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The Future of Psychiatry:
Cautious Optimism

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For those of you who know me well, my passion for psychiatry is no secret. I proudly consider myself a "budding psychiatrist," and accept the full range of ensuing responses. The future of psychiatry is an extremely pertinent subject and one that carries particular relevance for me. Although there is no clear answer to this highly speculative topic, I believe the specialty of psychiatry is going to become increasingly important.

Modern day psychiatry incorporates biological, psychological, and social paradigms in order to diagnose and treat mental illness. Psychiatrists strive to develop a thorough understanding of normal brain function from the microscopic level of the molecule to the macroscopic level of the mind.[1] With this knowledge, psychiatrists aim to gain a comprehensive understanding of how abnormalities in brain functioning manifest as symptoms of mental illness. Specific interest is directed towards improving our current knowledge of endogenous and exogenous influences by studying genetic coding and environmental factors, respectively.[1] The field of psychiatry is largely untapped and major breakthroughs are imminent.

I am optimistic about the future of psychiatry for several reasons. First, neuroscience research is growing at a rapid rate.[2] Our present understanding of the human brain will continue to improve, which bodes well for a number of fields. Aside from psychiatry, significant gains in neurology, psychology, biomedical engineering, and the computer sciences are projected.[2] Collaboration among these professions will uncover mechanisms that contribute to psychiatric impairment in addition to discovering innovative ways to treat mental illness. Dr. Thomas Insel, Director of the National Institute of Mental Health, suggests that a growing number of U.S. residents in psychiatry are pursuing combined MD-PhD degrees because they believe that resources are finally in place to make "unprecedented progress" in the field.[3] Given the widespread interest in the neurosciences, I am confident that psychiatry can make significant strides by continuing to attract avid researchers.

"Modern day psychiatry incorporates biological, psychological, and social paradigms in order to diagnose and treat mental illness."

Neuroscience research has also garnered significant attention in politics, no less. President Barack Obama's initiative to invest $100 million to map the human brain is a major recent development.[4] The Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) project is a testament to the growing interest and demand for further research in the neurosciences.[4] With respect to psychiatry, the BRAIN initiative will enhance our present understanding of mental illnesses such as Alzheimer's disease and autism. This may result in improved interventions or potential cures that have significant implications for patients and their families. While Obama's proposed federal investment represents a fraction of the anticipated costs, I am optimistic that extended financial support from the private and public sectors will pay significant dividends in the field of psychiatry.

Another reason to believe psychiatry's future is promising is exemplified by our current knowledge base. There are many opportunities for considerable growth given our present understanding of neuroplasticity and neurogenesis.[5,6] With respect to neuroplasticity, psychiatry can further elucidate the mechanisms by which human beings learn, remember, and adapt.[5] At the molecular level, we know that chemical neurotransmitters regulate changes in synaptic connections and eventually form structural changes. Future investigations can explore plausible means of reinforcing these existing synapses in disorders with significant memory impairment like Alzheimer's Disease.[5] With regards to neurogenesis, research studies have demonstrated that specific parts of the human brain can generate new neurons throughout life, even into old age.[6] Specifically, neurons located in the dentate gyrus and areas near the lateral

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INSIDE

Welcome to the Summer 2013 edition of Synergy.

This special issue displays some of the results of our Synergy Essay Contest. This winter, Synergy offered first- and second-place monetary prizes, as well as publication in this journal of the best four essays (the latter clearly the more valuable reward), in our first Essay Contest.

Any medical student or resident in psychiatry at an Ontario medical school was invited to write an essay of less than 2000 words on one of two topics: (1) "The specialty of Psychiatry is going to become less important, or (2) "The specialty of Psychiatry is going to become more important".

The panel of judges included members of Synergy's editorial board as well as a retired professor of history. An eclectic panel reflected Synergy's editorial mandate: To publish good prose, presented with vigour, on topics in psychiatry and psychology (and peripheral to them) of interest to the educated layperson. Therefore, that a judge had read thousands of essays over a career was more valuable than his knowledge of neurotransmitters.

The cover essay by Ashwin Ramasubbu won first prize, while second prize went to Anne Guo. We were also pleased to publish two other entries by Mark Rhyno and Marc Legault.

If, as a byproduct of the fun of the contest, we have inspired the next generation of psychiatrists to think creatively about their profession, we are satisfied.

We hope you enjoy the prose and, as always, welcome your comments.

