

neurotic conditions which were sufficiently disabling for them to seek help, but not so severe as to warrant referral to the over-stretched in-patient-based psychiatric services. The treatments offered were largely behavioural and psychotherapeutic. One woman with generalised anxiety was being treated entirely by family therapy: sitting in on a session conducted in a foreign language highlighted the degree to which such a therapy session relies on non-verbal means of communication.

### *Comments*

What are the overall impressions remaining from this brief introduction to Polish psychiatry? Certainly I was impressed by the dedication of all involved in helping those with psychiatric problems, and the efforts which were made to provide a high standard of care despite poor resources and lack of recognition.

The debilitating effect of the dearth of psychiatric research in Poland (and lack of access to published

sources) should sound a warning note to psychiatrists in our own country at a time when resources for research are dwindling. Without a healthy research environment and free exchange of ideas, practices which have not been fully assessed – or which are even unethical – may become established means of treatment simply because they are championed by a local consultant or university professor whom no-one dares to question.

Yet there is an opportunity for us too: Polish psychiatry has evolved over the last 40 years in isolation from Western practices. Now, uniquely, with the re-opening of communication between East and West, psychiatrists have the chance to compare and evaluate two very different approaches to the treatment of psychiatric illnesses. Polish psychiatrists may indeed be able to benefit greatly from access to Western postgraduate training and professional journals, but we should be deceiving ourselves if we assumed that the benefits of the new openness can only flow in one direction.

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*Psychiatric Bulletin* (1990), 14, 353–355

## **The times**

### **Who owns the brain?**

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As usual, I bought my wife *Vogue* magazine for Christmas. It always serves well as, in North America parlance, a 'stocking stuffer'. This year it had further value as it highlighted the brain. A well-known psychiatrist, Nancy Andreasen, set out to inform America about modern psychiatry (Andreasen, 1990). The article is entitled 'Brave New Brain' with the subtitle being 'Modern Psychiatry has Left the Couch for the Laboratory'. She takes the reader

through neuro-imaging, molecular genetics and psycho-pharmacology. It is an elegant synopsis and worthy of someone who had a doctorate in English before she took up medicine. Importantly, however, she prefaced her serious material with a mock-comic story about a conversation she had had with someone at a New York hospital recently. She was phoning about the retrieval of a brain for research and the ingenuous person at the hospital just could

not put the idea of psychiatry and brains together. Another sad tale of psychiatric breast-beating? Those of us who trained in psychiatry in Britain a generation ago might give a wry smile. After all, biological psychiatry was all that we ever knew. When I entered the Maudsley in 1964, part of the orientation for registrars consisted of going to the laboratories. A mouse was popped into a jar containing liquid nitrogen, it went rock hard and the group was advised that freezing the neurotransmitters in that way was the royal road to solving problems.

Unfortunately, however, there is more than a kernel of truth in Nancy Andreasen's story. There is dispute about who owns the brain and what in North America is known as a 'turf' issue. There are now several medical groups interested in the brain since this is where research and clinical funding are heading. What can psychiatry expect?

Leon Eisenberg (1986) in his Eli Lilly lecture talked eloquently about "mindlessness" and "brainlessness" in psychiatry. This interesting duality had, he thought, been a concern to physicians over several generations. He pointed out that recent biological research had been exhilarating but could be perilous. Thus:

"The peril is that psychiatry may come to focus exclusively on the brain as an organ and to overlook the experience of the patient as a person. We have for so long been pilloried by our medical and surgical colleagues as witch doctors and woolly-minded thinkers that it is tempting to seek professional respectability by adhering to a reductionistic model of mental disorder. We may trade the on-sidedness of the 'brainless' psychiatry of the past for that of 'mindless' psychiatry of the future."

Most of us would applaud this even-handed approach and his final statement that these extremes cannot be tolerated, especially since the role of psychiatry is thought by him to deal with the mind/body relationship. While Leon Eisenberg as a distinguished physicist encourages us to not eschew the mind or the body we must return to the matter of access to the brain and the 'turf' issue. Who, in other words, lays claim to study and treat the brain? It should be noted that recent brain research opportunities and findings have revived the traditional antagonisms between neurology and psychiatry (the history of the splitting and splicing of these two specialities is complex and varies from country to country but suffice to say that they are generally not kissing cousins). Presently, they no longer ignore each other because of the manifest overlap in interests and the influx of health care and research dollars. They do get nettled by each other and the old chestnuts about neurology diagnosing everything and treating nothing (and psychiatry vice versa) are

often wheeled out. However, when it comes to the crunch, who wins? Regrettably it would seem that neurology may have the edge. What is the evidence for this?

