Introduction

I.1 How I Became a Psychiatrist

Psychiatry has always had more questions than answers; it still does. But the mystery of the mind and its maladies is what attracted me to choose this profession. Like most clinicians, my aim was to help people suffering from mental disorders. I hesitated and made several false starts before committing myself to this career, but once I completed my training, I never looked back, and have only recently retired (after 52 years).

I have long been (and still am) a skeptic. I am suspicious of simple answers to difficult questions. As the American journalist HL Mencken (Wikiquote) once put it, "Explanations exist; they have existed for all time; there is always a well-known solution to every human problem – neat, plausible, and wrong." Thus, when less is known, ideas that are simple and dogmatic fill the gaps.

For me, the challenge of studying human behavior was irresistible. I was always interested in understanding the mind. Then, as a student at the University of Michigan, I took an introductory course in psychology, taught by a graduate student in a seminar. One day another student dropped by and asked if any of us wanted to spend a weekend as an observer at a nearby mental hospital. We ended up visiting there for about half a dozen weekends, observing patients and meeting with staff.

This was 1957, when antipsychotic drugs were just being introduced (in small doses). Thus, one could still observe patients paralyzed by catatonia standing like statues in the hallways, while paranoid patients spent days writing endless notes in dark corners. One young woman had spent over a year in hospital after making multiple suicide attempts. Fascinated with this world, I applied to medical school. I was accepted to McGill, which had a famous psychiatry department, and spent most of my life in Canada. (In view of the recent developments in the USA, my decision may have been prescient.)

In the 1960s, when I began my residency training, psychoanalysis dominated North American psychiatry. For some, even today, its theories offer a sense of certainty about mental illness, even if most of them are wrong. Its model attempts to explain almost anything about psychopathology, but it is not testable. Psychoanalysis is not an evidence-based discipline, but a collection of compelling anecdotes that claim to support a speculative set of hypotheses.

Why then did the psychoanalytic model flourish? The main reason was a lack of credible alternatives. Its main competitor at the time was behavioral therapy (BT), which I considered a nonstarter. The clinicians who developed the BT model were just as confident of the efficacy of their methods as psychoanalysts had been. But they made the fatal error of only measuring behavior, seeing the brain as a "black box" that could be ignored. This is why BT was eventually replaced by cognitive behavioral therapy (CBT), in which cognition became the main focus.

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In the late 1960s, many of my teachers were psychoanalysts. I have spent the rest of my career showing why they were wrong. Even then, I viewed their model with skepticism and was seen as a rebel. But when I talked to colleagues trained in other traditions, I was perceived as "one of them." My early years in academia were dominated by a psychodynamic perspective. Then, nearing age 50, I gave up these beliefs. I undertook a conversion to the scientific model of evidence-based psychiatry. I am still a "born again" proponent of these principles. I have never again allowed myself to believe in theories based on clinical experience alone, or to lose my respect for empirical data as the best pathway to truth.

My own journey paralleled what was happening in my chosen discipline. Psychiatry has long been divided into biological and psychosocial models. Advocates of biological psychiatry see changes in the brain as central to psychopathology. They talk to patients, but do not offer talking therapies. Instead, they make diagnoses and prescribe medications. But decades after the "pharmacological revolution" of the mid twentieth century, treatment of mental illness with drugs remains in its infancy.

Our arsenal of interventions benefited most dramatically from new medications for severely ill psychotic patients, whose delusions and hallucinations rapidly disappear with treatment. But these drugs do not cure psychotic illnesses. Moreover, no one knew (or still knows) quite how and why they work. Finally, a narrow biological model lacks a coherent theory to explain why some fall victim to mental illness while others do not. (To be fair, this is probably true in medicine as a whole.)

The other side of psychiatry overlapped with clinical psychology, in which psychotherapy was the main treatment. My teachers espoused a model that they confidently claimed could be applied to a wide range of disorders that fail to respond to medication. I practiced and taught psychotherapy over the first decade of my career. Then, like so many before me, I became disillusioned. Some of my results were good, some were not so good, and most were middling. This inconsistency led me to a crisis that was only resolved when I returned to my background in medical science.

