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Review Article

Psychiatry Today: The Profession's Uniqueness and Consequent Challenges to its Coherence and Effectiveness

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ABSTRACT

Objective: To consider some current challenges in psychiatry and their impact on the profession.

Methods: A descriptive overview drawing mainly on observations and reflections from professional practice.

Conclusion: The field of psychiatry is inherently unlike other medical specialties and more complex owing to a formidable set of factors, an appreciation of which can serve the profession in navigating through the prevailing challenges.

Keywords: Psychiatry; Profession; Challenges; Effectiveness; Reputation

INTRODUCTION

This paper eventuated from a conversation between an early-and a late-career psychiatrist with a shared appreciation of the profession's qualities yet also disquiet about some growing challenges [1]. And in line with the authors' favouring of inclusive perspectives, the views presented here are intentionally widely drawn.

LITERATURE REVIEW

How psychiatry differs from other medical disciplines

The following points introduce some of the complexities that have impacted disproportionately on the discipline of psychiatry and help to contextualise the challenges.

- The greater influence of patients' personal histories, sensibilities, subjectivity and circumstances in shaping their individual experience, and expression, of mental unwellness [2].
- The hazier demarcation between the suffering of everyday difficulties and clinical illness
- A multiplicity of markedly disparate conceptualisations of causation and treatment and lacking an overall, integrated theoretical basis [3].
- Substantial difficulties in parts of the major diagnostic classification systems with concomitant limitations of diagnosis-driven treatment guidelines [1,2,4].
- The dialogue between patient and clinician serving not only as a conduit for conveying information but itself constituting a clinical substrate of nonverbal cues, interactional style and nuanced use of language bearing essential diagnostic clues.
- The phenomena of observer bias and observer effect whereby the clinician's presence and manner considerably impact upon the patient's presentation and narrative, and hence the resulting psychological portrait and diagnosis.
- The clinical picture comprising not only the patient's symptoms but, also interwoven, their pattern of coping. Moreover, coping strategies (such as denial, overcompensation, self-harm etc.) may represent both a problem and a solution for the patient, hence their concomitant stuckness and ambivalence toward clinical engagement.
- Ambiguities in roles, tasks and agendas in the clinical relationship some of which can be conceptualised by way of Karpman's drama triangle. In the traditional medical scenario, the patient ('victim') and clinician ('rescuer') form a close alliance in which they occupy adjoining points and with the disorder ('persecutor') located at the opposite apex. In

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psychiatry however it can be difficult to differentiate the patient from their condition especially in cases of characterological disturbance. What's more, the perceived roles of victim, rescuer and persecutor can become fluid from the undercurrents of transference, countertransference and relational dynamics thus adding another layer of complexity.

Some current difficulties in psychiatry

We briefly highlight three sets of issues in psychiatry: (i) the profession's creative vigour, (ii) notional aspirations of holism in theory and practice, and (iii) some awkward matters that seem to have received limited attention.

Based on readings of the professional literature over recent decades, psychiatry appears to have lost some momentum in the creative vigour that kindles inventive thinking and epistemic advancement. Some contributing factors have included:

- The profession's tolerance of unacceptably ambiguous terms (e.g. 'major depression') and jargon which have exerted a subtle stultifying effect on psychiatry both at the individual and collective level.
- Defects in diagnostic classification which become absorbed by students/trainees and then propagated in their subsequent roles as researchers, teachers and supervisors [1,2].
- Based on perusals of psychiatric journals, academic attention having become more insular, narrow and derivative. Research work has tended toward greater procedural engineering accompanied by data generation/analysis though less of the incisive observational, conceptual or integrative thinking that offers useful insights to the majority of practicing clinicians.

Holistic aspirations in psychiatry

- A depreciation of observational/descriptive psychiatry, phenomenology and conceptual analysis which have become displaced by dry, scientistic or checklist-type thinking.
- A growing divide between general psychiatry and psychotherapeutic thinking with seemingly little awareness that psychotherapy constitutes not only a method of treatment but also a resource for providing perspectives on how to work more effectively with all patients irrespective of primary diagnosis, including the many with various collateral issues such as resistant engagement, self-sabotage of treatment, systemic dysfunction etc.
- Withering of case formulation to a mostly vestigial ceremonial function largely due to the promulgation of over-engineered approaches instead of more nimble and user-friendly ideas that enrich and enhance everyday practice.
- Professional subdivisions conducive to fragmentation and narrowing of skills, as illustrated by the trend in the outsourcing of psychotherapy supervision for trainees to other professions.

Exploring the awkward areas of psychiatry

- How to deal with those who are unhappy, primarily in the context of their struggles with everyday life. The use of v-codes (DSM), z-codes (ICD), and 'adjustment disorder' appear often to be bypassed in favour of higher-ranking diagnoses such as 'major depression' contributing to the medicalization of everyday life and widening expectations of clinical solutions to everyday difficulties [5].
- Those with recurring crisis presentations yet not otherwise engaging proactively.
- The very small yet pressing minority of individuals suffering mental disturbances so severely pathological (e.g. Refractory psychosis, tyrannical self-harm, consuming neediness etc.) that they might be considered untreatable (other than palliation) were they afflicted by an equivalently intractable medical condition, yet the notion of untreatability being taboo in psychiatry.

How the profession has responded to the challenges

A common response has been that of optimism, often pinned on the prospects of technological advances in classification, diagnosis and treatment. Frances has noted however that *"psychiatric diagnosis must still rely exclusively on fallible subjective judgments, not on objective biological tests [2]. Biological findings, however exciting, have never been robust enough to become test-worthy, because the within-group variability always drowns out the between-group differences. It appears certain that we will be stuck with descriptive psychiatry far into the future"*.

