

## CHAPTER 14

# *Science and Care*

Vivian Rakoff, the chair of the University of Toronto's Department of Psychiatry during the 1980s and one of the legends of Canadian psychiatry, used to say that psychiatry was both a science and an art, and the essence was to balance the two. More than four decades later, his words ring as true as ever. In that time, I have witnessed a dramatic swing in our profession away from the art and toward the science.

When I started in 1970, psychodynamic thinking and practice dominated psychiatry in the United States and to a lesser extent in Canada. Patients spent a great deal of time lying on the couch, or sitting face to face with their therapist as they explored their internal world, their dreams and fantasies, their past, and their relationships. Psychiatrists tried to help them see meaningful connections and relate these to their distress or disability. Psychoanalysts dominated academic centres and it was difficult to challenge their views, particularly if your critique was seen as a form of psychological resistance. They believed their ideas and treatment evaluations were beyond reproach.

The intellectual heirs of Freud and Jung largely influenced diagnosis until 1980, and the DSM, or *Diagnostic and Statistical Manual of Mental Disorders*, was written in the language of dynamic psychiatry. The DSM guided treatment in some places and split the profession over whether it had any basis in science in others.

By the time I ended my term as chief of psychiatry at Toronto General in 1990, the pendulum was swinging the other way. New drugs could allow people with severe mental disease to live outside an institution. They could relieve the burden of depression

and stop the delusions and hallucinations of psychosis. Science was clearly winning the war. The biologists, who believed drugs could cure or alleviate many mental illnesses were pushing aside the psychoanalysts, who still felt that therapy had all the answers. Scientists were legitimately demanding proof that treatments were effective. Overall, this was an incredible advance for mental health, but we would come to see that there was still value in talk therapy and that this was lost in the wholesale embrace of science.

Psychoanalytic thought was in freefall. Psychoanalysis might be a fascinating tool for illuminating the human condition and furthering the education of future psychotherapists, but it couldn't prove its value as a tool for healing. There was a concern that daily contact with a therapist may even lead some patients backwards—replacing the challenges of the outside world with an intense preoccupation with themselves and the therapeutic relationship.

In 1980, two momentous events hastened psychiatry's medicalization. The first was the 1980 landmark case of Dr. Raphael Osheroff, a successful nephrologist from West Virginia who fell into a depression after a difficult divorce. He had been admitted for seven months to a psychiatric inpatient centre, Chestnut Lodge, where he was treated with psychotherapy for what staff diagnosed as a personality disorder. This treatment did not help: he lost weight, was unable to sleep, and became agitated. Finally, his family transferred him to a centre that viewed his situation differently and treated him with medications. He recovered quickly. He sued Chestnut Lodge for negligence and won a large settlement.<sup>1</sup>

The second significant event was the 1980 publication of DSM-III. Introduced by the American Psychiatric Association in 1952, the *Diagnostic and Statistical Manual* had been dominated by psychoanalysts, who used concepts like reaction formation and neurosis to describe mental illness. Psychoanalytic theory, rather than observable symptoms, guided the diagnosis of mental illness.

Then, in the 1960s, Sam Guze, an internist who moved to psychiatry, thought psychiatric patients deserved the same scientific approach as other patients, and his colleague George Winokur, at Washington University in St. Louis, Missouri, felt the same way. The opponents of psychoanalysis began to gather together. There was Eli Robins, former chair of the Department of Psychiatry at Washington University School of Medicine and a leader of the movement to apply traditional medical and scientific standards to psychiatric research and treatment, and his wife, Lee Robins, a pioneer of psychiatric epidemiology. They and a few of their colleagues stood alone for years as they called for a scientific approach to psychiatric diagnosis, instead of those based on psychoanalytic theories. The American Psychiatric Association finally listened, and in 1974 it hired Robert Spitzer of Columbia University, a psychiatrist who had trained earlier in psychoanalysis, to work on a new approach to the DSM.

