Special Article

Psychiatry in 2001

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In the year 2001, the status of psychiatry is viewed through the experiences and thoughts of a hypothetical psychiatrist and a hypothetical family physician. Psychiatry is continuing its explosive progress in brain physiology and psychopharmacology, but has backed away from studies and practice in the psychosocial field. As practice patterns change and more outpatient psychiatric care falls into the purview of the family physician, the two physicians see a need for ever more collaboration between their specialties. A greater commitment by family medicine to psychosocial training and research, especially in areas such as physician-patient and physician-family relationships, is urged.

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It is 5:30 in the afternoon on a fall day in the year 2001, and Dr Gates, a family physician, has two more patients to see. One of them, Mrs Sommers, always tries to arrange it so that she will be seen last. She is a middle-aged, chronically complaining woman in reasonably good health, although her blood pressure is a little high. She has some arthritis, although nowhere near enough to account for her back complaints, and persistent constipation, which would probably clear up if she would stop overmedicating herself. She takes on everybody's symptoms; today Dr Gates is sure she will be concerned about her heart, as Mr Carden, her neighbor and Dr Gates's patient, died last week of an unanticipated heart attack.

No matter how many times Dr Gates has examined and reassured Mrs Sommers over the last 8 years, and no matter how many normal test results he has shown her, she is always sure that each new symptom is evidence of a serious organic illness. From the first time he saw her, Dr Gates has been convinced that most of her complaints are secondary to her emotional problems, but she is outraged if Dr Gates even hints at a psychosocial cause, and she has categorically refused to see a psychiatrist. Her visits always take a disproportionate amount of Dr Gates's time.

The other patient, Mr Desmond, is a self-employed attorney who has been Dr Gates's patient for many years, but has seldom come to the office. His wife called Dr Gates about an hour before, concerned about her husband's personality change. She said that Mr Desmond, usually a hardworking perfectionist, has gradually lost interest in his work and almost everything else. Lately he has been spending most of the day pacing the floor or staring at the wall. He wakes up early and cannot go back to sleep. He has lost his appetite and some weight. His wife has been trying to get him to see Dr Gates; finally, she thinks she has persuaded him.

Based on Mrs Desmond's description, Dr Gates believes that Mr Desmond is severely depressed. Dr Gates wonders whether he should certify the patient as an emergency case so that he can be admitted directly to the psychiatric unit of the local general hospital. Dr Gates decides to see him in the office first, however, to evaluate the patient and to explain his recommendations. He also wants to establish rapport with Mr Desmond, as he will probably care for him after his release, as well as provide support for Mrs Desmond while her husband is in the hospital. He calls his psychiatrist friend, Dr Sykes, to facilitate the likely admission to the hospital.

The Family Physician as Gatekeeper

Dr Gates is tired. His busy practice has become busier over the last few years since insurance companies, in an effort to reduce costs, have required "gatekeepers" to sanction referrals for secondary care. Although primary care internists and pediatricians are supposed to share these duties, the insurers prefer family physicians because they are more cost-effective.

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As gatekeepers, family physicians have control over referrals, and Dr Gates and his colleagues do not refer to physicians who fail to communicate well or who do not refer the patients back to the primary care provider upon completion of care. As a result, the outpatient practices of secondary care physicians have diminished. They now do mostly hospital work, retaining only outpatients who require highly specialized follow-up care. Except in rural areas, family physicians now do less hospital work than they did a decade before. As Dr Gates's hospital practice has diminished, his nursing home practice has increased, as has the proportion of elderly patients in his office practice.

Psychiatric Consultation

Dr Gates refers most of his serious psychiatric problems to Dr Sykes, a psychiatrist who, when Dr Gates started in practice, was spending most of her time providing psychotherapy. In the last few years, however, she has switched her practice almost entirely to inpatient care, although she is available for scheduled consultations over the two-way, closed-circuit color television in Dr Gates's office. Dr Gates uses the TV for many of his consultations; it is as good as direct consultation with psychiatrists, and almost as good with other nonsurgical specialists. Although it cannot transmit palpation and percussion, inspection and auscultation are possible, and radiographs and electrocardiograms can be seen and discussed.

