



Medicine and the Mind — The Consequences of Psychiatry's Identity Crisis

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About 100 years ago, the psychiatrist and philosopher Karl Jaspers observed that biologic and psychological investigations of the mind were like “the exploration of an unknown continent

from opposite directions, where the explorers never meet because of impenetrable country that intervenes.”¹ Since then, it has been the work of psychiatry to push further into the interior while also attempting to ease the mental suffering of real people. To succeed in this complex endeavor, both basic science and psychologically sophisticated care are needed. But something has gone wrong in contemporary academic and clinical psychiatry. Checklist-style amalgamations of symptoms have taken the place of thoughtful diagnosis, and trial-and-error “medication management” has taken over practice to an alarming degree. We are facing the stark limitations of biologic treatments, while finding less and less time to work with patients on difficult problems.

Ironically, although these limitations are widely recognized by experts in the field, the prevailing message to the public and the rest of medicine remains that the solution to psychological problems involves matching the “right” diagnosis with the “right” medication. Consequently, psychiatric diagnoses and medications proliferate under the banner of scientific medicine, though there is no comprehensive biologic understanding of either the causes or the treatments of psychiatric disorders.

The problem is not simply one of scientific and intellectual integrity. This state of affairs influences training and reimbursement and does a great disservice to patients, practicing psychiatrists, and our medical colleagues who are striving to provide the best

and most humane care to people with medically and psychologically complicated conditions.

Our mind arises from brain function, and both conscious and unconscious mind processes feed back continuously to shape that function. Over the past century, both the psychodynamic tradition and basic neuroscience have painted pictures of a brain-mind that is fundamentally dynamic and plastic, in which cognition is inseparable from emotion and feeling, and where conscious awareness is a porous vessel on a sea of unconscious processes. The influence of the wider social world on well-being and illness has also been systematically elaborated by fields such as social psychology and anthropology. Interpersonal relations, from family dynamics to cultural practices and political constraints, affect our brain-minds. And in all our interventions (whether medications, cognitive techniques, or insight-oriented therapy), the power and centrality

of the clinician–patient relationship are clear.

Basic science is, of course, essential both to developing new therapeutics and to increasing our knowledge of mental processes and pathology. New discoveries in genetics and neuroscience are exciting, yet they are still far from offering real help to real people in the hospital, clinic, and consulting room. Given the complexity of the human mind, this gap is not surprising.

In the meantime, psychiatry finds itself plagued by overprescription of psychiatric medication for a large segment of the population; abandonment and incarceration of people with chronic, severe mental illness; and an increasingly unwieldy diagnostic system of overlapping symptom checklists.²

In addition, medicine’s “era of high throughput”³ has promoted a one-size-fits-all approach to diagnosis and treatment, and time with patients has dwindled in all specialties. For psychiatry, which still faces substantial diagnostic and therapeutic uncertainty, these trends have been especially deforming.

Throughout medicine, patients and clinicians alike are feeling the absence of robust, therapeutic relationships. Psychiatry should be uniquely positioned to help with this crisis through example, scholarship, and consultation, yet the field seems to have largely abandoned its social, interpersonal, and psychodynamic foundations, with little to show for these sacrifices.

So what should be done? Historian Anne Harrington proposes that psychiatry limit its scope to severe, mostly psychotic disorders. “Make no mistake,” she writes, “today one is hard-pressed to find anyone knowledgeable who be-

lieves that the so-called biological revolution of the 1980s made good on most or even any of its therapeutic and scientific promises.”⁴

Harrington’s proposal would point to an understandably diminished role for psychiatry as it has come to define itself. But we believe that that would be too great a loss — for patients and for medicine as a whole.

The global aging, addiction, and immigration crises call for the expertise of geriatric, addiction, and social psychiatry, respectively. There is substantial unmet need for psychiatric treatments and care for children and adolescents, and the emergence of mental health as a priority in the global health arena has increased the role of psychiatry in both international settings and the poorest populations in the United States. Other areas, such as consultation–liaison psychiatry (which focuses on patients with coexisting psychiatric and general medical needs), have taken on added significance in an era concerned with improving the quality of health care in general medicine.⁵

Yet over the past half century, biologic research has come to largely replace all other forms of psychiatric research — psychosocial, cultural, public health, and community — which have thus been marginalized in spite of the useful knowledge these fields provide for everyday care of patients and prevention of mental illness. Similarly, psychotherapy, an essential and multifaceted tool that mobilizes the unique power of the clinician–patient relationship, has been increasingly neglected in psychiatric training and practice.