Under Spitzer's leadership, the association switched to an entirely new approach to diagnosis in 1980. It wouldn't rely on theories to explain why people got sick. Instead, the DSM would list symptoms and organize them into neat disease categories and checklists of precisely described criteria for more than 200 objectively described diagnoses. This would be published in the third edition of the DSM. When DSM-III came out in 1980, it was more than three times as long as the previous version. Spitzer and colleagues listed 265 diagnostic categories in 494 pages. They added bulimia nervosa and autism, which was previously called childhood schizophrenia. Instead of "hyperkinetic reaction of childhood," DSM-III renamed the condition "hyperactivity disorder" and introduced attention deficit disorder (ADD). Neurosis was dropped; personality disorders were added. They discarded the theories about repression and the unconscious. Mental conditions were described, but there was no explanation of why people

suffered from them. Most of the committee members for DSM-III were descriptive psychiatrists. The analysts were no longer invited to join the committees developing criteria for disorders.

The new DSM had a big impact on the profession. Checking symptoms often dislodged the art of understanding and empathizing with the whole person who is suffering a mental illness or distress. Yet psychiatrists didn't complain; many of them thought this new approach would be beneficial to them. Long relegated to the back seat of medicine, they wanted the acceptance and respect of their profession, and the way to get it was to start talking about medical illnesses and chemical interactions in the brain, and to stop talking about abstract theories of the mind—chief among them psychoanalysis—that many could not understand. They stopped resisting giving antidepressants on the theory the drugs might reduce the patient's motivation to get into therapy. They took it for granted that medicine was part of the therapy. Some clinicians went all the way and dispensed with therapy altogether. Too many just reached for their pens and wrote prescriptions.

Psychoanalysis took another hit from research that aimed to answer the question, did psychoanalysis work? By 2002, the verdict was apparently in.

The Research Committee of the International Psychoanalytic Association reported this: "Existing studies have failed to unequivocally demonstrate that psychoanalysis is efficacious relative to either an alternative treatment or an active placebo."<sup>2</sup> In other words, psychoanalysis was deemed not to be an effective treatment.

The swing seemed to be complete.

The economics of health care funding, especially in the United States, also played a significant role in pushing talk therapy out of the practice. It didn't pay psychiatrists to do therapy; psychiatrists could make more money just prescribing medicines every 15 minutes. Funders could save more money by dispensing with

psychiatrists for talk therapy; nonmedically trained therapists were a lot cheaper.

Big pharmaceutical companies played their part too in psychiatry's conversion to medications. They make far more money when depression is considered an illness requiring medication, as opposed to a problem of living or a response to adversity. The result is that, by the new millennium, psychiatrists had been pushed out of therapy: only 10% of US psychiatrists actually do psychotherapy for depression. It's a sad statement about the profession today.

Psychiatry had swung from the proverbial couch to the lab. In many ways, this was a good thing, but it raised a serious question for me in 1990 as I thought about my next move in the advancement of Canadian psychiatry: How do you balance science and caring?

Science, to be sure, was important for our field. For far too long, a significant part of psychiatry had considered itself to be beyond the rules of evidence, partly because it was impossible to look inside the human brain with any precision or confidence. As we've seen, asylum doctors and psychoanalysts usually operated outside the university. Untrained to the scientific method, the vast majority were not able to critically evaluate scientific evidence. Even when powerful new drugs to combat psychosis and then depression and anxiety were proven to be safe and effective by randomly controlled trials, these psychiatrists often ignored or rejected existing evidence, or relied on therapies that were not proven effective.

Opinion or intuition often guided clinical decision making, rather than proven evidence. Electroconvulsive therapy (ECT) provides another example. ECT had been proven to greatly improve the condition of people suffering severe depression in 80 to 90% of cases, and yet many psychiatrists refused to recommend it mainly because of prejudice (some theirs, some the public's). Starting in the mid-1970s following a public outcry and community lobbying action against ECT in the mass media, 35 US states passed laws

restricting the use of shock treatments, and by 1980 ECT use had fallen by half. Some US states even banned ECT in publicly funded hospitals, which meant that only people with money could afford this powerful treatment. Canadian physicians followed this trend.

