it was agreed, not without argument, that the new science was to be modeled on the methods of the relatively mature nineteenth century sciences of physics and chemistry: observation, prediction, and experimentation. Psychology was to be based upon empiricism. This has produced a mass of data based on controlled observation, however, this is not in itself an adequate basis for any science."

What has been said about psychology to some extent also applies to psychiatry and—as will become clear—to neurology as well. In a 1984 editorial suitably entitled "Whither Neurology?" Martin (6) expresses concerns that future neurologists are denied "the skills that would make them most useful to society." He complains about the decreasing number of neurologists choosing research training and believes that many applicants entering the field have questionable credentials, insufficient training in internal medicine, and limited exposure to neurosciences, causing residents to believe that such knowledge is irrelevant to clinical problems in neurology. He suggests that these deficiencies can be remedied by requiring that those interested in clinical careers spend at least 2 to 3 years in internal medicine before specializing in neurology, while those interested in research, unless they are graduates of M.D./Ph.D. programs with majors in neurosciences, spend several years in basic science research. Martin defines the responsibility of neurology as "the diagnosis and management of any disorder in which the involvement of the central nervous system is included in the differential diagnosis . . . [which could, if the neurologist is interested, encompass] the diagnosis and management of disorders affecting behavior."

TERRITORIAL IMPERATIVE

You may wish to register a complaint about the territorial aspirations of neurology. I submit to you, however, that the problem is not the lack of a clear boundary between neurology and psychiatry. Even though neurology, unlike psychiatry, always remained in the mainstream of medicine, neither discipline has been or is currently providing training that will provide the necessary competencies for patient care. Although exposure to neurology is a requirement for Board certification for psychiatrists, the experience provided is often perfunctory. Much the same can be said for the psychiatric training of neurologists. During the last 10 years both psychiatry and neurology have gone down the road with various more or less successful Scotch-taping measures to strengthen their scientific underpinnings. Both have recruited Ph.D.s, hoping that their methodologic expertise will somehow infuse the medical troops with the required sophistication to conduct research. Moreover, neurology, until it gave birth to a somewhat ill-conceived subspecialty called behavioral neurology, showed little interest in psychopathology, limiting itself primarily to the study of aphasia, apraxia, and agnosia and calling upon its equally uninformed colleagues from psychiatry to take care of clinical problems that were too tedious to handle.

Psychiatry, on the other hand, in an attempt to cope with its expanding responsibilities vis-à-vis the aged

and the developmentally disabled, populated its departments with neuropsychologists and also managed to lure away a few disenchanted neurologists who were interested in behavior. Specialty training in psychiatry and neurology now includes some exposure to clinical pharmacology, but neither discipline has sufficient knowledge of how the pathophysiology and treatment of various disorders affect the functioning of the nervous system. Recent advances in neurochemistry, neuroendocrinology, and computer-assisted electrophysiologic and imaging methods, for example, should have acted as a major impetus for the investigation of various encephalopathies and the attendant changes in mental functioning, but this is not happening.

TOWARD A CAREER IN CLINICAL NEUROSCIENCE

The real problem, and we might as well face up to it, is that if neurology and psychiatry are each involved in the study and care of disorders of the central nervous system, a position toward which both specialties seem to be inching, then the continued separation of neurology and psychiatry is no longer justified.

In my opinion, the only viable solution is a new career path leading to specialization in what, for lack of a better term, I would call clinical neuroscience. It should be concerned with disorders of the nervous system, regardless of whether the etiology of the disorder is known or unknown or whether the disorder is primary or secondary. Trainees should have adequate exposure to medicine, neurology, psychiatry, and pharmacology and be taught what neuropsychology, electrophysiology, and imaging methods can contribute to the assessment of brain functioning in living patients. Although training in neurosciences is important, acquisition of basic skills in epidemiology and biostatistics is no less significant. We must admit that the time for renaissance doctors who know everything about everything has long passed. Subspecialization in an area of choice, be it developmental disorders, metabolic encephalopathies, aging, neuromuscular disorders, so-called functional psychoses, or whatever, should follow an integrated and carefully thought-out curriculum in medicine, neurology, and psychiatry, which could take approximately 5 years. Armed with such knowledge, we could make a substantial contribution to patient care, allowing us to relinquish our role as social pseudoscientists on semipermanent vacation from medicine.

Research training, as Martin (6) has suggested, should follow clinical training and be tailor-made to suit the trainee's needs. Regardless of whether the career choice will involve patient care, clinical investigation, or laboratory science, the emphasis throughout training should be on the critical examination of problem solving and validation methods both to prepare young physicians to handle the explosion of new information and to protect them from the embarrassing mistakes our generation has made. In other words, what is being taught and for how long is less important than how the subject matter is presented and by whom. We can no longer rely only on clinician-educators. Clinical skills should be taught by active investigators, who by doing research have a clear appreciation that today's facts are merely way stations and should be taken seriously only until new findings have modified them or rendered them valueless.

