Lab to Smartphone

Psychiatrists Should Be Mental HEALTH Professionals

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At a recent get together, I was asked by someone I had just met what I do for a living. His response, after I told him I was a child psychiatrist, was, "So you drug up kids." I get this a fair amount. This is our new identity in the public eye. The caricature of the psychiatrist has changed over the past few decades from the bearded therapist in a tweed jacket asking about a person's dreams to a more antiseptic-looking doc in a white lab coat doling out "mind altering" medications.

Such a stereotype of psychiatrists isn't fair or accurate, but unfortunately it contains at least a nugget of truth. We psychiatrists often like to describe ourselves as "mental health professionals," a term also used to describe folks like clinical psychologists and others with slightly different backgrounds and training. It's a term that seems hardly controversial in our community—but is it accurate?

According to AACAP's online resources for medical students, a child psychiatrist is "a physician who specializes in the diagnosis and the treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents, and their families." *Disorders.* This statement certainly seems to reflect what most child psychiatrists do in practice and how we are trained, but the question for this installment of Lab to Smartphone is whether we need to challenge this conventional definition as being much too narrow. Ask most child psychiatrists what they hope for with their patients, and you are unlikely to hear very many being content that their patients have "an absence of symptoms" or are "less miserable." We want our patients not just to survive, but to *thrive* and to be able to lead lives full of happiness, accomplishment, and purpose.

To that end, we may be long overdue in taking a step back and looking at where we are positioned, how we are trained, and what tools we have at our disposal. For most of us, we are invited into our patients' lives only after things have unraveled to a major degree. Then we use our training toward the goal of getting our patients back to "baseline," armed with two main tools: psychotherapy and medications. Far too often, we fall short, and this unfortunate reality may not be that surprising given the way psychiatrists are educated. You can be a world expert in depression without knowing much of anything about happiness. You can be a thought leader in early trauma without needing to think much about the *positive* aspects of parenting that promote healthy brain development.

We find ourselves as psychiatrists in a bit of an identity crisis these days. Who are we? What, actually, do we do? Psychiatry's origin was in the domain of therapy, but market forces have made that a difficult enterprise, especially for clinicians wanting to remain available for people who are not wealthy. We morphed into psychopharmacologists as new medications in the 1980s and 1990s emerged that seemed to offer great promise with less risk. Unfortunately, we are beginning to learn that perhaps the benefits of many of those medications were overstated with the risks being underappreciated. More recently, we have turned to neuroscience and, in the process, learned a ton. But despite all the stunning imagery of the brain and elaborate diagrams of our genome, it has remained difficult to operationalize that knowledge into day to day practice. The final sentence of seemingly every clinically oriented neuroscience paper ends with the same line—something akin to "these findings will hopefully improve early identification and treatment for individuals suffering from [insert disorder here]."

All this sounds a little bleak, but there is also great optimism. Knowledge about emotional–behavioral wellness and the paths to achieve it have grown dramat-

ically in the past two decades, and we have learned that things like mindfulness, physical activity, musical training, and positive parenting not only help keep healthy children well but also can be powerful interventions for those who are struggling or at risk.[1] The scientific evidence and neuroscience supporting many domains of wellness and health promotion now well exceeds that of some of our more traditional psychiatric treatments (both in terms of certain medications and some forms of psychotherapy) that are much more commonplace in our field. Overall, these wellness elements can no longer be considered "alternative" or "fringe" or any other term we might use to justify our lack of knowledge or experience.

Luckily, people are helping us forge a new direction. At my own medical center in Vermont, child psychiatrist Jim Hudziak has created the Vermont Family Based Approach model, which is designed to fully incorporate family wellness and health promotion into day-to-day child psychiatry practice.[2] No longer is it acceptable to have a treatment plan for attention-deficit/hyperactivity disorder (ADHD) that includes only methylphenidate. Instead, clinicians and trainees are taught to engage families around things like exercise, screen-time reduction, healthy eating and sleep routines, treatment of parental ADHD and other disorders, and mindfulness techniques. Interestingly, when we explain our treatment model to non-psychiatrists, the most typical response is a combination of both enthusiasm and bewilderment that such an approach has taken so long to find its way into mainstream practice.

Elsewhere, former American Psychiatric Association President Dilip Jeste made the focus of his recent tenure the advancement of "positive psychiatry" to complement similar advances in psychology.[3] In the area of training, the recent child psychiatry milestones, which are standardized expectations for all child psychiatry fellows, now include the provision that our trainees have knowledge not only about illness but about wellness. This emphasis extends directly to our trainees as well in new initiatives designed to keep physicians healthy and resilient. In research, new models like the National Institute of Mental Health's Research Domain Criteria (RDoC) push us to acknowledge the reality that we are working with full dimensions here rather than discrete categories.

New models of health care delivery also offer the hope that true mental health approaches like those described here will not only be beneficial for patients but financially incentivized, as well. As reimbursement plans slowly move away from fee-for-service models that reward expensive interventions for people who are sick to capitated systems that promote prevention and early intervention, there is the opportunity to enact some major adjustments to mental health care practice in alignment with these principles.

While psychiatrists will never desert those who are suffering most, the time is right for our field to reclaim ground that we never should have abandoned in the first place. The science is reminding us that mental health encompasses a full spectrum, and that for too long we have been ignoring half of it. What's more, this science is ready to be utilized for the benefit of our patients and families not in a decade, but tomorrow, by making some modifications to what we choose to assess in our evaluations and monitor in our treatment plans. To be sure, there remains much that will need to be researched, measured, and fine-tuned, but make no mistake about it: this train is moving, and it is time to hop on.

References

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Disclosure: Dr. Rettew has received royalties for his blog for *Psychology Today*.

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