

# New Horizons in Psychiatry

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Psychiatry suffered its literal baptism of fire in World War II. It survived and flourished because for the first time in its history it was able to demonstrate on a mass scale a practical aspect of its nature which gave it a respectable identity in the medical family. The venerable Franklin Ebaugh, chairman of the department of psychiatry at the University of Colorado from 1924 to 1953, told a group of us who were interns in 1949 that he was pleased to see that young physicians were becoming interested in psychiatry simply because they desired to become specialists in emotional and mental aberrations, and not because they were seeking magical solutions to their own problems. He made this generalization from his long and varied experience to accent the point of the changing status of the profession.

The immediate post-war period concentrated on education with emphasis upon the post-graduate phase. There was a sudden explosion of the number of returning physicians going into psychiatry, and a side benefit of this aroused interest was an increase in the number of medical personnel available to care for hospitalized patients. The upgrading of mental hospitals and patient care received attention not seen since the days of Dorothea Dix.

The phenothiazines and related psychotropic drugs were introduced in the early 1950's. They went hand in glove with the changing concepts of care for the mentally ill—to reduce hospital stay and renew attention to neglected and hitherto almost hopeless areas. Use of the new drugs ignited greater interest in the chemistry of the central nervous system. The previously held faint hope of magical control of mental illness with almost antibiotic-like efficiency became almost a certain promise if only enough research time and money were made available. The flood of data about neurohormones, the limbic system, the hypothalamus, and metabolic disorders which came from laboratories continues today with only slight abatement. However, the promise of magical control of emotional and mental disorders via the new chemical means remains unfulfilled, however great were the benefits from them.

The 1960's might be called the decade of social awareness. A rising crescendo of voices demanded that the same attention be given to the quality of man's years as was being given to the quantity of them. It became painfully obvious that man's psyche could not be dissected from his environment any more than his mind could be separated from his body. Many of the concepts of Adolf Meyer were rediscovered, rephrased, and amplified. The psychiatrist, the behavioral scientist, and the social scientist suddenly discovered that they were playing in the same ball game, and that they needed to establish compatible rules and regulations. Community and social psychiatry became embryonic modalities with indistinct boundaries and with even dimmer convictions about how they were to accomplish their goals. Progress has been made, but much more remains for the future.

During this post-war period of massive change and rapid advancement the entire medical profession became increasingly aware of the significance of human behavior and emotions in relation to organic disease. The acceptance of psychiatry as part of the medical team was hastened by advances such as organ transplant, intensive care units, and by information showing that in some cases emotional factors could, by changes in the autonomic nervous system and its end organs, determine the outcome of otherwise superb technical procedures. Departments of obstetrics-gynecology and pediatrics began to include the psychiatrist within their own domains as an integral part of the system to teach central aspects of behavior once ignored or given only token attention. A new breed of student began entering medical school with an increased social awareness and with demands to be taught more than the technicalities of medicine. Curriculum time for psychiatry more than quadrupled in most schools.

Just as psychiatry was gaining a hard-won acceptance and was beginning to enter the medical world as a full-scale citizen, a jarring note appeared. The American Psychiatric Association approved a plan to become effective 1 July, 1970 which would allow the psychiatrist to enter residency and complete certifiable

training without an internship (Gregory, 1970). John Romano has aptly termed this a regressive move, and many of us agree (Romano, 1970). This plan could produce psychiatrists of doubtful maturity and questionable medical competence to understand the total patient. Perhaps no medical specialist so badly needs some clinical experience with the overall physiology and pathology of life as does the psychiatrist. Without the medical orientation and knowledge which can be built upon internship or a comparable experience, the psychiatrist may become indistinguishable from the clinical psychologist and Ph.D. social worker. Some of us do not hold that the changed and more clinical senior year of medical school is an adequate substitute for the internship.

Another very practical fact dictates against shortening the post-graduate educational period. The amount of data presently essential for the well rounded psychiatrist has multiplied astoundingly in the last two decades. There have been almost no compensating eliminations of material, and methods of transmitting the needed information and techniques have not improved measurably. Perhaps this decision to shorten training is a compliment to the increased sophistication and brilliancy of our medical students—and without question that is true of them—but it is hard to visualize this plan other than as a ploy to produce greater numbers at the sacrifice of quality.

What, then, of the future? All the advances of the post-war years must be considered as a continuum which will determine somewhat the way we go. There is first a decision to make about the general direction. Will psychiatry continue to be a medical specialty, or will it become another branch of psychology and head toward the elimination of medical requirements altogether? The present trend to reduce the medical training prior to residency, combined with the virtual elimination of neurology from many residency programs, is not a happy sign to those of us who identify as physicians. Some of us will resist this and actively attempt to reverse the trend.