Dr Gates consulted Dr Sykes recently when Jody Alden, one of his teenage patients, threatened suicide. This kind of threat has become frequent among pregnant teenage girls since the 1995 Supreme Court decision making abortion illegal except as a "lifesaving" measure. Dr Gates is uncomfortable in judging the validity of such threats, and he certainly does not like to be blackmailed. On the other hand, Dr Gates suspected that if he refused to approve an abortion on psychiatric grounds, Jody would see other physicians until she found one who would approve. Furthermore, he did not want to underestimate the seriousness of her suicide threat. It was a dilemma, not the only dilemma in his practice.

Dr Gates and Dr Sykes often chat informally about the problems of their respective specialties and about the interface between family medicine and psychiatry. After discussing Mr Desmond's case, Dr Gates complains about how hard it is to keep up with so many new medications. Dr Sykes agrees, and observes that the main action in psychiatry these days seems to be in the field of biological psychiatry.

The Increasing Domination of Biological Psychiatry

Psychiatry in 2001 has moved away from the preoccupation with psychosocial factors and long-term outpatient psychotherapy that dominated the specialty after World War II. As concern for serotonin has supplanted concern for the superego, psychiatrists now concentrate almost exclusively on biological psychiatry and on the pharmacological care of patients with severe mental illnesses.

Psychiatrists' interest in treating psychotic and other seriously disabled mental patients was rekindled by new research findings in genetics, pathology, chemistry, physiology, and pharmacology. Brain imaging and other new technologies have given psychiatrists a much better understanding of conditions such as schizophrenia, affective and obsessive-compulsive disorders, addictions, and eating disorders. In the field of genetics, scientists are now close to knowing which genes on which chromosomes predispose people to schizophrenia[1]; and they are experimenting with genetic engineering, the next controversial step toward controlling this predisposition. Neuropathologists have built on their knowledge of the limbic system of schizophrenics[2] to understand more about how these abnormalities are related to symptoms and how they arise.

Scientists now know a great deal more about the dysregulation of the neurotransmitter serotonin, which for several years has been the "hot" subject in brain chemistry and physiology. Researchers using PET (positron emission tomography), its younger brother SPECT (single photon emission computed tomography), and several even more recent techniques have reported that serotonin dysregulation is related not only to schizophrenia and depression but also to anxiety and panic states, obsessive-compulsive and eating disorders, headaches, and aggressive personalities.[3,4] The most recent studies have explored whether serotonin dysregulation is a cause or an effect of these conditions (answer: a little of each), and whether specific types of dysregulation accompany specific types of psychiatric disorders (answer: some are nonspecific and some are specific).

In the early 1990s, enough was known about serotonin dysregulation to prompt the development of an entirely new line of anxiolytic, antidepressant, and antipsychotic drugs.[5] In the intervening years, other even more effective drugs took their place. Although these drugs do not cure, they provide better symptom relief and fewer disabling side effects than the drugs previously used. Thus, the antidepressant that Dr Sykes prescribed for Mr Desmond began to take effect almost immedi-

ately, without the 2- to 3-week delay that was characteristic of earlier drugs.

In 2001, the severe side effects of the antipsychotic drugs, such as extrapyramidal reactions, tardive dyskinesia, and malignant neuroleptic syndrome, have been substantially reduced. Previously these side effects had complicated the care of psychotic patients and contributed to patient noncompliance outside of the hospital.

