

# Quo vadis, Psychiatry?

## Psychiatrists should not relinquish aspects of care to practitioners in other specialties

Psychiatrists frequently complain about their lack of recognition by other specialties, stigmatization of mental illness and the practice of psychiatry, and diminishing sense of identity as a specialty. Although I share these concerns, there is another trend that worries me perhaps more: the deliberate abandonment of more and more areas of what has traditionally been and should be psychiatry's area of expertise and skills. Not all of this is our own doing; the fact is that other clinicians would like to get "a piece of our pie"—a trend seen in other specialties as well (eg, parts of radiology taken over by cardiologists). However, I view our role in this process as larger than other specialties' or disciplines' efforts.

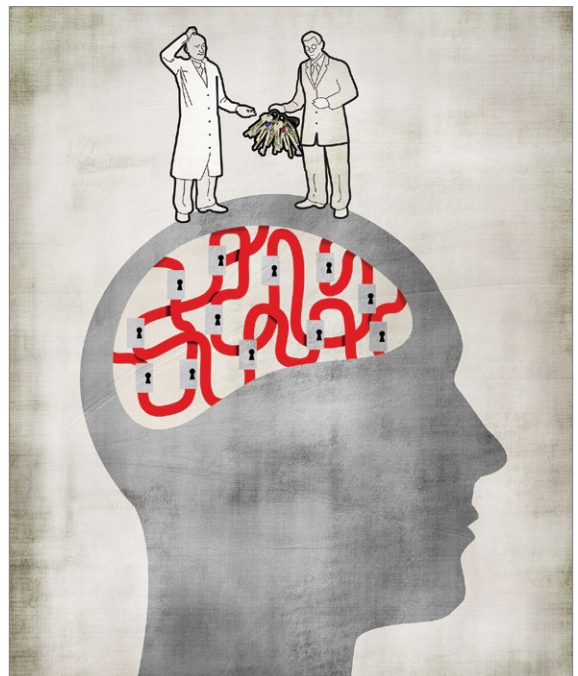
Many of us choose not to treat substance abuse patients and instead refer them to "specialists"; yet, don't we have enough of our own trained specialists and don't we fill our addiction psychiatry fellowship training positions? Similarly, many do not like to treat patients with comorbid psychiatric illness and substance abuse, although this occurs frequently in our practice. Cognitive disorders often are left to neurologists and our role in managing these patients is diminishing. Pulmonologists gradually are taking over sleep disorders; one wonders why. We do not like to ask our patients about their sexual history, not even talking about treating their sexual problems! Most psychiatrists are afraid of prescribing phosphodiesterase-5 inhibitors. We are leaving the entire field of human sexuality to gynecologists, urologists, and other specialists. Paraphilic disorders are something we do not want to manage and we would

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rather get the whole area out of our classification systems, with the implication that these are not really mental health problems.

Many of us prefer not to treat personality disorder patients—especially those with borderline personality disorder—because they are “difficult.” Some do not even feel comfortable managing adverse effects of psychotropics such as the metabolic syndrome, or use “unusual” augmentations such as thyroid hormone. We prescribe fewer and fewer older, yet efficacious, psychotropic medications; only a small fraction of psychiatrists still prescribes monoamine oxidase inhibitors. Other disciplines, eg, primary care and pain medicine, prescribe some tricyclic antidepressants more than we do. We irrationally avoid benzodiazepines and do not like prescribing lithium, because it requires ordering blood levels and lab tests. We seem comfortable only with newer antidepressants and anti-

psychotics. How is this way of prescribing different from what is done in primary care? Some of our leaders sneer at the idea of psychiatrists practicing psychotherapy, perhaps feeling that such a “lowly art” should be provided by psychologists and social workers. We do not address relational issues. Last but not least, I hear colleagues saying that they do not like to treat “difficult” patients.

What are we aspiring to be and to do? To treat schizophrenia, bipolar disorder, and maybe depression, with a limited medication armamentarium we feel comfortable with and no psychotherapy? I am sure that many will say I am exaggerating, but I think not. We have, as Pogo said, met the enemy and he is us. We should get off the slippery slope of selling out psychiatry piece-by-piece, and fully embrace—clinically and research-wise (funding!)—all of what has been part of psychiatry.