PSYCHIATRY AN[illegible]S IDENTITY CRISIS

by

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Fundamental Problems of Modern Psychiatric Diagnosis and Treatment

Psychiatry is a strange medical specialty:

1. It is not sure what constitutes its very substrate, i.e. psychiatric illness, itself, and thus is not sure whether and when it should go into action and give treatment ....
2. If a psychiatrist has decided that he should give treatment, in most cases he cannot be objectively certain about his diagnosis....
3. If he is sure of his diagnosis and the need for treatment, he may not know what kind of treatment he should give, because there are few definite rules about therapeutic indications in psychiatry....
4. If he is sure about the need for treatment, about the diagnosis and the type of treatment he wants to give, he finds it very difficult to objectively

determine the extent of changes in his patients' condition which might occur under treatment....

5. Even if he is sure about all the foregoing he often is not altogether sure which of the changes he observes constitute real improvement...

6. And even if he is sure of all of this, that is the need for treatment, the diagnosis, the nature of treatment he should apply, the measure of changes that have occurred and the amount of improvement represented by these changes - he still often does not know to what extent this improvement is due to his treatment or to unplanned factors, for instance his attitude towards the patient, placebo effects, or simply the natural history of the disease which has spontaneously subsided.

Anti-Psychiatry

Under these circumstances it is not too surprising that, for the first time in its history, psychiatry is faced today with a strong and organized anti-psychiatric movement. In the past, psychiatrists have become used not to be taken seriously by their colleagues and other medical specialties, to be ridiculed as well as being held in fearful awe by the general public or, on the contrary, to be overestimated in their potential capacity as being almost unlimited. But there has never been an organized anti-psychiatric ideology before.

Today's anti-psychiatric ideology is being supported by three movements: first, an intellectual movement sometimes lead by men who themselves are psychiatrists - e.g. Szasz - and who attack psychiatry by insisting - like Szasz - that psychiatry is not a legitimate part of medicine but rather "the practice of dialectic and rhetoric" and that "the principle roles of the contemporary psychiatrist are those of moralist and rhetorician" and "rarely that of physician." In line with this conviction, Szasz considers most psychiatric diseases as being "metaphorical" entities.

But another anti-psychiatric psychiatrist, Laing, has a moral involvement and sees contemporary psychiatry as a despicable system of artificial, hypocritical, inappropriate and often inhuman devices, which misses the essence of what it purposes to fight, that is, human psychic suffering.

The third support for antipsychiatry comes from a social movement which proclaims that psychiatrists are agents of the established social system, that society itself is sick and that the primary aim of psychiatry is to render people docile and to make them adjust and conform to the ills and evils of our present sick society.

An Epistemological Impasse

These two attacks - the intellectual and the social - on the very substrate of psychiatry, that is on the nature and existence of psychiatric diseases as we have traditionally known them, have today created an epistemological impasse on the nature of sickness in general. What is

particular? If we assume that it is sickness, then what characterizes sickness and distinguishes it from health?

I find that at least five different models of sickness or pathology are needed today to cover all the meanings various people in our society may attach to the term sickness. These models are:

The Five Models of Sickness (illness; disease; pathology):

1. The Bio-medical Model — Structural or chemical alterations of a living organism which can be objectively demonstrated, which tend to reduce the normal life expectancy of the organism in part or in its entirety, and which are not consequences of natural life processes such as pregnancy or aging.
   Examples: inflammation; tumor; wasting (atrophy); trauma; poisoning.

2. The Actuarial Model — Significant deviations from the normal structure or functioning of an organism, when this norm is determined by the statistical average within the general population.

Examples: dwarfism; high blood pressure, confusion; fever; myopia; impairment of judgment; reduced capacity for perception of reality (reality testing), as manifested in hallucinations, delusions or in grossly distorted moods, e.g. feelings of exaggerated well-being.

3. The Functional Model

Loss or disturbance of functions which for some time had been contributing to an individual's well-being and/or social integration - provided that the individual resents this loss or disturbance and that they are not consequences of natural life processes.

Examples: loss of memory (amnesia); loss of muscular power (asthenia); loss of drive (apathy); loss of sexual potency (impotence); loss of capacity for enjoyment (anhedonia).

4. The Experiential Model

Experiences which are characterized by suffering (dysphoria) which may lead to partial or complete incapacity of the

and expected consequences of life events (e.g. a catastrophe or a death in the family).