Patient noncompliance seriously handicapped the efforts of psychiatrists in the 1970s and 1980s who attempted to treat psychotic patients in the community rather than in state hospitals. The crucial, almost fatal, weakness in community psychiatry was rooted in its attempt to promote deinstitutionalization as an economy measure, ignoring evidence that effective community care costs as much as hospital care. The payoff of deinstitutionalization is not in reduced health care costs but in the patient's quicker return to work and thus to taxpayer status. Unfortunately, even in 2001, the states have still not realized that adequately funded community care for most—not all—psychotic patients is not only more effective and more humane but in the long run is more economical than either hospital or poorly funded community care.

In 2001 it is still possible, however, to find a few scattered settings in which community care is effective[6]; in most of these settings the family physician provides maintenance care and family support in collaboration with community mental health centers. If Dr Gates's community had such a center, it could have expedited Mr Desmond's care; he could have returned home sooner, perhaps to a day hospital, and the psychosocial aspects of his aftercare could have been better integrated with his medication.

Drs Gates and Sykes have discussed the impaired immune function reported in cases of depression like Mr Desmond's and even in cases of bereavement.[7] The two physicians have speculated whether an impairment in immune function may contribute to the increase in medical and psychiatric illness among recent widows and widowers.[8] They agree that the role the family physician plays in preventive psychiatry in the early care of the bereaved person is extremely important.[9] Dr Gates writes a note to himself to remind him to ask Mrs Carden, whose husband recently died of a heart attack, to drop in for a talk and perhaps to set up a series of bereavement counseling sessions.

Dr Gates will be caring for Mr Desmond when he leaves the hospital. He will be glad to have his patient returned to him, but he is somewhat apprehensive about the follow-up care, both the medication and the counseling aspects.

The Expanding Role of Medication

Dr Gates believes that medication is usually the best treatment for any psychiatric condition. Writing a prescription is so much easier and less time-consuming than counseling. Furthermore, the new antidepressants are highly effective and cause few side effects.

Medications are invaluable as the central treatment method when a psychiatric condition is self-limited, as in a major depression like Mr Desmond's, or when it is difficult or impossible to treat the cause of the disorder, as in schizophrenia. Medications also can be useful as adjuncts to counseling or psychotherapy in longstanding conditions for which the therapeutic goal is more to reduce symptoms than to root out the causes, as in chronic anxiety states. They should be used very sparingly, however, for conditions such as bereavement in which the physician needs to encourage rather than dampen the expression of feeling to prevent serious sequelae. In fact, investigators who study acute bereavement are virtually unanimous in cautioning against the use of psychotropic medications in such cases unless absolutely necessary.[10]

Deciding when to counsel and when to use drugs has always been difficult and probably always will be, and individual patient factors are more important than the clinical label in making this decision. Psychiatrists keep hoping that they will eventually find a classification system that will answer this difficult question. In 2001 a new *Diagnostic and Statistical Manual for Psychiatric Illness, DSM-IV*, has replaced *DSM-III-R*.[11] While *DSM-IV* does not solve all the problems of classification, it does provide official terms for some of the diagnostic "orphans" that were not covered in its predecessor. Most psychiatric conditions, particularly those seen in outpatient settings, are not discrete entities and usually have more than one cause. The causes of these conditions are seldom *either* organic *or* functional; instead, they are combinations of biological, psychological, and social factors, each interacting with the others.[12]

The Diminishing Role of Formal Psychotherapy

Family physicians in 2001 continue to provide adjunctive counseling and supportive psychotherapy, often along with drug treatment. What has changed is the availability of formal psychotherapy. Family physicians like Dr Gates used to refer patients for formal psychotherapy to psychiatrists like Dr Sykes or to members of other mental health professions. In 2001, however, most psychiatrists

no longer have psychotherapy practices, although they continue to provide outpatient consultation.

The change in emphasis from psychosocial to biological is only one reason why Dr Sykes gave up psychotherapy. The other reason was economic. Reimbursement for psychotherapy was reduced when insurers decided that it cost too much. Although psychoanalysis was always perceived as available only to the wealthy, until the 1990s long-term psychotherapy was substantially covered by insurance. In 2001, however, it is available only to those who can pay for it out-of-pocket. This is another example of how, in the United States, costs determine medical care.

