Psychiatria Danubina, 2012; Vol. 24, Suppl. 3, pp 267–271 *Conference paper*
© Medicinska naklada - Zagreb, Croatia

PSYCHIATRY AT CROSSROAD BETWEEN CRISIS AND NEW IDENTITY

Miro Jakovljević

Department of Psychiatry, University Hospital Centre Zagreb, Croatia

SUMMARY

Background: *The question of identity of psychiatry as a medical profession as well as of the future of psychiatry has been the subject of much controversial discussion.*

Method: *An overview of available literature on crisis and challenges in contemporary psychiatry as well as on future of psychiatry.*

Results: *In this paper we present our transdisciplinary multiperspective view on psychiatry based on the seven perspective explanatory approaches, on the art and practice of the learning organization as well as on the method of multiple working hypotheses.*

Conclusion: *Conflict between our current knowledge and various concepts and schools in psychiatry will probably bring with itself a new scientific paradigm with new diagnostic phenotypes and refining the old ones. Psychiatry has the historical opportunity to shape the future of mental health care, medicine, and society.*

Key words: *crisis - identity of psychiatry - future of psychiatry*

* * * * *

INTRODUCTION

The question of identity of psychiatry as a medical profession as well as of the future of psychiatry has been the subject of much controversial discussion. According to some opinions, "current psychiatry could be subsumed under neurology" (e.g. behavioral neurology), "psychology, social work, or policy making" (Lolas 2010). Contemporary psychiatry has not yet been a coherent field of scientific theory as well as one unified and standardized practice, but a loosely assembled set of theoretical concepts and practices. It seems as an aggregative collection of different branches etablished on a loosely assembled set of various kinds of theoretical concepts about etiopathogenesis, conditions and meanings associated with mental disorders, all based on different kinds and strengths of evidence and it is being practiced in many different ways with different treatment results. New ways of thinking about mental disorders and mental health have opened up in academic and scientific as well as in professional field of psychiatry (Bracken & Thomas 2005, Jakovljević 2008, Jakovljević et al. 2012). Public perception of scientific and treatment progress in psychiatry is still diabolic. Contemporary psychiatry is characterised by the significant disbalance between evidence-based medicine, value-based medicine, narrative based medicine and person-centered medicine. The challenges of the 21st century push main-stream psychiatry to move beyond the narrow and fragmentary frameworks that guided the discipline in the 20th century.

PSYCHIATRY IN CRISIS AND CHALLENGES OF THE TIME

Psychiatry has several partial or fragmentary identities related to its biologic, psychodynamic and social subspecialties with many psychiatric schools. Many of the psychiatric schools, not only do not accept, but critize the most basic tenets and treatment principles of the others. According to Ghaemi (2003) today's psychiatry at conceptual level can be divided into four approaches: dogmatic, eclectic, pluralistic and integrationistic (see Table 1). Dogmatists rigidly take one position or the other in a reductionistic way: either neuroscience explains everything, or some psychological theory explains everything. Eclectics escape to take a firm position, simply claiming that it is all very complex. "Pluralist" agree with dogmatists in claiming that specific methods need to be applied purely, but they agree with eclectics that no single method is sufficient. Integrationists seek to describe a single approach that bridges the subject-object gap, but they are not limited to one approach, as in the various dogmatic schools.

The majority of psychiatrists are not fully aware of the changing nature of science, psychiatry and psychiatric epistemiology, so the nature and position of psychiatry today is paradoxical. Psychiatry has increasingly become scientific, rational, and technocratic with no place for philosophy in it, while on the other hand there is a growing recognition of the role of subjectivism, identity, ethics, philosophy of science, mind and mental health, pluralism and holistic and comprehensive understandings. Evidence-based, narrative-based and value-based practice are all very important components. Psychiatry today is claimed to be threatened by centrifugal tendencies and its future is defined by either being incorporated in other medical specialties or being deprived of its medical character (see Katschnig 2010). Triple current academic, scientific and professional crisis in psychiatry is associated with evidence-biased and marketing based approaches in education, research and clinical practice.