What's more, the optimism in psychiatry seems to have become increasingly pinned onto scientistic and solutionistic notions. Wakefield has noted that *"the premature embrace of specific technical analyses to override compelling clinical and conceptual realities brings to mind Wittgenstein's famous admonition: 'In psychology there are experimental methods and conceptual confusion: the existence of the experimental method makes us think we have the means of solving the problems that trouble us, though problem and method pass one another by"* [6].

Another response has been increasing sub-specialization with an ensuing compartmentalization of theory and practice. The costs of this have included, first, an attrition of the breadth of clinical familiarity and discernment required for effective assaying of seemingly prosaic common clinical presentations. And second, disconnectedness (i) between psychiatry's sub-disciplines and (ii) between the profession as a whole and the broader world and in both contexts, disconnectedness risking imperceptible drift into solipsism.

Another trend has been that of 'evidence based' standardisation and manualisation of treatment which might have been hoped to lead to improving outcomes though without recognition of the inherent limitations nor the ensuing risks of regimentation and breeding out of critical thinking. And as stated by O'Donnell *"Evidence based medicine deals with populations clinicians deal with individuals"* [7].

As regards the earlier mentioned awkward issues in psychiatry, responses to these have mostly not yet been forthcoming.

What can be done and by whom?

Every psychiatrist can choose individual participation such as through: acknowledging and voicing the challenges they see; modeling how to 'keep it real' in their clinical work and

supervisory roles; remaining open and curious in outlook; and taking an interest in neighboring fields of endeavor e.g. neuroscience, evolutionary psychology, the humanities etc.

A reliable strategy in 'keeping it real' is to use plain yet precise descriptive language e.g. feeling 'low', 'demoralized', 'sad', 'regretful' or even simple, situational 'unhappiness' instead of the nondescript 'depression'.

It might be hoped for those in organizational and academic leadership positions to consider the need for better connectivity in psychiatry both within and with the world at large. This would require a commitment to keeping professional discourses real, accessible and meaningful beginning with the overdue rehabilitation of psychiatric classification particularly around 'depression' [8-10].

Amongst those most influential are the journal editors, conference organizers and training bodies who occupy truly strategic positions: the curation of agendas for psychiatric discourse. It might also be reasonably hoped that among the many considerations that inform their work there would be two particular questions: *"for whom is this article/journal/ lecture/ conference actually mainly intended?"* and *"how likely is that audience subsequently going to feel more edified or alternatively thinking 'but so what?' "*.

Progress in psychiatry requires above all a sound frame of reference, especially a broadly encompassing nosology. What follows is a sketch of an inclusive set of diverse conceptual considerations that could potentially be further examined, developed and eventually fashioned into an assemblage of formal differential diagnostic entities mapped out alongside each other whilst also recognizing, as with geographical mapping, the phenomenon of transitional zones.

So, for instance, on the matter of behaviors that distress others, conceptual considerations might include (i) the earlier maturational stages in Kohlberg's epigenetic model of cognitive-moral development, (ii) non-malevolently intended actions within an understandable context, such as stealing groceries to feed a family in need, or aggressive behavior that is primarily self-protective within a dangerous environment, (iii) problematic behaviors as manifestations of underdeveloped functional coping skills which tend to be poorly focused and crude (excluding reactions to narcissistic injuries), (iv) a narcissistic characterological structure with specific vulnerability to feelings of inadequacy/shame that are neutralised by overdeveloped defensive responses such as anger, hostility or otherwise hurtful behaviours whether coarse or sophisticated in style, (v) the more severe variant of malignant narcissism in which the person's psyche has been so damaged as to have come to positively identify with, idealise, and electively engage in perverse exploitative, humiliating or other harmful behaviour, (vi) criminality as a facultative behavioural pattern based on a conscious reckoning of rewards outweighing risks, and with the primary objective being material gain rather than inflicting harm on others, (vii) an innate, neuro-physiological dysregulation involving under-reactivity to pleasurable or hazardous situations which inclines the person to more extreme forms of stimulation-seeking and risk-taking behaviours, sometimes at others' expense, and (viii) neurodevelopmental and neuropsychiatric disorders.

An inclusive, descriptive perspective on psychiatric nosology such as briefly illustrated here might be hoped to be more edifying than narrow or semantic debates such as around notions of psychopathy, sociopathy or dissociality.

CONCLUSION

As already mentioned, a common pattern in patients' mental health struggles involves ambivalence and concomitant stuckness. Something not dissimilar might potentially also be said of psychiatry's struggle with its own evolving challenges. So the profession's first-order task now is to pause and take stock of the difficulties at hand whilst reflecting on the words of Merleau-Ponty that in order to get even a glimpse of the real world and grasp it as paradoxical, we must first be able to break with our familiar acceptance of it [10-12].

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Not applicable.

DECLARATION

Limitations of this paper

Given the complicated nature and range of the topic, the available space, and also the authors' intention of taking a 'big picture' view, the material presented here has of necessity involved distillation, generalization, perspective and opinion along with selective referencing.

Ethics approval

This research did not involve any references to any patient(s) or involve human participants.

CONFLICT OF INTEREST

No conflict of interest to disclose.

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AUTHORS' CONTRIBUTIONS

All the authors contributed to the study's development. All the authors have validated the manuscript's final version.

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