Examples: neurotic anxiety states; neurotic or psychotic depressions; hypochondriasis; any painful or disagreeable condition.

5. The Social Model

Asocial or antisocial behaviour reflecting a distinct and progressive change in the individual's ordinary personality - i.e. a change in his habitual way of acting or in his normal life style - and involving some causal and temporal connection between the observed change of behaviour and external agents or pathological conditions which may have led to the change.

Examples: social withdrawal; juvenile delinquency; promiscuity; loss of ambition; social parasitism.

Sydenham, a contemporary of Newton, is usually regarded as the father of the modern concept of nosology, i.e. of the science of diseases as entities with causes, morbid manifestations and/outcomes which are similar for each specific type of disease. Thus, Sydenham was the first to stress the

of the "natural hi[illegible] approach to medicine. Only 100 ye[illegible] Morgagni completed [illegible] modern concept of disease by intro[illegible]ing the study of morbid anatomy into medicine.

In the second half of the 19th century, Virchow constructed his cellular pathology and swept nosology clear of all vestiges of romantic speculation which at that time had started to dominate medical science. Then with the advent of bacteriology, the first decisive breakthrough was made toward achieving the nosological ideal of linking etiological factors with symptoms and course of a disease, resulting in integrated pictures of different specific disease entities. Rapid progress of the physical sciences led to the discovery of X-rays, the invention of the electrocardiograph and the development of numerous biochemical and endocrinological methods of diagnosis. Physicians were coming close to transforming the intuitive clinical art of diagnosis into a hard science, based more and more on objective procedures - at least in the realm of physical diseases.

However, the causes of the major psychiatric diseases, particularly the functional psychoses, are still unknown, and there are no objective methods for the diagnosis of functional psychiatric diseases. Optimism ran high when Wassermann's test in 1910 made it possible to establish the diagnosis of dementia paralytica in individual patients beyond any doubt and when, almost simultaneously, Noguchi demonstrated the presence of spirochetes in the brains of patients who had died from this disease, thus proving syphilis as the specific cause of the disease. A quarter of a century later, in the early 1930's, Berger's discovery of the electroencephalogram was greeted with great enthusiasm by psychiatry. Here seemed

to be the royal road to an objective diagnosis of mental disease. However, the case of dementia paralytica remained an isolated model and the electroencephalogram has not been very helpful in the diagnosis of psychiatric diseases; whether more sophisticated derivatives of the EEG - e.g. evoked potentials, will be more fertile for psychiatric diagnosis, remains to be seen.

Nosological Schisms

Although an ideal nosology would have to be based on etiology, Sydenham had already realized that this was impossible in practice and concentrated on morbid manifestations and course of the diseases. The early explorers of psychiatric nosology, men like Pinel and his pupil Esquirol, could only describe symptoms and syndromes. When, by the middle of the 19th century - for the first time in medical history - distinct and widespread interest in the nosology of mental diseases had crystallized, there developed also immediately an open schism between those who wanted a classification according to the causes and those who wanted a classification according to symptoms. Another embittered debate ensued between psychiatrists who, like Griesinger, postulated that all mental diseases were simply the reflection of brain diseases and those psychiatrists who, like Heinroth, conceived of mental diseases as the results of dynamic, psychological and spiritual struggles. Reacting with a totally agnostic attitude to this confusion, Heinrich Neumann, in 1860, declared that psychiatry would only be able to progress if it decided to "throw over-board the whole business of classifications..." But the march of nosological classification continued in psychiatry, and Morel, Hecker and Kahlbaum described their classical

syndromes of demence precoce, hebephrenia and catatonia. Falret introduced the time factor into psychiatric nosology and thus prepared the way for Kraepelin, whose system of psychiatric diseases combined a careful description of symptoms and syndromes with an appreciation of the course and outcome and, of course, their etiological factors, to the limited extent to which they were known at his time.

Indeed, Kraepelin's nosology seemed to fill a need which had existed for almost a century and his comprehensive classification was soon accepted throughout the world. However, Jasper (1959) pointed out that etiological factors were definitely known in only one group of psychiatric disorders, i.e. those comprising the organic brain syndromes and those psychiatric conditions which are caused by somatic disorders and intoxications. In another group, including the major functional psychoses, we can be certain that we are dealing with diseases, but their causes are unknown and the diagnostic limits often blurred. In a third group, which Jaspers characterized as psychopathies, under which he included the neuroses, character and behavior disorders, we can no longer even be sure that we are dealing with true diseases. Kurt Schneider (1950) refers to this group of psychiatric disorders as "abnormal variations of sane mental life" and concludes: "there are no neuroses but only neurotics." The concept of neurosis as a disease entity remains to this day a highly controversial issue in German psychiatry.