Table 1. The Conceptual Status Quo in Psychiatry (Ghaemi 2003)

1. Dogmatism
   - biological reductionism
   - psychoanalytic ortodoxy
2. Eclecticism
   - Biopsychosocial model (Adolf Meyer, George Engel)
   - Agnosticism (DSM-III onward)
3. Pluralism
   - Karl Jaspers's methodological consciousness
   - Leston Havens's approaches to the mind
   - Paul McHugh and Philip Slavney's perspectives of psychiatry
4. Integrationism
   - Edward Hundert's Hegelian neurobiology
   - Eric Kandel's neuroplasticity

SCIENCE IN PSYCHIATRY: ONE WORLD, MANY LANGUAGES

Neuroscience and clinical psychopharmacology have transformed psychiatry into a modern evidence-based scientific medical discipline. However, there have been many critiques of the concept of mental disorders as well as of psychiatry in general from a scientific perspective. Contemporary psychiatry rests on a simplified form of Cartesian dualism that posits two fundamentally irreducible ontological categories: a physical body/ brain and an embodied nonphysical soul/mind (Lake 2007). Four hierarchically related paradigms embodying different assumptions about phenomenological nature of mental health and mental disorders can be recognized: the body paradigm (biological psychiatry), the mind-body paradigm (psychodynamic psychiatry, psychosomatic medicine), the body-energy paradigm (biological psychiatry, energetic medicine) and the body-spirit paradigm (spiritual psychiatry) - (Tataryn 2002, see Jakovljević 2008).

According to critics, psychiatric diagnoses have no scientific background, they are harmful and lead to stigma. Psychiatric diagnoses are claimed to be incorrect ("two psychiatrists, three opinions") and harmful because they are barrier to recovery and invoke powerlessness, hopelessness and despair. In addition, they foreclose the importance of meaning and obscure the relevance of context. The two parallel psychiatric classification (ICD and DSM) systems, disease/illness and mental health definitions, and the poor diagnostic stability of mental disorders ("the DSM has fabricated non-validated psychiatric diagnoses out of the general human predicament") have long been criticized (Katschnig 2010). If psychiatric diagnostic categories have not yet be valid and scientifically proved, then research of any type in psychiatry, if performed with these diagnoses as inclusion criterion, is also non-valid. Despite a wide-spread belief that meta-analyses provide an objective appraisal of the state of art in a specific area of research, they have been critisized as the pseudoscience that has been compared to the alchemy (Fava 2012).

Science in psychiatry demands concepts that are universaly valid and reliable. The reliability of psychiatric diagnoses has been significantly improved over the last three decades. However, the relatively high reliability of mental disorders diagnoses was been achieved at the cost of the uncertain validity, desubjectivisation, decontextualization and reification of mental disorders (Thomas & Bracken 2004, Kecmanovic 2011). The validity of psychiatric diagnoses depends upon the extent to which they represent in reality occuring mental disorders, It is of huge significance for diagnostics and classifications of mental disorders as well as for psychiatry itself as a scientific discipline. The main purpose of diagnosis in psychiatry is to predict the future course of mental disorder if left untreated as well as the response to specific forms and methods of treatment.

Current categorical diagnoses in psychiatry are unfortunately associated with the uncertain validity. Uncertain diagnostic practice, variability in treatment response, and unpredictability of the course of mental disorders are likely to shake the very foundations of academic clinical psychiatry. The DSM-V development started five years ago with a grand ambition to provide a paradigm shift in order to increase diagnostic validity in psychiatry and develop a classification system based on biological markers (Frances 2009). There have been many putative biological abnormalities for particular major mental disorder, such as schizophrenia, bipolar disorder, recurrent depressive disorder, PTSD, etc., but all reflect no more than group mean statistical differences and none has had the needed sensitivity and specificity to be qualified as a dignostic marker. The application of any biological marker or diagnostic test for any particular mental disorder pressuposes that mental disorders are clearly delineated categories. The categorical diagnostic system has severely handicapped the biological marker studies of mental disorders (van Os 2003, Anckarsaeter 2010).