I became an advocate of evidence-based psychiatry and began a second career in research. I had a late start, but made up for it by publishing over 200 scientific papers and 30 books. I was now committed to facts rather than rhetoric. I felt comfortable asking my colleagues and students to back up their ideas with empirical evidence.

Another issue that troubled me early in my career was how psychiatry, when its practice was devoted to psychotherapy, was any different from clinical psychology. I wanted to make use of my medical training and knew how to prescribe medications. I suspected that many of my teachers were treating normal people with normal life problems, not patients with mental illnesses. I wanted to apply my skills to severely ill patients.

A friend of mine who had an academic career in medicine once advised me: "[E]very top doctor needs to be an expert on one disease." With this in mind, I developed a subspecialty in psychiatry that fit my wish to treat people who most required my services. I had always been interested in suicidal patients who present in emergency settings and hospitals. At the very least, these patients would be either alive or dead after therapy. But clinical psychologists avoided them, mainly due to fear of losing them to suicide.

The result was that I focused my career on the treatment of borderline personality disorder (BPD). This diagnosis has a history going back almost a century (Stern, 1938), but has always been controversial. Some of my teachers considered BPD to be fuzzy and

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unreliable, and advised me not to use this diagnosis. But I came to realize that I had been treating this disorder without recognizing it. Moreover, there is a role (albeit a smaller one) for medication in this population. This background allowed me to be comfortable in prescribing (and deprescribing) drugs. Given my training in medicine (a world where patients can and do die), I was in a better position than other professionals to manage chronically suicidal patients.

I continued to practice general psychiatry, where my skills could be applied to a wider range of patients. But I also needed to join a research community whose work could shed light on the etiology, outcome, and treatment of BPD. I only established myself as a researcher in my early fifties. I had to update my knowledge of statistics and research methods, but benefited from clinical experience as a consultant, a therapist, and a teacher. Half of my books are about personality disorders, while the other half focus on broader problems in psychiatry. All were intended to be read by practicing mental health clinicians. I have always felt validated when students and colleagues told me that my ideas resonated with their own experience.

I.2 What This Book Is About

The present book is a follow-up to an earlier one: *Fads and Fallacies in Psychiatry*, 2nd edition (Paris, 2022a). That book focused on some of the serious errors, past and present, that have plagued psychiatry since its beginning. I have also published a book titled *Prescriptions for the Mind*, which examines the current state of clinical practice (Paris, 2024). This book will, however, focus on the future. It will describe the most important unanswered questions about psychiatry and suggest what kind of research would be needed to address them.

Much of psychiatry remains mysterious, so I am not claiming that I can predict its future. To quote Isaac Newton (https://todayinsci.com/N/Newton_Isaac/NewtonIsaac-PlayingOnTheSeashore.htm), "I do not know what I may appear to the world, but to myself I seem to have been only like a boy playing on the seashore, and diverting myself in now and then finding a smoother pebble or a prettier shell than ordinary, whilst the great ocean of truth lay all undiscovered before."

I have heard it said that elderly psychiatrists write books about the future of their field; I am now one of them. There are many books about the practice of internal medicine and surgery, but one hardly ever sees books defending the validity of these domains. Psychiatry is the only specialty in medicine that has had to do so. It has even had to defend itself about the reality of mental illness. But psychiatry is too complicated for easy answers. That is probably why quite a few academic psychiatrists have written about the state of their specialty. Some are too congratulatory (Lieberman, 2015). Others have argued that overvaluing the manuals we use for diagnosis has distorted our research agenda (Frances, 2013).

I remember that when I was a child in the middle of the last century, pundits tried to predict the future of the next 50 years. Almost all turned out to be wrong. Building on advances in transportation earlier in the century, some predicted flying cars. Hardly anyone ever imagined the role of computers.

I have written this book from what I hope is a humble perspective. I will not propose, as others have, that technology will solve the problem of understanding and managing mental disorders, that reading the genome will support "personalized treatment," or that more powerful drugs are about to emerge to treat the most severely ill patients. I also

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doubt that we need any more forms of psychotherapy labeled by three-letter acronyms. We already have hundreds of them, and most are fundamentally the same. Finally, while my discipline has shown it can help troubled people, the belief that psychiatry should play a role in changing society is sadly mistaken.