Adolf Meyer's (1958) psychobiology - like modern psychosomatics - does not recognize clearly defined psychiatric diseases, but only reaction

types which are the results of complex habit patterns of non-adaptive responses in the life history of an individual. This type of conceptualization seems to carry a definite resemblance to the etiological orientation of modern behaviour therapy.

The German psychiatrist Kleist (1953), following Griesinger's conviction, considered every mental disorder as the direct result of a cerebral, structural or functional lesion. His nosology is impressive in its monolithic consistency and single-minded concentration on physical causes. Unfortunately, his evidence has not kept pace with his theoretical aspirations and has prevented a more general acceptance of his nosological system, although Leonhard's (1960) classification which has a similar neurological bias with an emphasis on genetic factors, has in recent years aroused more interest in psychiatric circles.

Psychoanalysts have not proposed a comprehensive classification of mental disorders. The psychoanalytic-psychodynamic theory is their frame of reference for all psychiatric disturbances, with comparatively little scope left for clinical observations and the demonstration of physical causes. The old schisms of the "symptomatologists" versus the "etiologists", and of the "organicists" versus the "dynamicists" have survived a century and to this day are very much part of our ongoing discussions in modern psychiatry. To these two fundamental splits two others have been added: Stengel (1959) calls attention to a split between the "separatists" and the "gradualists" in psychiatry. The separatists conceive of the psychoses as autonomous disease entities which are qualitatively different from the neuroses and character disorders. The gradualists, led

by Menninger, the French psychiatrist Ey, advocate a unitary concept of mental diseases, and see mental pathology distributed on a continuum from the normal to the psychotic, the latter being, according to this school, only quantitatively different from the neurotic, that is sicker. The other new schism in nosology has developed between those who insist that a meaningful and consistent classification of mental diseases can only be made by the actuarial approach, that is on a statistical basis by quantitative recording of observable behaviour manifestations, and those who are convinced that clinical evaluation should remain the basis of psychiatric classification.

Today all official classifications continue in the Kraepelinian tradition and combine symptomatological with etiological criteria, in spite of Jasper's early warnings against this kind of conceptual glibness. In 1947, Essen-Möller and Wohlfahrt made a specific attack on the thoughtless mixture of these two principles of classification. By recommending the continuation of the tradition of Morel who, in 1860, was the first to use explicitely the "double voie" of syndromes and causes to classify mental diseases, they asked to do it at least in the sense of Birnbaum's (1928) "structural analysis", which, for example, distinguishes lucidly between "pathogenic" (etiological) and "pathoplastic" (symptomatological) factors. Moreover, in addition to syndrome description and etiology, Essen-Möller and Wohlfahrt propcsed a third dimension of psychiatric diagnoses, namely the intensity of the disturbance; and in a more recent publication, Fernandes (1967) hasssuggested the addition of a fourth dimension which

would refer to the specific pattern of a mental illness, wh[illegible] calls the "syndromatic melody".

Langfedt's system (1956) classifies psychotic disorders according to main diagnosis, personality type and situational background. The latest international classification on diseases (1959) allows for multiple diagnoses and, like all generally adopted diagnostic systems in psychiatry, continues to compromise by mixing etiological criteria with symptom and syndrome observations.

Considering the present state of our knowledge, it would indeed be unrealistic to insist on absolute consistency of a scientific classification in psychiatry. Marchais (1966) has referred to the results of the existing conceptual imperfection as nosological polymorphism, and Minkowski (1967) has compared the different systems we use in classifying psychiatric diseases to the different languages of different cultures.

Diagnostic Confusion

However, it would be much easier to live with the present nosological inconsistencies if the practice of making a clinical psychiatric diagnosis were not in such a state of confusion. A medical diagnosis serves a variety of purposes. In the first place a diagnosis has the signaling function of indicating a specific treatment for the condition under consideration. Another important function of the diagnoses is that of establishing a prognosis. Clues to the etiology of the disease are often provided by the diagnoses. Epidemiology needs diagnosis as its essential substrate. Furthermore, diagnosis is the symbolic, shorthand language which physicians use for rapid communication with each other. Finally, to make a

diagnosis satisfies the clinician's need for conceptual security - in a way, it removes the magic from the treatment of the sick by making codified concepts out of nameless phenomena and subjective impressions.