Formal psychotherapy has never been a viable option for Mrs Sommers. In the first place, she categorically refuses even to see a psychiatrist for a consultation; in the second place, Dr Gates has not found psychiatrists to be very interested in patients like her. Although he has resigned himself to the fact that he is "stuck" with her, he would like to find a new and more satisfactory approach to her care.

New Psychotherapies

Patients like Mrs Sommers who have many somatic complaints have always been difficult for the family physician to manage. We now say that they are "somatizing"; in earlier years they were called hypochondriacs or hysterics, as well as some less scientific expletives. Their medical care can take up a great deal of the physician's time and can generate a substantial number of expensive laboratory tests.

The role of psychotherapy, not only for somatizing patients but for any patients, has dramatically changed, stimulated more by insurance limitations than by scientific study. For quite a while it has been evident that, at least for the average patient, traditional long-term psychotherapy is not an option. Regardless of its merits, it costs too much for today's conditions. Some psychiatrists have been working on ways to streamline the process. They developed techniques to contain the needs and demands of patients like Mrs Sommers,[13] and they were able to cut down drastically the number of visits for patients with more acute conditions.[14] They did so by concentrating more on factors such as grief and other losses that *precipitate* a condition and less on early childhood experiences that *predispose* a patient, or make the patient vulnerable to later precipitants.

Psychotherapists who use these shorter techniques are more concerned with relieving symptoms than with attempting to change basic personalities. (Therapy for patients with personality disorders, however, continues to take a long time.) Unfortunately, although "brief," or "short-term," psychotherapy is still marginally covered by some insurers in 2001, it is getting progressively more difficult to find a psychotherapist. A therapist needs a steady flow of referrals to keep a small psychotherapy practice going, and the volume is seldom enough.

The reduced insurance support of psychotherapy has affected not only psychiatrists, but privately practicing psychologists and social workers as well. A good many of them have left the field, and as the pool of psychotherapists has dwindled, it has become more and more difficult for family physicians to find anyone trained to do psychotherapy.

The Family Physician as Psychotherapist

Back in the 1960s, the National Institute of Mental Health underwrote a series of programs aimed at teaching family physicians psychotherapy. At that time the effort was not successful: psychotherapy required too many changes and too much of the family physician's time. However, it has now become a necessity.

In 1964, a comparative study of the mental health activities of American and Scottish family physicians found that none of the Americans were carrying out formal psychotherapy, although they had been encouraged to do so in medical school and after.[15] On the other hand, several of the Scots provided psychotherapy, although they had never been taught or encouraged to do so. The major identifiable difference was that the Scottish physicians were affiliated with the National Health Service, in which each physician is responsible for a panel of about 3000 patients, while the Americans were in conventional fee-for-service practices.

The Scottish physicians were paid the same no matter how often they saw their patients, so the crucial variable between the two groups was time. The Scots found that doing psychotherapy actually *saved* them time. Those who used formal psychotherapy with their somatizing patients were the ones who had more leisure time, while their colleagues were frantically trying to catch up with their patients' demands. As one of them said, "By doing psychotherapy I am providing better service to my patients; they are less preoccupied with secondary symptoms; I do many fewer unnecessary laboratory tests; and I have enough time so that I can enjoy my work more."

Psychotherapy thrives best in clinics or organizations that pay physicians salaries that are not based on the number of patients seen.[16] As more family physicians have moved into salaried practice, and as more psychiatrists have moved out of psychotherapeutic practice,

there has been a recurrence of interest in psychotherapy by family physicians. This development has not turned out to be as difficult as it first appeared. The Scottish physicians in the study mentioned above either taught themselves, using books such as Castelnuovo-Tedesco's guide,[17] or they formed groups to share experiences and to get help from each other similar to the groups pioneered by Michael Balint.[18]

Dr Gates wonders if Dr Sykes would be interested in participating in a Balint group with him and some of his colleagues. Now that family physicians are doing more outpatient psychiatric care, Dr Gates thinks that the interest would now be greater than it was several years ago when he first mentioned the idea. Dr Gates's experience in working with Dr Sykes on cases involving the aged, teenage suicide, and violence encourages him to think that she would work well with other family physicians, too.

