Psychiatry's Identity: Scope, Complexity, and Humility

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In recent years, the notion that psychiatry is having an identity crisis has gained some traction again. Articles that have pointed to an identity crisis include a perspective in the *New England Journal of Medicine* [1], an opinion piece in the *New York Times* [2], and an editorial in the *Lancet* [3]. In our own journal, Morreale [4] published a book review this past year wisely titled “How Long Will the Identity Crisis in Psychiatry Last?” The April 2021 issue of *Academic Psychiatry* offers several reflections on the nature of our identity as a profession and provides an opportunity to take seriously the question of whether, in fact, our identity is in crisis. We provide some historical context to the notion of psychiatry's identity crisis and briefly summarize the perspectives offered in this issue. We argue that the concept of psychiatry's identity is necessarily broad and complex, which provides a foundation for guiding our many responsibilities to our patients and the public at large.

Some Historical Perspective

Although a full review of the literature is beyond the scope of this editorial, the concept of an identity crisis in psychiatry has persisted for a very long period. Looking back over writing from the last century, it is hard to find a time when the

argument that our identity is in crisis was not being made [5–16]. Here is a sample of titles: from the 1930s, “The Crisis in Psychiatric Education” [7]; from the 1960s, “Psychiatry Beleaguered: Or the Psychiatric Identity Crisis” [12]; and from the 1970s, “Psychiatry Under Siege: The Crisis Within” [13]. It is almost paradoxical; a crisis is, by definition, a crossroad or a turning point during a time of some intense difficulty or danger. What can it mean for a crisis to last a century?

Since the language of “identity crisis” has so often been invoked, we will here paraphrase these concerns as our collective expression of anxiety over the decades. We are often worried that we are missing something or that a core value or belief has come into question. Our thought leaders have argued that we need to focus more on biology or the brain, or the psyche, or on culture and society. For example, Humphrey Osmond, in “Psychiatry Under Siege: The Crisis Within” [13], asserted that we need to refocus on the underlying “physiologically determined processes” of brain disturbance in psychiatric illness. In counterpoint, Gardner and Kleinman [1] argued that educators must not forget to cover “epidemiology, social science, cultural expertise, community studies, prevention, and consultation–liaison work — and most important, psychotherapy.”

In a related vein, we worry that our scope has become too narrow. Here is Franklin Ebaugh [7] in 1932: “This crisis in psychiatric education ... demands a greater recognition of the important part social forces play in the activities of the individual as well as continued scientific achievement in preventive medicine.” And yet, just as often, we become worried that we are casting too wide a net, by embracing an agenda for fundamental social change or by attempting to encompass too many underlying areas of science. Humphrey Osmond, in “Psychiatry Under Siege: The Crisis Within” [13], thought that the scope of our aspirations had grown too expansive, “confusing three massive human endeavors - treating mentally ill people, attempting to prevent the occurrence of mental illness, and teaching people how to enlarge and better their lives.”

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As a result, we tend to overcompensate and lurch from paradigm to paradigm, which is also not a new idea. In 1967, the authors of “The Swing of the Psychiatric Pendulum” [11] called for an end to our history of paradigm shifts with the modern possibility of an integration of biologic, psychologic, and social approaches. The reader will not be surprised to learn that this optimism may have been premature. Our field continued to lurch between competing perspectives, and one might sympathize with the title of Shorter’s 2013 paper “Psychiatry and Fads: Why is this Field Different from All Other Fields?” [17].

We also worry about where we and our patients fit into the larger health care universe. Have we become too isolated from our identity and role within mainstream medicine? Authors such as Ebaugh [7] have called for “liaison activities and ... combined clinics with each field,” essentially integrated care, as early as the 1930s. In addition, we worry that our work is stigmatized by our colleagues in other specialties. As Hartwell [8] put it in 1937 “... is the medical profession as thoroughly convinced that psychiatry is a part of medicine, as is the psychiatrist?” We do not seem to have outgrown this concern as we moved into the 21st century. More recently, for example, a *Lancet* editorial [3] began with the concern that we are “viewed negatively by other medical professionals.”