There are three ways in which physicians may obtain information enabling them to make a diagnosis. These are:

1. History. Because of the reporter's bias, inaccuracy of memory and observation, there remain always many subjective components in any history of an individual's disease.

2. Clinical observations. They depend mainly on the diagnostician's special training in evaluating pathology, on the amount of his clinical experience and practice, on his medical education and cultural background and on his personal, theoretical or emotional biases.

3. Laboratory tests. They may be of a physical or chemical nature, but they can always be reduced to objective pointer readings, whether obtained through an electron microscope or electroentalograph or a chromatogram.

And a fourth way of obtaining important information - but available only for psychiatric diagnosis - is empathy. Empathy is an entirely subjective diagnostic tool. One may define it as an immediate sensing of another person's emotional state within the situation of an interpersonal relationship. To use one's own emotional responses to the patient in making a diagnosis is a legitimate procedure in psychiatry, because in this branch of medicine we must deal with phenomena which transgress the biological aspects of the system we seek to evaluate.

A clinician is not a detached observer as a physical scientist is, nor is he a participant observer like the social scientist. The clinician is essentially a maniuplative observer. He observes only in order to change the data he is observing. Because of this, the clinician is guided primarily by pragmatic considerations. In contrast to him the researcher should always try to establish firm and objectively verifiable criteria for his findings. This means that the researcher, far from being pragmatically should be independent of the clinician's subjective judgment. Since mental disease manifests itself mainly in behavioural deviations, the behavioural symptoms - serving as criteria for psychiatric diagnosis - should ideally be capable of objective and unambiguous recording. This is, of course, possible only for a very limited number of behavioural manifestations - for those that are capable of physical registration, e.g. the speed and directions of a patient's movements, the amount and intensity of his vocal production, the number of specific sounds or words he utters in a given time, etc.

However, most of the important behaviour items which must be recorded by the research scientist searching for new and better methods of diagnostic classification are of the type that have to be judged by human observers and have to be recorded in rating scales, usually in some measure of intensity which dependsnon the subjective estimate of the rater. The items to be rated are such deviations as conceptual disorganization, depressive mood, anxiety, hostility, guilt feelings, conformity, somatic concern, euphoria and similar complex phenomena. Even if many of these concepts are broken down in the rating scales to a number of simpler behavioural manifestations, the rater's task will in most cases still remain

a subjective recording of human phenomena which can only be appreciated by another human being. And this - at least in my opinion - transposes much behavioural rating from the objective scientific dimension into the subjective clinical one.

Since the making of an accurate clinical diagnosis in psychiatry depends on valid and reliable observation and recording of such basic behavioural observations, it has recently been stressed that the traditional form of mental examination based on the free clinical interview should be replaced by structured interviews and the scoring of standardized rating scales. It is true that it is possible to obtain a high reliability between the scorings of various observers on such scales but reliability is not the same as validity, and often it is not more than an artificially produced conformity of well endoctrinated and overtrained subjects. As for the validity of the behavioural ratings, particularly when it involves the evaluation of feeling states and sttitudes, I do not believe that one is allowed to assume that every normal person either possesses or may acquire the ability to judge accurately such behavioural manifestations or emotional states. In a clinical conference, it is sometimes almost impossible to come to any general agreement even on such simple behavioural phenomena as what is bizarre, what is confused, what is depressed, what is apathetic, what is anxiety, what are guilt feelings, happiness, conformity, productiveness, hostile behaviour, belligerence? Sometimes it may take hours of seminar sessions and discussions and much training and demonstrations to get a group of residents to recognize these phenomena when they are there and not to misidentify them.

Furthermore, some experiments conducted a few years ago in our hospital, have indicated that certain persons seem to be able to make reliable and highly valid judgments of the behaviour of psychiatric patients without ever having received much systematic training or having had much experience in this field, while some experienced professionals after many years of training fail to come even close to the performance of these naive but somehow gifted observers.

It seems therefore, that in addition to clinical training and experience which are required for the making of valid psychiatric observations, there is also another, apparently primary, factor involved which is quite independent from experience and training, and therefore, at the present time still uncontrollable.