Failure to achieve what one might broadly call psychosocial competence in our trainees, however, would merely create another kind of reductionism, replacing the brainless with the mindless approach to clinical problems. There is increasing recognition that much of what is now taught to psychiatric residents should become an integral part of the medical school curriculum. What Eisenberg (7) calls the "sociobiologic process of becoming ill, being ill, and getting well," what social anthropology can teach us about patienthood and illness, and what political science contributes toward the understanding of health care delivery systems properly belong in graduate medical education and should be learned by all physicians (8). I do not believe that any specialty should be given the sole responsibility and the priestly duty to become an expert and proselytizer of interviewing techniques or psychotherapy. Every physician must learn how to gather data that are critical for diagnostic and treatment decisions and to do so in a way that is vigorous and precise without being relentless or insensitive and, for that matter, without pretending that all encounters between patient and doctor are or should be therapeutic. Last but not least, all physicians, whether they are engaged in research or clinical care, should be trained to become practitioners of the informed consent doctrine. Discussing with our patients the pros and cons of various diagnostic and treatment options is not just a moral obligation but a major contribution to our own education. The very process makes it mandatory for us to acknowledge how limited our information is, encouraging us to behave modestly. Familiarity with the principles of informed consent will also help physicians to come to grips with the peculiar fact that the only difference between clinical practice and clinical research is that the latter is controlled while the former is not.

WHITHER CLINICAL FREEDOM?

There are other issues requiring our attention. Quite bluntly, we live in an increasingly cost-conscious world which insists that we provide something of value for the money. In doing so, we have entered a new era that has aptly been described as "the end of clinical freedom" (9). Oracular statements by senior clinicians regarding the efficacy of diagnostic methods or treatments will no longer be acceptable. Our diagnostic and treatment methods will have to be evaluated by rigorously controlled clinical trials. To meet the challenges,

we must do more than tinker with our traditional curriculum. Indeed, I doubt that any changes in curriculum, including the drastic ones I have proposed, will suffice. I agree with Ellard (10) that the best remedy, at least for the leading academic departments, is to strive for unabashed elitism by raising standards and "trading numbers for prestige."

Before closing, I might as well admit that my views find little support in psychiatric circles. Many still believe that our crisis is nothing more than a temporary halt in our final triumph. All we need is to assert ourselves and stop the other disciplines in their efforts to deplete even further the reservoir of "desirable" patients. Repeating with great conviction that we are physicians and thus absolutely anything we do is medical is one way to implement this scenario (11). Others think that dealing with noncompliant medical patients by using family therapy and behavior modification, perhaps even becoming primary care givers by getting acquainted with the management of one or two nonpsychiatric conditions, would be consistent with our aspirations to fulfill our mission (12). A more modest view is that the psychiatrist of the future will be restricted to providing "secondary and tertiary care for complex and difficult cases, whether the patients require psychoanalytic psychotherapy, pharmacotherapy, or environmental manipulation" (13). Regrettably, however, there is little evidence that competence in interpersonal relationships is something that psychiatrists are uniquely trained for or should be; thus, such skills have limited value for assuring our survival (14).

Last, there is what one might call the moral argument put forth to preserve psychiatry "as is," it being the only specialty that really cares about the patient as a whole. Frustrated patients, their families, legislators, and television talk show hosts all seem to agree that the humane touch is increasingly absent from the practice of medicine. This rising public outrage has led to vast curriculum changes in several reputable medical schools, the purpose of which is to counter the allegedly dehumanizing influence of our education and make us more responsive to our patients' psychological needs. All this sounds quite wonderful, but there are a few small problems that might abort our efforts to achieve personalized care. The first is economic: remuneration for patient care in the United States is inversely proportional to the amount of time a physician spends in direct personal contact with the patient. Thus, the income of high technology, surgical, and so-called hospital-based specialists is rising while the income of internists, pediatricians, and psychiatrists is steadily declining. The second minor problem has to do with the selection process. To be sure, premed students often have something touchingly caring listed among their extracurricular activities. Those who are ultimately chosen to enter our sacred order, however, continue to be the ones who have quantitative skills and high marks in science. I could go on, but it would not be productive.

I do not think any of these options are viable, but then again I must also be prepared to entertain the possibility that I am wrong. In fact, all of us who live long enough to see what we will be doing in the next century should be fully prepared for a disappointment. The chances that everyone's predictions will turn out to be wrong are overwhelmingly high. We already know that we educated too many physicians and built too many hospitals for tuberculotic and psychiatric patients. Our forecasts about traffic density, which guided plans for the size of highways and airports, our manpower and energy need projections, were all way off. In the meantime, new commissions are still being formed to study the future practice of health care in this country at great expense to the taxpayer. These commissions may come up with new buzzwords that make for stirring speeches at medical conventions, but usually they fall far short of solutions.

I end, then, where I began, preferring to fall back on the comfort of my own predictions than to trust those of someone else. As we learn from ever more persuasive evidence that the mind and the brain are one and the same, we must, as a specialty intent on evolving in a way that assures survival, abandon the false boundaries we have established in our game of king of the mountain with other medical and health care disciplines. Our new strategy should be a decisive move, carefully conceived, meticulously executed, and dedicated to providing clinical and research training to create a new breed of psychiatrists who are truly neuroscientists.

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