In this respect, psychiatrists are not so different from other doctors. When doctors diagnosed and treated patients for a physical illness, they have traditionally based their decisions on clinical experiences, or on the oral or written tradition of medical learning. Science is a relatively recent addition to medicine.<sup>3</sup>

I agreed that psychiatrists should use scientific evidence more to inform clinical decisions for diagnoses and treatment, and not just rely on subjective practical reasoning. I felt that this required three things: more science in our field, more people capable of interpreting the findings of science, and a willingness of clinicians to adapt new evidence into practice. However, I never thought that psychiatrists should turn into pure technicians who examine patients, check off a list of symptoms, and dispense pills. It is impossible to reduce an ill person to a checklist of symptoms. Diagnosis can never replace understanding. Who has ever sat with a seriously depressed patient and felt that this was merely a collection of symptoms rather than a unique individual immersed in a sense of hopelessness and lost meaning?

We can never forget that psychiatry, like all of medicine, is a helping profession that aims to improve the physical, mental, spiritual, and social well-being of human beings. Psychiatry is concerned with illness but also with the texture and drama of the human condition. Yet the art of medicine, the caring side, is easily dismissed in a scientific world. This was true then, and it still is true today. Caring in medicine can be neglected at a time when the pursuit of science has brought us powerful and effective new treatments. I believe this is a mistake for our profession. Practitioners need to be healers who connect to patients on a human level.

Rather than just focusing on the illness, they need to see people as they are—multidimensional and complicated individuals with strengths that can be fostered. They must tailor their treatments to individual patients, and never forget that the practice of medicine, while based on scientific evidence, is first and foremost a social interaction between someone who is suffering and a healer.

When we lose this caring side of medicine, we lose the ability to sit and be with people who are ill. A physician in one of our studies put it this way: “I think we have failed, somewhere along the line, to teach our residents how to cope with someone who is suffering. To sit in a room with someone who is crying, someone who is in pain, someone who is psychotic and confused and frightened of you, and I think we hide behind our pills. Because the pills become an interaction that says, I’ll solve this problem for you quickly so that I don’t have to sit with your tears.”<sup>4</sup>

The challenge to balance caring and evidence-based science is not new. I’ve always been an admirer of Sir William Osler, the Ontario-born and McGill-educated physician who was the first professor of medicine at Johns Hopkins and later the Regius Professor of Medicine at Oxford. A great man and an outstanding doctor, he fundamentally changed medical teaching in North America by introducing the clinical clerkship and medical residency. The idea of the residency, with its emphasis on bedside teaching, was borne of his insistence that students learn from seeing and talking to patients.

I have collected the first editions of many of his books, and loved to quote him in my addresses to psychiatrists, especially when I was at Toronto General. The group there even came to expect it, and when I left they gave me a first edition of his *Principles and Practice of Medicine*. In his day, Osler used to complain that doctors relied excessively on treatments that had never been proven to be effective. Since they were not interested in proof,

doctors often believed in a particular school of thought, which led to the growth of denominations. Members of denominations resisted the advances of knowledge because they were ideologically committed to particular therapies. Practitioners maintained their beliefs rather than applying new evidence when it was powerful, or testing or refuting it.

This description could fit psychiatry as it was in 1990. We had dichotomous value systems—clinical practice and scientific research. The clinicians were the humanists who tried to understand complicated human beings in all their dimensions. The scientists thought the cure would come from the lab and the thrilling new insights about the workings of the brain. As the pendulum was swinging from the caring side of the profession to the power of science, the two camps were deeply split.

This wasn't good for patients or for doctors, so I wanted to introduce a value system and an educational program that integrated both streams of thought. We need science and humanism together—together at the bench and together at the bedside.