I must, of course, admit that in spite of all their deficiencies such diagnostic instruments as structured interviews and behaviour rating scales have considerable advantages over the unstructured clinical approach when it comes to tasks which involve the comparison of clinical data obtained from different persons or at different times, as in epidemiological and comparative therapeutic studies. Such diagnostic instruments are also very important for the teaching of clinical techniques and skills, and finally they serve the purpose of systematic reviewing and stock-taking of the clinicians' available tools.

But let me mention two particular criticisms which I have about the currently available rating scales.

1. No attempt is usually made to establish the relevance of all the symptoms and phenomena that are considered in a statistical search for a specific diagnostic pattern. Such factors as anxiety, hostility and excitement, which all exist to some degree normally in every person,

may carry very little, if any specificity. Even while they may be extremely important for the patient's therapeutic management and his prognosis, they frequently do not contribute to a specific diagnosis.

2. The hierarchy of psychotic symptoms is disregarded by most diagnostic methods based on the simple scoring and statistical evaluation of any symptoms which are present. It appears unjustified to have such symptoms as hallucinations, delusions, lack of self-care, (thought disorder), posturing, verbigeration and mirror gazing all treated as though they were of equal significance for the diagnosis of schizophrenia, when the first three of these symptoms may occur in just about any psychotic illness, while the last three (or four) - in combination and sometimes even singly - are almost pathognomonic for schizophrenia.

An interesting observation was made by Grinker and Nunnally who found that more agreement among a group of psyciatrists could be reached when they were asked to rate patients' feelings and concerns than when they reported their observations on the patients' overt behaviour. Thus, these psychiatrists were more reliable when they made inferences about their patients' private emotional processes than when they reported on their observations of the patients' public performances. It is not stated how valid their inferences were. At any rate, this finding does not inspire particular conficence in the scoring of behaviour rating scales which are the product of psychiatric observers.

Compared to the measuring devices of the physical sciences the methods of psychiatric diagnosis appear to be pitifully primitive, even

when carefully standardized behaviour rating scales are used and evaluated by computer-based, high-powered statistical methods.

Zubin (1967) has reviewed the agreement between different examiners for diagnostic categories and found that it ranged from 46% in the psychoneuroses to 84% for organic brain syndromes. He also reports that the consistency of diagnoses for a given patient over a period of time is relatively low, ranging from 24% for the neuroses, to 65% for organic psychoses and 74% - in one study - for personality disorders.

With the growing use of structured interview schemata, behaviour rating scales and multivariate analysis of the resulting data, we discover that a new and rather disquieting nosological phenomenon has appeared to which I have referred as the "syndrome explosion" (Lehmann, 1967). A constantly increasing multitude of new computer-made psychopathological syndromes, clusters and factors is being added to those already in existence, and no end is in sight.

A painstaking study of North American and British diagnostic methods and findings has recently established that American psychiatrists have a marked tendency to over-diagnose schizophrenia (a tendency to which British psychiatrists have sometimes referred as schizophreno-mania). A recent "thesaurus" of psychiatric diagnoses records that the number of psychiatric diagnoses at present has swollen to an incredible 340 different diagnostic classifications (Pörasen, 1967).

However, things are perhaps not as hopeless in the field of psychiatric diagnosis as the present confusion seems to indicate. A

ent methodological exercise in psychiatric diagnosis, organized by the World Health Organization (Shepherd et al., 1968), suggests that the use of carefully written histories and videotaped interview material is invaluable for the delineation of basic issues in clinical diagnosis. Shepherd's group isolated the following three factors as accounting for most disagreement and difficulties of communication:

1. Variations at the level of clinical observation and perception;
2) variations in inferences drawn from observations;
3) variations in nosological schemata followed by individual clinicians.

The WHO group concluded that the greatest need to establish general agreement was in the area of nosological schemata which involves the teaching of diagnostic criteria. However, there are many psychiatrists today who have become agnostics when it comes to diagnosis. They ask: "Do we really need diagnostic labels on our patients?"

All our modern and sophisticated efforts at building new systems for the grouping of psychiatric patients are the direct outcome of Kraepelin's descriptive chef d'oeuvre which almost simultaneously with Freud's psychodynamic and Pavlov's psychophysiological discoveries, ushered in the scientific era of psychiatry at the turn of the 20th century. Observed phenomena (Kraepelin), creative theories (Freud) and ingenious experiments (Pavlov) respectively are the essential components of the achivements of these three giants. Somehow, it seems however, that we are on more solid ground in psychiatric theory and experiment than we are in psychiatric phenomenology and diagnosis. This may sound strange but

is probably due to the fact that we are better able to control the crucial factors in theory and experiment, most of which we ourselves initiated, than we are capable of controlling clinical phenomena because they are given to us as end results of nature's experiments.