Psychiatry’s Identity in This Issue

This historical perspective provides some context to the papers in the April 2021 issue of *Academic Psychiatry*, which include perspectives on the scope of the practice and educational mission of psychiatry and on the complexity of our work. Scope is the sum of all activities and learning experiences, and a basic principle of curriculum construction and organization [18].

In the “Comment on ‘Psychotherapy and the Professional Identity of Psychiatry in the Age of Neuroscience,’” Petriceks [19] wrote from the perspective of a medical student considering joining our field. His reflection on the necessity of psychotherapy to psychiatry speaks to the anxiety that he will join a profession where something essential is “missing.” Seeing psychotherapy as “grounded in science and humanism,” the author considers it a bridge between different fields of study, as well as a means to learn about the mind, which must ultimately be engaged through subjective experience.

Zagoloff et al. [20] reported on the changing names for psychiatry departments, and wisely noted “a name is more than a name.” Names are powerful indicators and contributors to identity. For example, the creation of compound names (“Psychiatry” plus “X”) can be a statement of what areas of science we claim as our foundation. The authors note that the most common addition is “Behavioral Science.” It is possible that the rise in the use of the terms *behavioral science* and

behavioral health in recent years has been related to the growth of stigma that had accrued to older terms like *mental illness* and *psychiatric illness*. It is also possible that terms such as *behavioral science* or *psychological medicine* indicate an intent to have a wider scope, including connections to physical health or inclusion of psychology and social work.

In “Conceptual Competence in Psychiatry: Recommendations for Education and Training” [21], Aftab and Waterman also referred to the “identity crisis” discussed in the 2019 commentary in the *New England Journal of Medicine* [1]. Their approach, however, is not historical, but philosophical. They argued convincingly that our “current predicament is that the conceptual and philosophical underpinnings of psychiatric theory and practice have not been accorded the prominence they deserve and require and, in fact, have been excluded from medical student and residency training in most programs.” To remedy this, the authors offered the framework of “conceptual competence” [21]. The path to competence begins with identifying the assumptions and questions that underlie our practice. These include the relationship between mind and brain, the distinction between psychological and biological illnesses, and the social values embedded in diagnoses. Trainees should then learn a set of basic philosophic tools to address them, which leads to active discourse to exercise the capacity to apply these tools, all of which must be done from a position of humility that respects the complexity and tentative nature of these issues. Aftab and Waterman [21] have done psychiatry education a profound service with this paper, which deserves to have a lasting impact on residency curricula.

The Learner’s Voice piece “Complexity, Intellectual Humility and the Psychiatric Trainee” [22], by Horien and Bommersbach, would indicate that some trainees already appreciate the need for conceptual competence and will welcome such efforts. In fact, they arrive at very similar conclusions. They begin their reflection by noting, “The conceptualization of psychiatric illness continues to be an elusive pursuit.” They have observed that “...psychiatric diseases are complex, multifaceted, multi-causal disorders.” They urge us to remember that relieving suffering is our priority, best pursued with a humility that avoids attachment to any favorite etiological or ideological approach to psychiatric illness.

Psychiatry’s Identity Is Complex Because It Has to Be

Of course, the idea that psychiatry is complex is not new. Instead, it is something that our profession has had to relearn many times over. Almost a century ago, Adolph Meyer [6] wrote, “I sometimes feel that Einstein, concerned with the relativity in astronomy, has to deal with very simple facts as compared to the complex and erratic and

multicontingent performances ... which we psychiatrists are concerned with.” The notion that we have been learning the same lesson—and having the same identity “crisis”—for the past century could dishearten us. Perhaps there has been some reluctance to embrace complexity? Simpler illnesses hold the possibility of simpler solutions. The idea that we could define “the cause” of psychiatric illness has often been a source of hope for clinicians, patients, and families. If the problem is an imbalance of a neurotransmitter, we can hope to find a problem with the neurotransmitter gene and then identify a medication that corrects function.