SYNERGY SUBMISSION GUIDELINES

Synergy invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.

Articles may be submitted in the form of a Microsoft Word document as an email attachment.

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walls involved in olfaction have this remarkable ability.[6] The dentate gyrus of the hippocampus is an interesting area of further research as it plays a significant role in memory processing. The ability to create new neurons in this location may have particular importance in our ability to process novel information. The future of psychiatry will determine whether cells capable of neurogenesis can be harvested and used to improve the prognosis of mental illnesses including dementia, schizophrenia, and major depression.[6]

Past biomedical advances in genetics, molecular biology, and cognitive sciences hold well for the future of psychiatry.[7] Reflecting on our recent past, science has progressed significantly beyond our imaginations. What used to be impossible is now the status quo.[7] As a field that offers great breadth, depth, and variety, psychiatry will continue to benefit from major discoveries that have taken place over the past few decades. With the highly anticipated completion of the Human Genome Project (HGP), researchers are involved in untangling the mysteries of many genetic diseases.[2,7,8] Psychiatry identifies a genetic component to a majority of mental illnesses and, therefore, the HGP equips psychiatry with the means of using these data to explore molecular targets. This forms the platform for new and improved interventions.[8] To draw on an example illustrating the rapid rate at which we have progressed, consider how far we have come in terms of our storing capabilities. At present, we are able to hold gigabytes of data on a tiny computer chip. Less than three decades ago, we relied on floppy discs to store trivial amounts of data that pale in comparison. Just as the floppy disc had considerable potential to evolve, so to does our knowledge of psychiatry. This leads me to believe that, thirty years from now, psychiatry will be a specialty the details of which few have predicted, but the outline of which many have realistically anticipated.

The future of psychiatric diagnosis is moving in the right direction with our improved understanding of the biological basis of symptoms.[9] Such advancements are seen in work related to dementia and mental retardation.[9] Psychiatry seeks to define, recognize, and discover methods for treating mental illnesses. The ultimate goal is to identify their cause and prevent their occurrence. As psychiatry becomes more evidenced-based and our knowledge of the biology of syndromes improves, our ability to recognize fundamental defects in normal brain functioning will parallel these gains.[9]

Psychiatry is currently experiencing a shortage of physicians, which is most pronounced in the child/adolescent and geriatric subspecialties.[10] Met with an increased demand for mental health services, this highlights a practical problem. Furthermore, as many psychiatrists approach retirement, significant challenges are inevitable.[10] With a decreased number of available specialists, general practitioners (GPs) will assume a greater proportion of this patient population. This is problematic since GPs may be overwhelmed by patient demands and face similar shortages in supply. Social workers, clinical psychologists, and licensed counselors may expand their professional autonomy and advocate for prescribing power in order to remedy this problem.[10] Given their lack of training in managing complex medical illnesses, side effects, and drug interactions, allowing these professionals the opportunity to provide extensive patient care is disconcerting.[10] This reinforces the importance of psychiatry in future years as a specialty devoted to diagnosing and treating mental illness. Our education system demands unparalleled training before we can practice medicine and provide optimal care for patients. We must concentrate our efforts to address the growing trend of fewer medical students interested in pursuing psychiatry before even greater concerns begin to emerge.

In order to paint a complete picture of the future of psychiatry, I will now address skepticisms. One main challenge revolves around decreasing confidence related to psychiatric diagnosis and classification. Historically speaking, the public has led the opposition with respect to psychiatric diagnostic classification systems.[11] In recent years, however, much of the conflict has arisen from within the specialty of psychiatry itself.[11] Examples of internal conflict include debate concerning the validity of psychiatric diagnoses and poor diagnostic stability.[12,13] Psychiatrists fear that any subsequent research related to these diagnoses are vulnerable to the same discussions regarding validity.[11] While I disagree with the notion that future research in psychiatry is threatened, I do believe that we must be more critical of the process in which psychiatric diseases are diagnosed and classified. Regardless of the approach, we must strive for unity in the profession in order to strengthen psychiatry's image and credibility.