STIGMA IN PSYCHIATRY

The stigma is a very important issue in contemporary psychiatry, particularly the self-stigmatization of psychiatrists.The stigma and discrimination may occur at different levels, from the individual level through interpersonal interactions to the level of social structures by virtue of unfair policies, practices, and laws (Sartorius et al. 2010). The stigma associated with mental disorder and all that is related to it is the main obstacle to better mental health care and better quality of life of psychiatric patients and their families as well as to development of mental health programs (Sartorius & Schulze 2005, Beldie et al. 2012). Stigmatization

means to draw a clear dividing line between "them" and "us" (Kecmanovic 2011). The causes of stigmatization are complex and largely derived from deeply rooted cultural attitudes to madness, and popular beliefs about the nature of mental disorders. People with mental disorders are perceived as unpredictable, unreasonable, less inteligent, violent and dangerous, thus they do not reciprocate in social relations and social life, even more they deconstruct sociality and promote instability and chaos (Kecmanovic 2011). Unfortunately, psychiatrists sometimes contribute to stigmatization of their patients. Is is surprising that an increase in public acceptance of biomedical explanations of psychosis in Germany was associated with the public desire for increased distance from people with schizophrenia (Angermeyer & Matschinger 2005). It is interesting that this trend was not reported for major depressive disorder.

Diagnosis of mental disorder commonly leads to stigma in various ways with various consequences. Accepting a psychiatric diagnosis usually means that the individual must also accept the diagnosis-associated stigma related to the negative public attitude. The diagnosis is frequently associated with the expectations of a gloomy outlook of lifelong dependency on psychiatric treatment and little chance of full recovery. Thus rejecting the diagnosis and the diagnosis–related treatment may be recognized as a positive attempt of coping with the implications of the diagnosis for personal identity.

PROFESSIONALISM IN PSYCHIATRY

The human rights of psychitric patients to interpret their experiences in their own way, and to receive help accordingly, have become a fundamental and confusing challenge to the old order of beneficient paternalism that has characterised professional work in mental health care (Thomas & Bracken 2004). The typical paternalism of medical psychiatry, characterized by doctor's benevolence and beneficience for patients without their autonomy, is a rough form of expertocratic thinking based on the idea that "doctors know best" (Lolas 2010).

Professionalism can be defined as "a set of attitudes, skills, and knowledge that defines the professional role of psychiarists" with "next benchmarks: 1.respect, compassion, integrity, and honesty; a responsiveness to the needs of patients and society that supersede self-interest; and accountability to patients, society, and the profession; 2.high standards of ethical behavior, which include respect for patient privacy and/or autonomy; maintaining professional boundaries; and understanding the nuances specific to psychiatric practice; 3.sensitivity and responsiveness to a diverse patient population including, but not limited to diversity in gender, age, culture, race, religion, disability, and sexual orientation" (Gabbard et al. 2012). The cornerstone of professionnalism is related to six fundamental terms: altruism, accountability, excellence, duty, honour and inegrity, and respect for others, patients and collegues (Gabbard et al. 2012). Overlapping roles are natural in real life, but commonly related to a possible conflict of interest. Interactions with pharmaceutical industry that supported clinical trials or lectures is a field of special concern. According to Gabbard et al. (2012) special preventive protections include "role separation, full disclosure, setting up parameters that limit the potential for undue influence, diversification, ongoing monitoring of overlapping roles, oversight groups with sufficient authority, active efforts to remain informed and well-educated regarding the conflict of interest issues, and clear consequences for those who choose not to follow policies". Psychiatry presents a formidable challenge in defining and implementing professionalism with monitoring, observing, and assesing which is not always welcome in a field in which autonomy is highy respected. In the brave new world of psychiatry, psychiatrists should be proficient in many new roles (Patel 2009) related to the new view on professionalism.