As we know, the story has turned out to be more complicated. The fact is that we deal with the most complex system or organ—the central nervous system or brain—and we are still in the early stages of understanding its development and function. Scores of different genes contribute to the etiology of most psychiatric illness [23]. As the brain wires and rewires its circuits throughout development and adulthood, the influence of these genes is profoundly modified by epigenetic changes. At least some of these epigenetic influences are social stresses and adverse childhood experiences (ACEs) such as isolation, socioeconomic deprivation, and trauma. These “social determinants of mental health” [24] are distributed unequally throughout societies, and different communities face divergent circumstances [25] (although the coherence of social and spiritual groups may partially offset these negative forces). Furthermore, different cultures offer distinct frameworks for understanding the meaning of adverse experiences. The individual brain, finding itself at this intersection of biology, psychology, social hierarchy, and culture, then does what it can to construct a personal narrative that can interpret its experience and guide its future choices.

If we have arrived yet again at the biopsychosocial (or biopsychosociocultural) model [26, 27], the challenge for psychiatry going forward is in how to integrate these spheres. We know that we can no longer think about the brain developing biologically and then bring in the psychological, social, and cultural spheres as later modifiers. A healthy brain only develops within a sociocultural matrix. Disruptions in that matrix impair brain circuit development, which then creates dysfunctions that impact the sociocultural experience of others. This paradigm is at the heart of our identity as a profession.

This conception of a mutual feedback loop aligns with some contemporary views of human evolution. We may be accustomed to thinking of biologic evolution (through genes) having been succeeded by cultural evolution (through memes). However, a persuasive argument can be made for a model of gene-culture coevolution [28, 29]. Our success as a species, from this perspective, is not about individual brains becoming smarter but about culture accumulating so that our “collective brain” is smarter. And as the toolkit available to this collective brain becomes more valuable, social learning and all its components—close contact, reciprocity, social

norms, recognition of expertise—became selected for within the individual brains. The individual brain developed through evolution to be “designed” for cultural success. But this also left us vulnerable to being colonized by cultural artifacts that are infectious and “go viral” without offering adaptive advantages and may actually be harmful to the individual, as in some examples of the cultural spread of psychiatric syndromes from western nations to less developed ones.

If adaptive and healthy brain function is always embedded in culture, what are the implications for psychiatrists? We should not be surprised that when the brain becomes ill we find sociocultural causes, as well as disturbances in the growth and function of neuroanatomic circuits. Our neurobiology only exists as a consequence of millennia of selection for its responsiveness to, creation of, and integration with culture. And our psychologic and social experience stems from that neurobiology. Unfortunately, it is much easier to demonstrate that social and structural determinants of mental health exist than to define the exact way they warp the development and function of a brain whose genetic blueprint has been shaped by millennia of selection for collective cultural function.

We are in a similar position when we attempt to integrate narrative experience with neurobiology. We have long appreciated that narrative meaning is crucial to the development and recovery of mental illness as well as physical illness. Coherent narratives are critical in the establishment of secure attachment—learning to write and relate a more flexible, less defeated story of oneself is fundamental psychotherapy. Such narratives connect events and experiences in the past with the present and are fundamental for autobiographical identity in individuals. Collective narrative is also crucial to the forming of collective identity and thus to the formation of a profession’s identity. In 1928, Meyer [6] wrote: “Similarly I feel like asking every inquirer, student or worker in psychiatry: What has been the evolution of what you thought psychiatry was and is? It seems to me we might get closest together on what psychiatry means in and to each of us and in general, if we could pool the various stories of how it came to mean anything to each of us.”

Stories are crucial to optimal teaching and learning, and the brain’s inclination to create narrative around ambiguous stimuli is well known [30]. In fact, there are intriguing suggestions from the literature that the default mode network (the brain at resting state), extending beyond the brain’s specific linguistic regions, may be involved with narrative construction or processing [31]. And yet, we remain unable to translate the subjective experience of renewed agency and dignity that comes from narrative meaning with corresponding changes in brain circuit structure and function.