The next challenge is decreasing confidence with respect to therapeutic interventions.[11] Evidence-based medicine dictates clinical practice guidelines, and psychiatrists rely on rigorous studies to facilitate decision-making. The difficulty of extrapolating the results of these studies to general populations is a challenge that all medical specialties experience. Psychiatry faced this scrutiny when randomized controlled trials investigating schizophrenia were criticized for a lack of "real world" trials.[14] Subsequent pragmatic trials failed to reproduce prior results that suggested second generation antipsychotics were superior to conventional antipsychotics.[15,16] Moreover, the 2008 meta-analysis that suggested anti-depressants are no more effective than placebo in treating mild to moderate depression casts further doubt around the confidence of psychiatric therapeutic interventions.[17] In spite of declining confidence, I believe pharmacology is steadily improving. Side

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effect profiles are diminishing, and when combined with adjunctive psychotherapy, pharmacological management of mental illness illustrates marked synergistic benefits. Further research is essential if we want to improve existing treatment interventions. Given the financial commitment by governments and a growing supply of researchers, I forecast a positive future.

Psychiatry faces increased competition from other professions, as they look to expand their clinical and professional practices.[11] Within medicine, neurologists and GPs are the biggest threats. In fact, several countries report that GPs prescribe greater quantities of antidepressants than psychiatrists.[11] Perhaps this is a reflection of the large disparity between the number of primary care physicians and specialists. This may also be an indication that patients establish stronger therapeutic relationships with their GPs, suggesting why some expectant mothers prefer to have their labour and delivery managed by their GP instead of an obstetrician. The real concern, as previously addressed, is the pressure mounted by other professionals to expand their scope of practice and adopt a more direct role in patient care.[11] Dr. Martin Gee, a consultant psychiatrist, worries that the field may "lose respect, credibility, and competence" if psychiatrists spend a greater amount of their time supervising those who have a much more visible role to the patient.[18] These concerns may be felt more within psychiatry because of their impact on developing interpersonal therapeutic relationships. Perhaps the solution requires us to reiterate our fundamental guiding principles illustrated in the CanMEDS framework.[19] If we focus on training and recruiting psychiatrists who exemplify all CanMEDS competencies, I am hopeful that this specialty will maintain its sovereignty.

A lingering challenge psychiatry continues to struggle with is its image within society and the medical community.[11] Just as patients with mental illness face significant stigma, so to do psychiatrists. This has been propagated by films, many of which portray the profession in a negative light.[20] Stereotypes, which continue to plague psychiatry, may also be contributing to a shortage of medical students interested in pursuing this career. With resurgence in mental health awareness and services spearheaded by initiatives such as "Bell Let's Talk," I anticipate the stigma surrounding mental illness and psychiatry to decrease.[21]

So what is the future? I cannot help but think that psychiatry will triumph yet again in the face of adversity. Dr. Pierre Pichot, former President of the World Psychiatric Association, believes that the current crisis of psychiatry represents "just another transitory episode in its history".[22] I tend to support this theory, considering many of the aforementioned challenges have existed for several years.

After careful reflection, I maintain my viewpoint that psychiatry will become increasingly important in the years to come. Compared to other medical specialties, psychiatric research has immense potential to flourish, lending hope to cures for mental illness. I acknowledge the concerns that critics present and am inspired to become involved in change. As a second year medical student, I can make a difference by continuing to promote this unique field and dispelling any myths that detract from its credibility. I hope others will join me on this quest, and together we can work towards building a bright and secure future for this remarkable career.

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Freedom from Criminal Thoughts

ANNE GUO

One of the earliest tragic stories I remember in the media is the Columbine High School shootings, where two students murdered 13 others and subsequently committed suicide. A community was left stunned. In the extensive media coverage to follow, neither of the two boys was described as a cold-blooded killer. Despite the tragedy, public opinion was highly empathetic towards these two individuals as victims of teenage culture in America – bullying, cliques, violent video games, antidepressant use, and troubled parenting. While gun control laws were thrust onto centre stage, not far behind was how our society could have done more in preventing such acts of violence, in noticing the prelude to the final act.

Mental health became the prominent buzzwords spilling from the mouths of government officials assigned to the inquiry. The two boys had already run into troubles with the law previously and openly kept a website of hateful criticisms toward members of the high school community. Psychiatrists and psychologists were heavily involved with the investigations and, in fact, one of the killers was diagnosed with anger management issues and depression, with therapeutic levels of fluvoxamine in his system when he committed the crime. Following this and other similar acts of violence, the public has increased its expectations of the medical community to actively promote early recognition of mental health issues.