Therapeutic Controversies

To compensate for this shortcoming, there is, however, the promising impact of developments in the field of psychiatric therapeutics. During the last 30 years, progress in the therapy of psychiatric disorders has outpaced progress in the fields of diagnosis and etiology. However, in the field of therapy not everything is harmonious either. Instead, we find ourselves in the midst of a number of therapeutic controversies. First, there is the classic one, that has been with us for so long: physical therapy - e.g. pharmacotherapy or electroconvulsive treatment - versus psychotherapy. While there prevails today much less of an either/or attitude then there was some years ago, there are still too many radical advocates of eitherposition.

And if the psychotherapeutic approach is chosen exclusively or in part, which should it be? Individual or group therapy? Psychodynamically or psychosocially oriented treatment? Therapeutic community or no therapeutic community? Only crisis intervention - repeated, if necessary - or prolonged therapy with the aim of achieving a restructuring of the patient's personality? Interpretive psychotherapy based on insight into psychoanalytic principles, or behaviour therapy based on learning theory?

A new new school is developing today which isno longer trusting any structured techniques regardless of their theoritical background, but instead relies entirely on existential encounters, confrontation and ensuing remedial interpersonal relationships - if they happen to occur.

Unfortunately, we have practically no reliable data - with the exception of some physical therapies and recently some results of behaviour therapies. - on the relative effectiveness of the various therapeutic approaches. Moreover, the issue is not entirely one of questionable facts and unproven theories. It has also become an ethical problem for many psychiatrists when it comes to such treatments as prefrontal lobotomy and certain behavioural therapies using negative reinforcement.

Finally, the increasing number of needed and successfully practicing parapsychiatric and paramedical therapists is posing a rapidly growing threat to the status of the psychiatrist who for so long had enjoyed unquestioned dominance.

Identity Crisis

And now - besieged by all these uncertainties of his craft - where does this leave the psychiatrist? In an identity crisis - that's where! As we have seen, the purely medical model of disease has only limited relevance for the psychiatrist, who bases his diagnoses almost entirely on behavioural and social observations and only very rarely on objective, physical evidence of a biological nature. But, this being so, are other behavioural scientists, e.g. psychologists and sociologists not

equally well or even better prepared than psychiatrists to make behavioral and social observations? And has not Freud himself insisted that one need not have medical training in order to be a psychoanalyst? Are not many psychologists and social workers giving effective psychotherapy today? Are not those working in community psychiatry - and what progressive psychiatrist is not doing this today? - insisting that we must train more indigenous and other parapsychiatric personnel to do psychotherapy in the near future?

There are, of course, the physical treatments used in psychiatry drugs, hormones, ECT, etc. And there always remains the need for a careful physical examination to rule out physical causes of a psychiatric disorder. And for physical treatment and diagnoses medical training is a prerequisite. But the new breed of comprehensively trained, sophisticated primary family physicians or up-to-date internists or neurologists could surely master the techniques of ECT and the prescribing of psychotropic drugs without much difficulty; and as far as the making of a physical diagnosis is concerned, they are already better equipped to do this than the average psychiatrist.

It is not altogether improbable that in 10 or 20 years psychiatrists may be exclusively assigned the roles of consultants and super-specialists in particularly complicated and problematic cases.

Perhaps I am presenting you with an overdrawn caricature - nevertheless, the possibility of such a picture must definitely be considered in view of the present developments in our field.

Let us look again at a list of the fundamental problems in psychiatry today?

1. Epistemological Impasse

2. Nosological Schisms

3. Diagnostic Confusion

4. Therapeutic Controversies

5. Identity Crisis

Of these five ailments of contemporary psychiatry only the first and the fifth are new and potentially malignant. Psychiatrists have learned to live for more than a century with nosological schisms, diagnostic confusion and therapeutic controversies - but until recently they usually knew who was sick and needed treatment. They did not face an epistemological impasse on the nature of psychiatric disease - and they were always sure about their role in the scheme of things medical, even if this role for many years was neither as glamorous nor as powerful as it has been of late.

I can not see clearly into the future of psychiatry. There is only one thing I am sure about - it will be an exciting future.