For now, perhaps the best we can do is take seriously Kendler’s [23] concept of distinct “explanatory levels”: “The human brain/mind not only self-wires—a system far more intricate than the genome can specify in any one-to-one

relationship—but also is the great organizer and compiler of our own existence. It interfaces between our organism and the psychological, social, and cultural world around us to provide the structure and meaning of our existence. We have chosen to study and treat the most complex of human disorders, the causes of which span the many levels of our biology, our psychology, and our social existence.” [ref] Embracing the complexity of multiple explanatory levels means that departments of psychiatry need to be firmly attached to multiple academic disciplines. Neuroscience and other behavioral sciences are obviously essential and clinical psychiatry departments should consider formal, structural ties with these programs. Similar efforts should follow with departments in the arts and the social sciences including philosophy, anthropology, sociology, and public policy. Listening to the perspectives on mental illness generated by different academic disciplines is also an excellent path to developing the humility that the authors in this issue call us to.

This is not just a matter of academic theory. Embracing complexity is essential to optimal clinical work [32]. We know that treatment of patients with serious mental illness is often best provided by interdisciplinary teams. Even patients with less grave prognoses, who continue to function while burdened by the weight of depression and anxiety, are increasingly cared for by integrated teams that may include a primary care provider, an advanced practice provider, a health psychologist, a social worker, and a psychiatrist, among other disciplines (in any number of different structures/combinations). And yet, our patients will always need a psychiatrist who has been trained to encompass the full complexity of their mental illness and to participate in the leadership of these multidisciplinary efforts, while also having the humility to respect the expertise of other disciplines and to appreciate the tentative nature of our formulations and treatment plans.

Accordingly, we should promote a broad scope of learning in our educational curricula, and guard against a biological or psychological reductionism [33]. Our perspective should be informed by the abundance of ideas and knowledge from the arts and sciences, which contribute to our understanding of human nature and mental disorders. These curricula should be balanced and articulated [18] from pre-medical education through medical school and residency programs as important stepping stones in our life-long educational efforts. And they should remain grounded in our historical identity as an intrinsic part of the overall field of medicine.

For some examples, we should learn to appreciate the roles of neurobiology, genetics, physical illness, attachment, loss, loneliness and despair, alcohol and substance use, adverse childhood experiences, homelessness, climate change, trauma and all forms of violence, and their interrelationships and consequences for mental health and disease. We should learn about the methods of primary and secondary prevention of mental disorders and evidence-based biopsychosocial

treatments. This is indeed a broad and ambitious learning agenda, but necessary if we are to be effective advocates and skilled clinicians and meet our responsibility to patients and the general public.

From this foundation, we can return to a consideration of the idea of an “identity crisis.” In offering the idea, Erikson [34] posited developmental phases as individuals navigated their biological, physical, emotional, and social lives. The “crises” are defined as how we are confronted with, and resolve, the intrinsic and natural dilemmas that occur during universal developmental phases. Young adults, for example, struggle with intimacy versus isolation. It is not that they throw one out and embrace the other. Success is in how they form a balance between two important aspects of their lives. The reason Erikson called it a “crisis” is because it comes with an intense emotional valence, indicating that the stakes are high. But what cannot be attained at one age in life can be worked on and refined later in life. Similarly for our profession, different eras bring with them asymmetric bursts of progress, or at least interest, in essential aspects of our work, such as neurobiology, culture, or narrative. What is called an identity crisis often only refers to the anxiety elicited when our field is paying relatively greater attention to one inalienable part of who we are as a profession and the full scope of our mission.

We will close with this call to communal action: “Psychiatry has, surely, no narrow conception of its plan of work. The technical knowledge demanded for a successful attack upon all its problems is enormous. The methods of a whole series of subsidiary sciences must be drawn upon. No single investigator, of course, can hope to be active in all parts of this large and varied field of inquiry.... The work is cut out for the aggregate of the world’s psychiatrists for at least many generations ahead” [5]. That call for action was written in 1914. It is time for us to fully embrace this scope and complexity of our identity and the humility it inspires.

Declarations

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