Nowadays when a shooting takes place, a flurry of articles ensues offering wide-ranging attempts at analyzing the perpetrator's motives and intents. What was going through his mind as he committed murder? What prompted an otherwise normal individual to behave so out of line from social norms? Why did no one around him notice any aberrant behaviour leading up to the shootings? By no means am I suggesting sessions with a psychiatrist are the solution to violent crimes, but the mere fact that these people are not immediately shunned as psychopaths in the media demonstrates an awareness in our society for psychiatric causes and stressors; these individuals are viewed as persons with disturbed thought processes. The discussion now lies in how society has failed to help them correct these thoughts.

In fact, psychopathy is not a disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders,* but antisocial personality disorder is. This diagnosis is vastly different from many other psychiatric illnesses in that the individual is not psychotic, not manic, and not neurotic. There is simply a detachment from emotions and from remorse. Upon closer inspection, the criteria include impulsiveness, recklessness, lack of remorse, deception, aggression, and most prominently, failure to conform to social norms. In other words, breaking the law. The police are enforcers of the law, but they often act on an ad hoc basis, by punishing those who have wronged. Citizens, however, value a society where crimes are prevented, ideally where everyone is satisfied with their lives and accepting of the rules that are in place. The people are now looking within the jurisdiction of psychiatry, where illnesses are defined based on social norms, to build a community free of criminal thoughts.

The law is set out to provide for its citizens and protect them from harm. Public policy and regulations are designed to govern human behaviour, to optimally enable a harmonious coexistence of the masses. With a mature and highly functional legal system operating in the western world, citizens are now, more than ever, expecting lawmakers to institute strategies to prevent individuals from succumbing to criminal thought patterns.

Nobody finds it easy to stomach a story where a hard working average Joe, well liked by colleagues and neighbours, is found to be constructing detonating devices in his basement with the intent of bombing innocent people. While one is expected to take respon-

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sibility for one's own actions, actions are guided by thoughts, which can be out of line with the accepted norm. The law can govern actions but it cannot govern thoughts. The solution in patching this discrepancy lies in a population with good mental health; in the public eye, this responsibility falls largely on psychiatry as a medical discipline. Just as doctors should prevent infectious diseases from spreading, doctors ought to prevent individuals with mental health issues from behaving inappropriately and causing undue harm.

When we read about stories like the Columbine shooting, most would agree that teenagers go through moody phases or inevitably experience cliques in high school. Parents can only too readily imagine a young person being pushed over by life's stressors into a depressive, reclusive state. This can happen easily even to the most highly functioning individuals, and the prevalence will only rise with the high stress, high demand lifestyle we lead today.

One would not have dreamed of encountering a psychiatrist 50 years ago unless one was being unwillingly institutionalized in a mental hospital. Attitudes toward psychiatry have changed dramatically since then. Society now values individuals as proponents in identifying mental illnesses; citizens and their families are their own advocates in seeking medical attention. All too often patients want to talk to a psychiatrist, they want to be assessed by a healthcare professional and walk away with the peace of mind that "nothing is wrong." The service being offered by psychiatrists is in high demand, and increasingly so, given the stronger focus our society has built around mental well-being.

During my time as a residence don at university, I regularly referred students to counseling and psychiatry services for very different reasons. I was approached frequently by students who were overwhelmed by the demands imposed on them in life and who were highly receptive to the idea of speaking with a healthcare professional. This is the generation that is armed with the knowledge that illnesses of the mind manifest themselves physically, and one that makes no compromises on the health of its members.

By promoting awareness of mental health issues and encouraging members of our society to identify individuals at risk, we have effectively implemented a universal screening program at the secondary prevention level. As such, psychiatry will only see its importance grow as people wish for their minds what they wish for their physical beings – preventative health measures, to make changes before it is too late. It is not surprising that we are now increasingly seeing the integration of psychiatry into other disciplines from surgery to medicine. Consider the management of a post-operative patient who sustained a deforming injury or a cancer patient undergoing palliative chemotherapy; concurrent care provided by psychiatry significantly impacts the patient's quality of life.

There are no vaccinations against criminal behaviour, but with growing insults to mental health in a modern life, there lies a greater expectation from the public on medical professionals to curb the progression of ailments. The improved acknowledgement of mental illnesses as health issues also serves to strengthen the discipline of psychiatry both now and in the future.

The Locked Room:

Psychiatry at the Limit

MARK RHYNO

"The other time I was in quarters such as these was in the Verdun mental hospital in Montreal," Leonard Cohen quips to a full audience assembled in a lecture theatre at McGill University in 1964. "I was *visiting*," he says, and pauses for a beat. The audience laughs.