We believe that a fundamental rethinking of psychiatric knowledge creation and training is in order. If only the highest-quality biologic research were supported,

substantial funding could be redirected to psychosocial, cultural, public health, and community studies that directly support the work of practicing psychiatrists responding to the needs of patients, families, and communities. The most pressing work is research on addiction, elder care, community care programs, consultation aimed at improving the quality of care in medical clinics and hospitals, child and adolescent psychiatry, and global mental health, as well as cultural studies of vulnerable populations.

Biologic psychiatry has thus far failed to produce a comprehensive theoretical model of any major psychiatric disorder, any tests that can be used in a clinic to diagnose clearly defined major psychiatric disorders, or any guiding principle for somatic treatments to replace the empirical use of medications. Biologic knowledge is foundational to good psychiatry, but we believe that misapprehension of its limitations is stunting the field from within and subjecting it to manipulation from without by corporate and administrative interests that, intentionally or not, strive to benefit from a falsely simplified and deterministic formulation of mental illness and its treatment.

It seems clear that psychiatry needs to be rebuilt, and academics can lead the way. Biology and dynamic psychological considerations can complement one another. Psychiatric training programs can promote epidemiology, social science, cultural expertise, community studies, prevention, and consultation–liaison work — and most important, psychotherapy.

If advances in modern neuroscience have taught us anything, it’s that the brain–mind and its emotional and cognitive processes are even more complicated

and mysterious than previously thought. It is crucial that this work continue. At the same time, we are learning more and more about the interconnections of mind, body, and society, and the interdependence of mental, medical, and social health. This interdependence has profound and prac-

 **An audio interview with Dr. Gardner is available at NEJM.org**

tical implications for the practice of general medicine as well

as psychiatry. In many ways, the unknown continent of the mind looms even larger now than it did in Jaspers' day — a reality that is both humbling and inspiring.

Rather than contracting in an exclusive focus on biologic structure, the field needs to expand if we are to meet the needs of real people in the clinic, on medical wards, and out in the community who require comprehensive, relational care to address their suffering effectively and humanly.

Disclosure forms provided by the authors are available at NEJM.org.

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Enabling Healthful Aging for All — The National Academy of Medicine Grand Challenge in Healthy Longevity

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During the past century, human life expectancy has nearly doubled globally, increasing by more years than it did in all previous millennia combined. Today, 617 million people are 65 years old or older; by 2050, the number will reach 1.6 billion — nearly 20% of the world's population — and the population of the “oldest old,” 80 or older, will more than triple, growing from 126 million to 447 million.¹ Major advances in public health, socioeconomic development, education, and health care have driven these dramatic gains. Yet this triumph presents challenges as well as opportunities.

Combined with declining fertility rates, the rapid growth of the older population is yielding aging societies, in which the old outnumber the young. This demographic transition creates economic, social, political, and health care challenges. Our core societal institutions, including education,

health care, work and retirement, the built environment, and our economies, were not designed to support populations with this anticipated age distribution. As older adults leave the workforce and proportionally fewer younger people line up to replace them, economies will lose their equilibrium. Health care systems will struggle to fulfill increasing demands for treatment, hospitalization, and in-home caregiving. Communities will strain to meet needs for housing, social services, and transportation. As a result, older people's well-being may suffer.

Population aging affects both high- and low-income countries, though the specific challenges facing each country depend on its economic resources as well as the structure and function of its health care, social insurance, and retirement systems and cultural factors including the severity of ageism. The changes are currently

most profound in Japan, Europe, and North America. By 2050, the United Nations estimates that older people will constitute more than one third of the population in Europe; approximately one quarter in North America, Latin America, the Caribbean, Asia, and Oceania; and 9% in Africa.

Aging is a major risk factor for multiple chronic diseases, including cancers and cardiovascular and neurodegenerative conditions such as Alzheimer's and Parkinson's diseases, all of which require extensive long-term care. Many countries are grappling with rising health care expenditures, elder care workforce deficiencies, and care needs associated with aging, disability, and having multiple coexisting conditions. Japan, whose over-65 population reached 21% in 2006, has made substantial investments in robotics, artificial intelligence, and other innovations to meet these needs. On