PSYCHIATRY AT A CROSSROAD BETWEEN CRISIS AND NEW IDENTITY CHALLENGES

Psychiatry should help patients in retaining their well-being and control over their lives at times of adversities and intense emotional distress. The world of mental health, involving emotions, needs, thoughts, beliefs, values and behaviors, is a world of meaning and thus of context (Bracken & Thomas 2005). It is not an easy task to define mental health. There are seven interesting models for conceptualizing positive mental health: mental health as normal functioning, epitomized by Global Assesment of Functionig (GAF) score of over 80, mental health as the presence of multiple human strengths rather than the absence of weakness, mental health as the mind-brain maturity, mental health as the dominance of positive emotions; mental health as a high socio-emotional intelligence; mental health as subjecttive well-being (self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, personal growth) or wellness rather than the simple absence of illness; mental health as resilience (Vaillant 2012, Kecmanovic 2011)). Mental health can be altered by what a patient «has» (disease), what a patient «is» (personality, vulnerability-resilience, identities, the way of being in the world), what and how a patient is thinking about, perceives and learns about or assesses as valuable (cognition, life philosophy), what a patient «does» (behavior, morality, roles), what a patient «encounters» in her/his life stories (narrative self) and what a patient tends to be (spirituality, life management). The brain that changes and rewires itself constantly is fundamental and neccesary to understanding mind, mental functions, mental health and mental disorders. Mind also impacts the brain. The mind-brain interactions go in both directions, though without brain, there woud be no mind (Ghaemi 2003).

Psychiatry is more than a medical specialty: from competition to integration

The amazing world of psychiatry today is more than medical specialty. It is a "broad church" of disparate discources and different practicies which "should become a specialized profession solving the problems of integrality of approach and human relevance that no other prudent expert could provide" (Lolas 2010). Psychiatry as a profession may remain an integral part of medicine because the integrative work between body, brain and mind, socialty, transcendentality and spirituality lies at the core of this specialty. Thus psychiatrists should be familiar with several different models of explanation (perspectives) in order to comprehend both the diversity and complexity of mental disorders and the pitfalls of their treatment (McHugh & Slavney 1998, Jakovljević et al. 2012). Psychiatry should move from a pluralistic aggregative coexistence of many disciplines to a coherent transdisciplinary and comprehensive mental health science and practice. Trandisciplinary holistic integrative approach psychiatry is built on the premise that human be eings in health and disease are complex systems of dynamically interacting biological, psychological, social, energetic, informational and spiritual processes. It is of great importance for further scientific credibility, professional maturation of psychiatry and increasing treatment efficiency to integrate neurobiological, intrapsychic, interpersonal, cultural, societal and spiritual processes in diagnostic and therapeutic considerations. Transdisciplinary integrative psychiatry with a "person life-story centered integrative diagnosis" approach is promising in search of approriate answers to very relevant interindividual variability in order to 1.close the gap between evidence-based medicine, value-based medicine, and narrative-based medicine with regards to effective care and valid clinical trials; 2.improve the course of mental disorders with earlier diagnosis and prevention measures; 3.improve adequate monitoring of vulnerability, resilience and psychological growth factors (see Costa e Silva 2012, Jakovljevic et al. 2012).

CONCLUSION

Due to progress in many mental health disciplines, psychiatry has the historical opportunity to shape the future of mental health care, medicine, politics and society. Conflict between our current knowledge and various concepts and schools in psychiatry will probably bring with itself a new scientific paradigm with new diagnostic phenotypes and refining the old ones. The fundamental nature of stirring up and shaking up of the various concepts of mental disorders and practices in psychiatry, which are merging on the horizon do not suggest a smooth road ahead.

Acknowledgements: None.

Conflict of interest: None to declare.