Two hundred or more people have gathered to listen to Cohen read poetry, and the National Film Board of Canada is shooting the event at McGill for a documentary. Cohen, the *raconteur*, goes on to tell the story of his mix-up in the psychiatric ward in Verdun. The friend he was visiting sent him to the cafeteria for coffee, and Cohen, trying to leave the ward, found himself in a "kind of arena" downstairs in which he could imagine "every possibility except for the one that happened": two orderlies stopped him.

"Where are you supposed to be now?" they inquired.

Cohen told them that he was supposed to be in the cafeteria. The orderlies nodded to each other and repeated the question again, the second time in a knowing (and ominous) way.

"*Where* are you supposed to be now?"

One of Canada's most recognizable celebrities found himself, as Cohen says to the McGill audience, "protest[ing] too much," pushing past the "guards," and running to the information desk so that he could be identified and returned safely to his friend.

As amusing as Cohen's anecdote is, the scenario he describes does betray something sinister about the practice of Psychiatry: our definitions, our diagnoses, and our spaces of practice are suffused with contingencies and competing valences, and even experienced clinicians can have difficulty distinguishing aberrancy from health. Psychiatric illness can be a snarled-up, tortuous entity not unlike the fabled Gordian Knot. And while we would like our interventions to disentangle the ambiguities of the major psychiatric illnesses, to cut through, Alexander-like, the many and complex threads that comprise a patient's history and presentation, the psychiatric "arenas" in which we practice can often effect the opposite. If the meaning, use, and function of psychiatric spatial intervention – for instance, hospitalization, confinement, seclusion – is not clear, patients may suffer.

What I will attempt to argue in this paper is that the specialty of Psychiatry will become increasingly important because it will be psychiatrists who will be charged with the task of negotiating the ambiguous spaces that house the mentally ill. As awareness of mental illness increases in the community, and more people present to hospital with complaints of a psychiatric nature, psychiatrists will be expected to intervene in the safest and most effective way possible. Much of our interventional arsenal depends on space; if we are to be effective physicians, we must understand (and attempt to stabilize) the nuances (and implications) of using space itself as a treatment.

There is a centuries-old tradition of depicting the psychiatric hospital – a space that is supposed to provide retreat and reprieve for sick people – as a place that strips people of their surroundings and nullifies their ability to transact within the greater social economy. Three famous studies of the asylum by William Hogarth and Francisco Goya portray the absurdity and agony of being trapped in the limitless system of early psychiatric institutions. Hogarth's *A Rake's Progress* (1735) depicts, in a series of plates, an incorrigible philanderer's descent into madness. The final plate of the series is set in Bedlam, and Hogarth stages that institution as a disorderly dungeon where the unruly mad are free as they please to urinate on walls or put on airs of royalty. Here chaos reigns. In fact, the only people who appear to be healthy in the etching are the bourgeois women who eye the obscene behaviours of the mad; if we examine the mise-en-scene of the Bedlam plate, a narrative of psychiatric (mis)treatment emerges. Hogarth is highly critical of a place that

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amasses people, confines them, and then offers their sufferings up for the general entertainment of upper-class (and healthy) *voyeurs*.

Goya's *Yard with Lunatics* (1794) and *The Madhouse* (1819), like Hogarth's Bedlam plate, figure the institution as a confused space and render patients as pitiful. The denuded and disheveled victims of confinement are littered about the frame of Goya's paintings. Unlike Hogarth, Goya's works eschew the comical or parodic elements of imaging the mad, instead envisaging the incarceration of patients as a horrific and frightening *mêlée* (and perhaps one that needs to be carefully contained). Whereas Hogarth seems to delight in the absurdity of his scene, Goya's paintings are far more sinister. For Hogarth, the asylum creates a crazed and farcical orgy in which its inhabitants participate (and titillated spectators gather). Hogarth's mad people succumb to folly, and the psychiatric ward becomes carnivalesque. For Goya, the asylum is dank, cloistered, and claustrophobic. Both of Goya's paintings feature stone archways, half-lit, leading nowhere. Above these archways one almost expects to find Dante's dictum written above the gates of Hell: *"Lasciate ogne speranza, voi ch'intrate,"* or, "Abandon all hope, ye who enter here." Light falls on only a few subjects, and these figures loom out of the blackness like the undead emerging from the depths of their catacombs. Beyond the wretched few that are illuminated lies a mass of writhing bodies and limbs that, vermin-like, seem to breed in the outer dark. There is no viewpoint from which someone may safely observe the scene in Goya's paintings. Wealthy onlookers cannot exist in Goya's hellish spaces. It is as if the insanity within the asylum has power enough to seep outward and assimilate anyone; Goya's madness is horrific, and the space of the asylum is not one of refuge or respite but instead serves to contain madness' infectious and explosive power. Insanity for Goya is almost transcendentally threatening and must be imprisoned. It is a monstrosity that is housed in a monstrous space.