Instead, this book will be organized around a series of *unanswered questions* that have important clinical implications for those who work with mentally ill patients. Psychiatry needs to be seen as a young and exciting field. I will focus on what kind of research is needed to address its problems. I will mainly recommend carrying out studies that measure biological and psychosocial risk factors in the same population. We also need much more longitudinal research that studies patients across the life course.

Meeting these goals will be expensive and require a good deal of patience. But these questions will eventually have to be answered, even if it takes another century to do so. As it stands, the most basic mechanisms driving mental disorders are still unknown. We need to know much more, but that will take time. There have been too many false promises that basic sciences are on the cusp of a breakthrough. This book will show why such predictions are unlikely. We have to accept that, given the fact that, with 86 billion neurons and trillions of synapses, the human brain is the most complex structure in the entire universe.

Here are the 10 major questions this book will explore:

(1) What causes mental illness, and what is the role of evolutionary forces, genes, neurobiology, life experiences, and social stressors?
(2) How should mental disorders be classified? Do we need a categorical system, a dimensional system, or both?
(3) Can adherence to a biopsychosocial model of mental disorders inform clinical practice?
(4) Do psychiatrists need to stop centering their practice on symptoms, and allow a more central role for personality traits?
(5) Is it possible to ensure a broad commitment among clinicians to evidence-based practice?
(6) Why is treatment with psychopharmacology, after dramatic advances 50 years ago, in a state of suspended animation?
(7) What is the role of psychotherapy in psychiatric practice, and should medical practitioners still be offering it?
(8) Why, in spite of extensive research, are psychiatrists unable to predict or prevent suicide?
(9) Do psychiatrists have a mandate to recommend how modern society could be made less stressful?
(10) What can we do to increase access to mental health treatment?

Each chapter will be devoted to one of these questions. Chapter 1 will examine the multiple interacting forces involved in mental disorders. None are sufficient by themselves, and in most cases, all are necessary. While biological risks lead to a *risk* for mental illness, they do not necessarily *cause* disorders on their own but have effects that are due to interactions with environmental risks. Similarly, adverse life experiences do not necessarily lead to mental disorders unless they interact with heritable risks. That is why most people are resilient to adversity, and why negative life events are most likely to affect a vulnerable minority.

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This chapter will then review the current relationship of neuroscience to psychiatry. We have a better understanding of how genetics relates to psychopathology, but this domain of research is still at a very early stage. The same can be said for research based on neuroimaging. We have invested enormous resources in this domain, based on a hope to define mental illnesses as brain diseases. Some advocates do not even speak of psychiatry, but of "neuropsychiatry," and foresee a fusion of neurology and psychiatry into one specialty that focuses on disorders of the brain (Insel and Quirion, 2005; Taylor, 2013). These views are premature and deeply misleading.

While I have seen much progress in my lifetime, I am much more impressed with what is unknown than what is known. We have effective drugs for some illnesses, but do not know exactly how they work and what brain functions they target. That remains a project for the future. We need to be guided by a better theory. I will show that the hope that cognitions, emotions, and behaviors can be accounted for at the level of neurons is implausible. We need to study brain and mind at a more complex level.

A noted biologist (Theodosius Dobzhansky, Wikiquote) once said, "[N]othing in the life sciences makes sense outside the context of evolutionary theory." This chapter will review the role of evolution in psychopathology. But that point of view raises another question. If the main goal of any organism is to pass on its genes, why are human beings so often afflicted by mental disorders that make doing so more difficult? The answer requires us to understand that nature is not necessarily benign or progressive. There are major individual differences between individuals, some of which are of clear benefit, while others are beneficial in one set of circumstances but not in others, and still others are often harmful.

The alternate view, that life experiences are a main cause of psychopathology, while it has been downplayed by biological researchers, has had great influence on psychiatry and clinical psychology. This model has been largely debunked for severe mental illnesses, but it lives on in the construct of post-traumatic stress disorder (PTSD). As we will see, most people who suffer traumatic experiences do not develop PTSD, or mental disorders of any kind (Paris, 2023c). Resilience is the rule. Adverse life experiences can trigger mental illness but are not its main cause. *This having been said, severe stressors can also be risk factors for severe forms of mental illness.* Above all, we need to avoid separating biological and psychological pathways to psychopathology, and to treat casual pathways as one interacting system.