REFERENCES

1. *Angermeyer M & Matschinger H: Causal beliefs and attitudes to people with schizophrenia: Trend analysis based on data from the population surveys in Germany. British Journal of Psychiatry 2005; 186:331-334.*
2. *Beldie A, den Boer JA, Brain C, Constant E, Figueira ML, Filipcic I, Gillain B, Jakovljevic M, Jarema M, Jelenova D, Karamustafalioglu O, Kores Plesničar B, Kovacsova A, Latalova K, Marksteiner J, Palha F, Pecenak J, Prasko J, Prelipceany D, Ringen PA, Sartorius N, Seifritz E, Svestka J, Tyszkowska M & Wancata J: Fighting stigma of mental illness in midsize European countries. Soc Psychiatry Psychiatr Epidemiol 2012; 47 (suppl 1):1-38.*
3. *Bracken P & Thomas P: Postpsychiatry: Mental Health in a Postmodern World. Oxford University Press, 2005.*
4. *Costa e Silva JA: Personalized medicine in psychiatry: New technologies and approaches. Metabolism Clinical and Experimental 2012, http://dx.doi.org/10.1016/j.metabol.2012.08.017.*
5. *Fava GA: Clinical judgment in psychiatry. Requiem or reveille? Nord J Psychiatry early online 2012; DOI: 10.3109/08039488.2012.701665*
6. *Frances A: Whither DSM-V? The British Journal of Psychiatry, 2009; 195:391-392.*
7. *Gabbard G, Roberts LW, Crisp-Hahn H, Ball V, Hobday G & Rachal F: Profesionalism in Psychiatry. American Psychiatric Publishing, Washington, DC, 2012.*
8. *Ghaemi SN: The Concepts of Psychiatry – A pluralistic Approach to the Mind and Mental Illness. The John Hopkins University Press, Baltimore & London, 2003.*
9. *Jakovljević M: The brave new psychiatry: A pluralistic integrating transdisciplinary approach in theory and practice. Psychiatria Danubina 2007:19:262-269.*
10. *Jakovljević M: Integrating brave new psychiatry of the person, for the person, by the person and with the person: The postmodern turn. Psychiatria Danubina 2008; 20:2-5.*
11. *Jakovljević M: Transdisciplinary holistic integrative psychiatry – A wishful thinking or reality? Psychiatria Danubina 2008; 20:341-348.*
12. *Jakovljević M, Tomić Z, Maslov B & Skoko I: New image of psychiatry, mass media impact and public relations. Psychiatria Danubina 2010; 22:145-148.*
13. *Jakovljević M, Brajković L, Jakšić N, Lončar M, Aukst Margetić B & Lasić D: Post-traumatic stress disorder (PTSD) from different perspectives: A transdisciplinary integrative approach. Psychiatr Danub 2012; 24:246-255.*
14. *Katschnig H: Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. World Psychiatry 2010; 9:21-28.*
15. *Kecmanovic D: Controversies and Dilemmas in Contemporary Psychiatry. Transaction Publishers, New Brunswick & London, 2011.*
16. *Lake J: Textbook of Integrative Mental Health Care. Thieme, New York-Stuttgart, 2007.*
17. *Lolas F: Psychiatry: a specialized profession or a medical specialty. World Psychiatry 2010; 9:34-35.*

18. *Sartorius N & Schulze H: Reducing the Stigma of Mental Illness: A Report from a Global Programme oft the World Psychiatric Association. Cambridge University Press, 2005.*
19. *Sartorius N, Gaebel W, Cleveland HR, Sruart H, Akiyama T, Arboleda-Florez J, Baumann AE, Gureje O, Jorge MR, Kastrup M, Suzuki Y & Tasman A:WPA guidance on how to combat stigmatization of psychiatry and psychosis. World Psychiatry 2010; 9:131-144.*
20. *Tataryn D: Paradigms of health and disease: A framework for classifying and understanding complementary and alternative medicine. Journal of Alternative and Complementary Medicine, 2002; 8:877-892.*
21. *Thomas P & Bracken P: Critical psychiatry in practice. Advances in Psychiatric Treatment 2004; 10:361-370.*
22. *Vaillant GE: Positive mental health: is there a cross-cultural definition. World Psychiatry 2012;11:93-99.*

Correspondence:
Prof. dr. Miro Jakovljević, MD, PhD
Department of Psychiatry, University Hospital Centre Zagreb
Kišpatićeva 12, 10000 Zagreb, Croatia
E-mail: predstojnik_psi@kbc-zagreb.hr