One of the great tensions surrounding our institutions – both the asylums of the past and the modern inpatient wards we have today – is the dialectic between two poles of interpretation about what institutionalization means: either the hospital is a restorative, curative refuge, or it is a chaotic, hellish prison. Erving Goffman's work argues that this tension is present from the very moment a patient enters a hospital. For Goffman, who wrote in the 1950s and 1960s (just as the deinstitutionalization movement was emerging), psychiatric hospitals were "total institutions" that had the real effect of engulfing people and homogenizing their complaints and their suffering to the point that a person's individuality was negated. In *Asylums* (1961), Goffman observed that many institutionalized patients were reduced to uniform, automaton-like beings capable only of operating and living within a hospital. Goffman called this phenomenon the process of "disculturation": people herded into the space of treatment (which is also a space of confinement), Goffman argued, lose their ability to transact in their own culture and are dispossessed of the skills that made them capable of functioning outside of the institution. They are psychiatrized completely. No rehabilitation occurs, and, because of their interaction with the hospital, patients learn how to further withdraw into their illness.

And what of our modern hospitals? Do the tensions described by Cohen and Goffman (and illustrated by Hogarth and Goya) still exist, or have we, with our modern sciences and enlightened practices, banished such confusion to the dark ages? An anecdote of my own might help call attention to the ambivalence that continues to haunt our psychiatric spaces.

As part of my residency I work several overnight shifts every month in an emergency setting. Not too long ago, in an effort to bolster our security and to prevent involuntary patients from eloping, we locked the door to the waiting room. The idea was sound

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enough: if a person wanted to leave, we reasoned, there would be at least two checkpoints – the door to the locked psychiatric unit itself, and the waiting-room entrance – that would allow us to verify whether or not a person was safe to go. What I did not expect was the Kafka-esque metamorphosis that occurred. Our waiting room, once a humdrum affair with a few chairs and a fern, mutated into some new species of space that was neither a locked unit (family members, visitors, housekeeping, and paramedics were an almost-constant presence coming in and out) or a waiting area (occasionally, in cases of overflow, the room would house involuntary, psychiatrically-unwell patients). This chimeric room might have allowed for the kind of misidentification that Cohen talks about. I say "might have," because I am lucky enough to work alongside a dedicated staff of nurses, allied health professionals, and managers who recognized immediately the distinct and problematic nature of a newly secured area. It was the nurses who took charge of the space and maintained order by clearly demarcating which people were ailing patients and which were visitors. The nurses, like Cohen's orderlies, were sage enough to ask the question, "Where are you supposed to be now?"

Our efforts to reinforce a barrier thus transformed the very nature of our waiting room. We did nothing to dramatically alter the architecture of the hospital; we simply locked a door. What changed, arguably, was the *threshold* of the psychiatric unit. Etymologically, the word "threshold" denotes a doorsill that one steps across to enter someone's home. A threshold is, therefore, the limit of the public sphere, and beyond it lies the private space of treatment. By entering into the locked waiting room, people crossed a threshold into a psychiatric space proper. But something was still amiss, even after we had identified who in the room was a patient and who was not: what was the *status* of our patients? Were they "in" or "out," or were they somewhere in-between?

The anthropologist Victor Turner describes such in-between spaces, spaces that arrest in their development between one state (say, a waiting area) and another (say, a secure unit), as being both vulnerable and threatening. These spaces – Turner calls them *liminal* – represent a kind of interruption. They never quite serve their intended purpose, and yet, by resisting categorization, these spaces challenge the very classification system that enables our understanding of them. What is a waiting room? What constitutes a "psychiatric space"? Is a waiting room private or public? Where stands the threshold?