Collaboration Between Family Physicians and Psychiatrists

Both Dr Gates and Dr Sykes worry about the increasing numbers of aged in our population, and the concomitant increasing numbers of people with Alzheimer's disease. In 2001 as in 1993, psychiatrists care for Alzheimer patients in mental hospitals, whereas family physicians care for many more who are at home or in nursing homes. Although the roles of amyloid and intracellular calcium in the etiology of this condition, and of tacrine and a dozen other substances in its treatment, are being studied, medicine is a long way from understanding the causes of Alzheimer's disease. Effective therapy seems even farther away. Drs Gates and Sykes participated in establishing a joint committee of specialists in their community to share experiences and frustrations. The committee also is forming better guidelines to help practitioners to differentiate between the more treatable depression of old age and Alzheimer's disease.[19]

Drs Gates and Sykes also have talked about how the increase in Alzheimer's disease, along with improved methods of maintaining life in other severely damaged patients, has created a steadily increasing number of people whose quality of life has deteriorated but who continue to live, some comatose and others wanting to die. Health care for these people is a social problem that has been gradually forced upon medicine.

Another area of potentially greater collaboration between psychiatry and family medicine, they believe, is in the care of troubled children and adolescents, especially those with depression and suicidal tendencies. Both physicians wonder to what extent this increase is related to the increase in mothers who are single or working or both. They think that this is another area in which their specialties might work together, perhaps to carry out a joint research project to learn more about how these conditions develop, how to prevent them, and how to recognize and treat them early in their course.[20]

Suicide threats made to obtain medical sanction for abortion increased greatly after the 1996 US Supreme Court reversal of *Roe v Wade*. Neither Dr Gates nor Dr Sykes feels confident of his or her ability to determine the seriousness of such threats; most of them seem manipulative, but underestimating their seriousness could have lethal consequences. The two physicians agree that this is yet another area where collaboration would provide better answers than either specialty could reach alone.[21]

The epidemic of violence in this country continues to rage in 2001, despite gun-control legislation, which finally passed after a Congress responsive to majority opinion was voted into office. The results of violence are not just seen in emergency departments. Dr Gates sees it in cases of child abuse and hears about it in stories of spouse abuse and parents afraid of their adolescent children; Dr Sykes not only sees it in some paranoid schizophrenics and alcoholics but hears about it in family histories and in school consultations. As their two professions alone cannot expect to solve these social problems, they are involved with others in and out of medicine in society's efforts to cope with it.

Facilitating collaboration in these various areas will be a challenge that will take more than conventional case consultations can provide. Part of the arrangements are in place already, in settings like Dr Gates's, in which communication between psychiatrist and family physician is free and open. The need for such collaboration is greater than ever before; Drs Gates and Sykes believe, however, that when a need of such dimensions becomes evident, psychiatrists and family physicians are resourceful enough to find ways of meeting it.

Speculating About the Future

Dr Gates asks Dr Sykes what she thinks the next 20 years or so will bring in psychiatry. Although she anticipates that the revolution in psychopharmacology will continue, she is somewhat pessimistic about psychiatry's identity as a specialty. She believes that by subordinating its concern with personality to a concern with the brain, psychiatry has lost its unique place in medicine. Family medicine, which is defined by its inclusion of psychosocial factors such as continuity and attention to the physician-patient relationship, and emphasis on the family as the basic unit of medical care, may be psychiatry's suc-

cessor in this special area. To make the best of this opportunity, both Dr Gates and Dr Sykes believe that family medicine must make a greater commitment to psychosocial research that includes further exploration of the physician-patient and the physician-family relationships.

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