The other and preferred orientation is medical. This route will produce the future psychiatrist whose basic orientation is, to borrow a word from James Weiss, operational (Weiss, 1970). This term is used to refer to "a marriage of experimentally derived principles and naturalistic clinical observations." To further quote Dr. Weiss:

The operational psychiatrist is concerned not only with the biology and psychology of the "whole patient" but also with the social environment which is invariably involved in the predisposition, precipitation, and perpetuation of illness. He needs to understand and to use effectively the language of the culture (as well as that culture's and its people's attitudes, mores, biases, and concerns), to communicate with patients.

He needs some appreciation of cultural differences and cross-cultural variations, without losing sight of the individual patient in that broad social matrix. He has an interest in limiting the two major defects from which psychiatry as a total discipline, despite its remarkable advances in the past half century, has suffered: a lack of sufficient researched knowledge and a lack of adequate proportion of psychiatrists who are both professionally and characterologically competent.

Operational obviously indicates flexible. A profession or specialty must reach a certain stage of maturity before the luxury of flexibility can be afforded. It appears that a degree of rigidity and fanaticism may be an essential, albeit unfortunate, defense for the insecure and the actually limited. Hopefully, psychiatry in the future will no longer require this defense, although it admittedly has used it in the past.

The operational psychiatrist in the future will have a subdivision dependent upon individual interests and talents. Some will work primarily with communities, and others with the basic building block of the community, the family. The recent growth of interest in forensic psychiatry will necessitate a sub-specialty in this field. Adolescent psychiatry already is becoming an entity. Psychiatric research will continue, but most of it will not be done by clinical psychiatrists. Hopefully, though the clinical psychiatrists will be an important cog in research machinery, they will act primarily as consultants to those more specifically trained for scientific research.

One thing will not change if the future psychiatrist is to be effective. The base line of knowledge and skill will still be drawn from a complete understanding of the structure, development, function and malfunction of the total individual. He may call himself a behaviorist, a psychoanalyst, an operationalist, or a social or community psychiatrist, but he must operate from a thorough knowledge of the most basic unit of all society, the individual. All other information and technical skills will be layered upon this foundation and it must remain the core of the educational program.

It follows from this line of reasoning that the future psychiatrist may be primarily a consultant to other disciplines. One-to-one psychotherapy with individual patients will remain an important facet of his work. In fact, this type of contact is essential if the psychiatrist's skills as an expert in human behavior are to be maintained, but there will be many other professionals equally adept at this. Already there are those who feel that the lay analyst, the clinical psychologist, and the well-trained psychiatric social worker are as adept at individual psychotherapy as are many psychiatrists with less special or more general interests.

The future psychiatrist's identity will depend upon

## NEW HORIZONS IN PSYCHIATRY

his ability to correlate the psychological, pharmacological and sociological treatment modalities within the medical community. Each of these areas will have its own expert, but the psychiatrist will translate this expertise into a clinically usable form.

The work of the future psychiatrist, and all others in the field of mental health, will be dictated by a trend that is now quite well established. The major problem of the present, and it seems fairly certain that it will continue so, is with the broad category of personality disorders or behavioral disorders. The classical neuroses that filled the clinics a generation or two ago are declining in number and changing in symptomatology. The disorders of behavior including alcoholism, drug abuse, delinquency and violence are growing with alarming frequency. The explosive events of the past decade have caught us literally with our couches down! Our therapeutic modalities for these entities have been relatively ineffective, and even if this were not so, the problems of numbers and finances have made delivery of treatment in sufficient quantity virtually impossible. Disorders of personality and behavior constitute psychiatry's number one problem of the future.

It would take either colossal narcissism or unbelievable ignorance to make a concrete prediction about the future. And yet, those of us in medical schools must try to do this to some extent, and attempt to educate for the future with present knowledge based on past experience. The danger lies in making a prediction and then trying to manipulate events so as to make the prophesy self-fulfilling. Only two things appear absolutely certain if psychiatry is to maintain its identity as a medical specialty: 1. The future psychiatrist must have a thorough grounding in the physiological, psychological and sociological aspects of the human being. 2. He must be so flexible as to give any one of these three facets precedence when a given situation indicates the need.

Psychiatrists have long held that there should be more psychiatry in general medicine, and the non-psychiatric physicians have said that there should be much more medicine in psychiatry. Both groups have been perfectly correct and are being told by the consuming population that there must be more sociology in each of them. The future psychiatrist must and will work with his colleagues in medicine, not to achieve a utopia, but at least to approach this desirable situation in some degree.

### References

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