It is this tension, the tension of the liminal space, that imbued our waiting room with the air of uncertainty that I described above. I am not arguing that patient safety was compromised; we have a dedicated and attentive team of staff and managers who ensured the safety of each person coming in to and out of the waiting room (and through the door to the locked unit). Nor am I arguing that our situation was unique. What makes Psychiatry indispensable as a discipline is our ability (and duty) to negotiate with – and stabilize the meaning(s) of – hospital spaces. Each entry-point into our hospitals, each threshold, will bring with it some aspect of the liminal. We must be ever aware of the ambivalence that permeates the actual spaces in which we work, and we must try to exorcise the spectre of Bedlam that haunts our institutions. In our age, post-deinstitutionalization and pro-community, an age in which the public is becoming increasingly savvy about mental illness and an untold multitude of sick people are hovering in the doorways of our hospitals, we must learn to negotiate the boundaries of psychiatric treatment, we must act as guarantors of both the public good and the incarcerated ill, and – when faced with liminality – we must *learn where to draw the line*. If transformations occur within our places of practice, we must adapt our approach so that potentially injurious spaces become therapeutic once more. We must practice at the limit.

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Of Sunflowers and Starry Nights

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"The artist is the creator of beautiful things" (Oscar Wilde)[1]

Van Gogh painted "Starry Night" and "Sunflowers" with access to the same palette and canvas. In the former, the brush stroked whorls of clouds and stars blanket the clandestine hamlet in a cloak of beautifully eerie tranquility. In the latter, the bright yellow bouquet of flowers – some large, healthy, and filled with the colour of life, others miserably wilting away in light of the transition from earth to vase – points to their natural history. To witness these creations first hand is a privilege. They exemplify the tremendous range of craft that one artist can possess, and shows that the limits of imagination stretch far beyond the bones and sutures of our own skulls.

We all have traits that help identify us uniquely as human: we share genetic makeup, physiology, and behavioural tendencies such as smiling and crying that are conserved amongst cultures. Yet where we diverge from one another is the quality that makes us the most unique among species, and it is the most complex, the least understood, and arguably the most beautiful. It is the canvas upon which our impressions are painted for the world to see; it draws its inspiration from the non-modifiable (genes, temperament) and the modifiable (friends, lifestyle choices), as well as from mixed influences (pre-, peri, post-, and neo-natal, cultural and family norms) that affect us with or without our knowing. It is what for centuries psychiatrists, psychologists, and philosophers have healed, studied, and contemplated: The human mind.

"The critic is he who can translate into another manner or a new material his impression of beautiful things" (Oscar Wilde)

While researchers investigate the complexities behind what gives rise to thought, and what goes awry in the instances of anxiety, depression, post-traumatic stress disorder (PTSD), or another Axis I disorder yet defined, new discoveries posit several challenges for the future of psychiatry. We are forever expanding our mechanistic understanding of pathophysiological processes, uncovering etiological origins for previously elusive diseases – thus ever more rendering the term "idiopathic" vestigial – and designing rationally based targets and strategies for treatment with this understanding. With mounting evidence for vascular lesions, autoimmune markers, and infectious causes for diseases previously thought to be purely "in the mind," one of the questions raised is whether psychiatry is losing its footing on the medical platform as these diseases are becoming more thoroughly understood?

The corollary to this question would be that the psychiatrist's role as a medical professional is to treat the inexplicable; this a reckless assumption to say the least, and it steers it away from the true ambition of psychiatry, which is simply to heal the mind, regardless of etiology. The psychiatrist is also skilled in taking the entirety of the social determinants of health into consideration in the evaluation of a patient as a whole.[2] No two psychiatric presentations are the same; there is no one molecule designed specifically for one target. Anyone given access to the same paints and canvas as Van Gogh could make an attempt at reconstructing one of his works, but even the best imitation would still be just that; and it would lack the intangible ingredient that electrified his works. Psychiatrists possess the skill-set to stratify psychiatric symptoms along a spectrum, and give recommendations based on that assessment of an individual's mental status.

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"Those who find ugly meanings in beautiful things are corrupt without being charming. This is a fault. Those who find beautiful meanings in beautiful things are cultivated. For these there is hope" (Oscar Wilde)

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Today, advanced imaging studies such as functional MRI (fMRI) and diffusion tensor imaging (DTI) can give us a better picture of spatio-temporal changes in the brain in light of pathology, and offer us a link between impairment at the functional level and at the neurological level.[3] Additionally, genetic predispositions towards a plethora of psychiatric illnesses are being identified. From this perspective, it has never been a richer time to be able to provide patients with information regarding biological sources of their illnesses. From a mechanistic level, we have never been closer to unlocking the secrets of psychiatric disorders.