Chapter 2 will focus on how psychiatry classifies mental illness. Several systems are currently in use. As a practitioner in North America, I make use of the Diagnostic and Statistical Manual (DSM), now in its 5th edition (DSM-5-TR, American Psychiatric Association, 2022). In Europe (and in most of the world), the standard system is the International Classification of Diseases, now in its 11th edition (ICD-11; World Health Organization, 2018). I will also examine alternatives to these systems, which are based on quantitative dimensions instead of categories of illness.

Psychiatry has long struggled with how best to classify psychopathology. Given our limited knowledge about the causes of mental illness, how could it be otherwise? Medicine has usually seen illness as a set of categories. That model works well with a wide range of diseases that have biological markers and that can be treated in specific ways. Yet some medical illnesses (e.g., hypertension) lie on a dimensional spectrum, and can only be diagnosed when they pass a cut-off point.

Psychiatry and clinical psychology have used categories and dimensions for different purposes at different times. These research domains have a strong tradition of using

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quantitative data derived from self-report. Dimensions are particularly relevant when doing personality assessments. They are also favored by biological psychiatrists who find a lack of biomarkers in psychiatry, due to their being related more closely to traits than to categories of illness. But hardly anyone would suggest eliminating categories such as schizophrenia or bipolar-I, diagnoses that closely resemble medical illnesses.

This chapter will explore some of the debates about the DSM system of diagnosis used by many psychiatrists, particularly in North America. My view is that this system is better than its predecessors, but that, in spite of the best intentions, it mistakes symptoms for illnesses. I will also explore how the public, with the help of the internet, has used the DSM system for self-diagnosis, with troubling results.

Examples of these problems include seeing depression as one illness, diagnosing ADHD for inattention of any kind, and viewing life adversities as the one and only cause of PTSD. I will also show that the ICD-11 does not avoid the problems with the DSM system but repeats them. Finally, I will review the dimensional systems that have been proposed to replace categories in diagnosis and will show why they have serious problems of their own.

Chapter 3 will examine the biopsychosocial (BPS) model of psychopathology. It will show why this approach is more compatible with a scientific psychiatry than biology, psychology, or sociology by themselves. It will argue that problems in causation need to be addressed by an interactive model. This biopsychosocial approach has had its critics but is still the best way to move forward. Testing the model will ultimately require longitudinal research in large samples to measure biological, psychological, and social risk factors. This chapter will also identify problems with the idea of linear causation, which is reductionistic and ignores crucial ideas of complexity and emergence.

Chapter 4 will address the question of whether psychiatry focuses too much on symptoms and fails to understand the role of personality in psychopathology. If diagnoses in psychiatry can be slippery and somewhat misleading, what should clinicians target in treatment? Is it sufficient to focus on the symptoms for which patients seek help? Or should we also be concerned with the traits that underlie these clinical features?

Keep in mind that heritable traits have different effects in different environments. Thus, biological and psychological variability can lead to better chances of passing on one's genes, but that need not always happen. In psychology, we describe these differences as *temperament* or *personality*. These are heritable differences. Many are normal variations, but some are equivalent to losing in a genetic lottery.

Personality traits set a limit on the effects of standard treatments for symptoms. We have reasonably good tools for managing problems such as depression and anxiety, through medication and/or psychotherapy. Even so, only a little more than half of these patients obtain a stable remission. There is a good body of evidence indicating that personality profiles (especially high neuroticism, as well as diagnosable personality disorders) interfere with recovery. People who lack success in work and intimate relationships over long periods of time will have more difficulty with changing their personality. Many patients with "comorbid" PDs have only a fair response to either pharmacological or psychological treatment. Yet we now know that some personality disorders (especially BPD) are treatable with specialized forms of psychotherapy.

While psychiatry has sometimes been called a stepchild of medicine, personality and personality disorders might be called the stepchildren of psychiatry – acknowledged but

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not well loved. Personality profiles affect work and intimacy and are linked to more chronic psychological symptoms over the lifespan. Psychiatry has given these traits insufficient attention and needs to acknowledge that personality profiles can also require treatment.