The field of dementia is the area that I am most familiar with where the tension between psychiatry and neurology declares itself. Some years ago a consortium was assembled, mainly guided by neurology, to decide on criteria for dementia. These became known as the NINCDS-ADRDA or McKhann's criteria (McKhann *et al.*, 1984) and have become the benchmark for dementia research in North America. While psychiatry certainly had input into these criteria the guiding influence was neurology. Notwithstanding, it is ironical that within these criteria the measurement of cognition (Folstein *et al.*, 1975) and function (Blessed *et al.*, 1968) were developed by psychiatry and further confirmation of the diagnosis is made by neuropsychology. Neuropsychology and neurology are not best friends either. This US view of dementia has been accepted holus-bolus by those in Canada. How else does psychiatry fare? In the field of the epidemiology of dementia psychiatry has always seemed to be pre-eminent. In my innocence as a registrar at the Maudsley the work of Martin Roth and the Newcastle school seemed original and inventive. They were able to provide prevalence data for dementia, the types of cases and, most importantly, the distribution between home and community. Currently the Americans and Canadians are repeating this exercise. Clinical epidemiology and population based epidemiology studies are proceeding in the United States and Canada. However, those running these studies tend to come from clinical neurology and cancer epidemiology rather than from psychiatry. A psychiatric colleague in the United States has called this the "neurologisation of dementia". This means that the history of the present illness and neurology symptoms and signs are deemed of much more importance than behaviour, mental state, function and neuropsychology. In fact at times the purpose of psychiatry is seen merely to exclude depressive pseudodementia.

Is there a white knight? A figure so revered in corporate affairs. Regrettably not. The only other medical speciality involved is potentially even more divisive. (It should be noted that general practitioners in fact diagnose most cases of dementia but it is not their main area of concern.) It is made up of geriatric physicians who are essentially generalists to old people in the same way that pediatricians are generalists to young people. They know about all body organs but have no particular training in the brain compared to that given to psychiatry and neurology. Nevertheless, they feel confident to comment in detail on the dementing brain. I was recently a participant at a 'consensus' meeting on dementia organised by geriatric medicine with token

attendance from geriatric psychiatry and neurology. There was a two day discussion on how the general practitioners, few of whom were present, should diagnose dementia and screen for secondary and possibly treatable dementias. The discussion proceeded despite evidence that incidence cases coming to an individual general practitioner would be a mere handful annually. Naturally there would be many more prevalence cases but 'burden of care' was not of prime importance to this group. It was far more interested in deciding what medical examinations and tests were warranted for the handful of new cases. Behaviour and function were cheerfully decided as having no relevance. Since this group intends to publish a detailed and lengthy report then it is a force to reckon with.

Conversely, there are those, of course, who would argue that times have never been better. That any convergence between the above specialties is a good thing and that there is enough work for everybody. Thus the American NeuroPsychiatric Association has just been organised and at the 1989 International Psychogeriatric Association meeting in Tokyo there was a splendid assemblage of psychiatrists, neurologists and geriatric physicians. Such inventions as imaging have demonstrated anatomy and physiology of common interest to all concerned. We are encouraged to believe that such features as the frontal lobe, partial complex seizures and serotonin are of mutual interest. They may indeed be mutual but may be of passing interest to the main body of psychiatrists. Detre (1987), an eminent psychiatrist in Pittsburgh, energetically deprecates this situation and argues "that the mind and brain are one" and that "our new strategy should be a decisive move, carefully contrived, meticulously executed and dedicated to providing clinical and research training to create a new breed of psychiatrists who are truly neuroscientists".

Given the competition for brain, is psychiatry prepared to enter the fray? Many psychiatrists are indifferent to the issue of who owns the brain. In North America I see nice, kind, bright residents who dutifully learn all of this for their specialist exams but

who sheepishly admit to preferring psychoanalysis. They like to be thought of as eclectic but essentially have little interest in measurement. So psychiatry is numerically strong but biometrically weak. In Canada there are 3,200 psychiatrists, 400 neurologists and 100 geriatric physicians with specialist qualifications. Within each specialty only a minority is interested in dementia. Nevertheless, neurology and geriatric medicine are on the high ground when it comes to clinical recognition and research funding. Where are the psychiatrists who can understand neurology, imaging and neuropharmacology? Our own institute is about to purchase a PET scanner, one of the 50 in the world, and yet there is a fear that the technology will be too complex for psychiatry and other disciplines will pre-empt us.

So looking again at Eisenberg's duality, it would seem that the interest in "mindlessness" may go both by competition and default and the profession will continue to embrace "brainlessness". This scenario is one from North America, especially from Canada, and may be inexact for those in Europe and Australasia. What is the situation in Europe with its emergent strength and influence? Are mice still being solidified on the first day of training?

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