Psychiatry needs to take an active role in pursuing further knowledge of diseases at this level. Just as cardiac surgeons lost ground in their field by remaining true to their tried techniques and resisting change at the outset of less invasive techniques, psychiatry stands to lose credibility should it fail to adapt. However, in the past this discipline has shown tremendous plasticity and always remained true to its form. One study[4] demonstrated that a large proportion of psychiatrists randomly polled on fundamental concepts in genetics lacked such knowledge, and it is this type of pitfall that needs to be watched out for should psychiatry desire to have a voice in the debate about the ethical applications and clinical impact these new advancements could bring to mental health.

An additional challenge facing psychiatry in light of the increased understanding of mental health is the internal stigma carried with it. Stigma associated with mental health prevents arguably some of the most enlightened individuals with regards to the subject (medical students) from coming forward with their mental health issues or seeking professional help for fear of the impact this may have on their prospective careers.[5] How can we champion the importance of mental health on wellbeing when there are those we revere for their surgical or medical skills who easily dismiss the impact mental health has even within their own practices? Art all too often goes unappreciated during the artist's lifetime. Advocacy needs to start from within.

"It is the spectator, and not life, that art truly mirrors" (Oscar Wilde)

Each of us appraises things differently given our background and personal experiences; it is an inherent consequence of the human psyche. Just as one would most certainly describe "Starry Night" and "Sunflowers" differently than I chose to, so too do individuals react differently to the same medical conditions. Outcomes of patients differ too, and studies show that mood and personality have a tremendous impact on use of outpatient services,[6] morbidity, and mortality.[7] That is not to suggest that every surgical ward have a psychiatrist on deck to round on sick patients; however, there is no denying the important link between mental health and overall well-being. Indeed, it is the psychiatrist herself who is best able to objectively compile a profile of someone based on their pre-existing genetic, epigenetic, metabolic, and peri/pre/neonatal factors, combined with experience, environment, temperament, and personality. Psychiatrists need to be pioneering the strategies to understand, empathize, and treat when necessary the minds of all patients, from the mildly anxious to the terminally ill. One thing psychiatry can do is reintegrate

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itself within the spectrum of medical specialties. It has found itself an outlier where even other medical professionals won't venture. Since we measure the merit of interventions based on outcomes, numbers needed to treat, and reduced mortality and morbidity, it becomes clearer why psychiatry falls short because often much of its impact is measured by way of self-reported symptoms and subjective expressions of the patient.

"Diversity of opinion about a work of art shows that the work is new, complex, and vital. When critics disagree the artist is in accord with himself" (Oscar Wilde)

The most daunting question remains. In medicine, a profession that was once nearly exclusively practiced by clinical expertise and experience but is now headed in a one-way, evidence-based direction, will psychiatry be able to transition while lacking objective investigations to confirm diagnoses? In actuality, the definition of evidence-based medicine should emphasize the even more important role of psychiatry. Even with all the information presented with all the studies regarding a particular intervention, two people might not make the same choice with the same thought process or for the same reason. By definition, evidence-based medicine necessitates psychiatry as it is currently practiced, for it is ultimately supposed to allow the patient to make the most informed decision based on one's social determinants of health.[8] It is this patient-specific individuality emphasized in every key medical decision that we need to empower, preserve, promote, and try to better understand so we can help guide future decisions towards better physical and mental health.

"We can forgive a man for making a useful thing as long as he does not admire it. The only excuse for making a useless thing is that one admires it intensely" (Oscar Wilde)

Noting Van Gogh's complex mental status changes over the course of his life and career as an artist does not change the quality of his masterpieces, but it adds another layer of insight for us to appreciate the differences between his crafts; it provides for a more rich discussion. Psychiatry is artful medicine. The more we know of underlying mechanisms behind psychiatric disorders, the more we can opine towards better treatments; and the richer the quality of care shall be. The skill of the psychiatrist to assess, understand, empathize, and heal a patient's mind will be strengthened by these achievements. With increasing knowledge we can become more empathic and stronger advocates for mental health, and improved physicians.

We can strive towards a deeper understanding and admiration for the true beauty of starry nights and sunflowers.

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