Chapter 5 will examine the state of evidence-based treatment methods in psychiatry. It will show why the rise of evidence-based medicine has been a boon to the specialty. It is no longer acceptable for practitioners to rely on expert opinions based on ideology rather than data. However, we cannot assume that all practitioners are committed to evidence-based practice, as opposed to following their own ideas. Moreover, given that clinicians do not always have the time to update themselves on research, we need better ways to offer continuing medical education, without depending on pharmaceutical companies to inform (or misinform) us.

Chapter 6 will focus on the future of psychopharmacology. Are psychiatrists relying too much on medication and not making use of alternatives? The story of psychopharmacology is one of dramatic success over a period from the 1950s to the 1980s. Those of us who are familiar with the history of this research know that some of its greatest triumphs came from luck (e.g., antipsychotics from use in anesthesia, antidepressants from drugs for tuberculosis). Sadly, this research domain has been in stasis for some time. Many patients do not fully respond to drugs, and we continue to struggle with "treatment resistant" illnesses. The result is all too often futile attempts at polypharmacy associated with an unnecessarily large burden of side effects.

Chapter 7 will review research on the practice of psychotherapy. Why are talking therapies, long known to be as effective as psychopharmacology for many mental disorders, not used more often? This situation is puzzling, considering the large body of research supporting the efficacy of psychological methods in depression, anxiety, addictions, eating disorders, and personality disorders.

The main obstacle is cost. Human resources are more expensive than prescriptions. Also, psychotherapy tends to go on for too long. Research shows that most therapies work within a few months, and there is little evidence for additional benefits beyond six months – or at most a year. Like the psychopharmacologist who keeps adding more drugs, some psychotherapists offer endless therapy in the vain hope of a breakthrough.

For now, the identity of psychiatry depends on its links to neurobiology. We are considered experts in drug treatment, and fewer of us spend a great deal of time talking to patients. Psychotherapy may only come to mind in disorders where it has a definite advantage over medications. It would help if psychiatrists read more about research on this form of treatment, which is mainly published in psychology journals. It would also help if psychiatrists would more regularly collaborate on treatment teams with psychologists. Finally, it would help if medically trained clinicians were open to carrying a few complex patients in therapy to understand the challenges of this kind of work.

Chapter 8 will focus on the question of whether psychiatrists can predict who is at risk for suicide, or whether they can actually prevent fatal outcomes. When patients attempt or threaten to attempt suicide, psychiatrists are usually called in to consult. Yet while we can often make useful treatment recommendations, there is no evidence that these evaluations predict or prevent fatalities.

The reason is simple. Death by suicide is much more rare than suicidal ideas or attempts. That discrepancy makes for too many false positives. The vast majority of those with suicide attempts or suicidal ideation never kill themselves. Long-term follow-ups

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have developed algorithms for predictions of risk, but they fail to predict outcomes in any individual case. Thus, in spite of the many books and articles promoting suicide prevention in clinical practice, it is not evidence-based. The main exceptions are based on reducing access to the means of suicide. There will always be suicides, but when they happen, we need not hold ourselves to blame.

Chapter 9 will focus on the relationship between psychiatry and societal forces and social risks. It will question whether having clinical experience allows clinicians to prescribe for society. Psychiatrists are not trained to solve social problems, and there is no evidence to show that they can do so. Yet some, whether on the left or the right politically, have not resisted temptations to pontificate as public intellectuals.

This chapter will show, however, that social risk factors play a role in the risk for psychopathology (e.g., social defeat in immigrants, or social breakdown in indigenous communities). But our profession lacks hard data to show that psychiatric expertise can make a difference in preventing mental disorders at a population level.

Chapter 10 will examine the prospects for access to care for mental disorders. There is little point in advancing the field if mental health services are inaccessible to most patients. But difficulty of access remains characteristic of mental health systems.

A brief epilogue will end the book with a summary of what psychiatry needs to do over the next half century. It will take a cautious view, given that accurate prediction of the future is not possible. I am skeptical of the claim that neuroscience will be the main source of advances in treatment in the near future, but hope this will happen in the current century. In the meantime, I strongly recommend designing mental health systems that provide better access to a wider range of therapeutic choices. Doing so would allow us to treat patients more effectively, and would actually save money for mental health systems.

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