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Challenges for trainees in psychiatry and early career psychiatrists

ANDREA FIORILLO[1], AMIT MALIK[2], MARIO LUCIANO[1], VALERIA DEL VECCHIO[1], GAIA SAMPOGNA[1], LUCIA DEL GAUDIO[1], MARTINA ROJNIC KUZMAN[3], NIKOLINA JOVANOVIC[3], ALEXANDER NAWKA[4] & UMBERTO VOLPE[1]

[1]*Department of Psychiatry, University of Naples SUN, Naples, Italy,* [2]*Consultant Psychiatrist, Hampshire Partnership NHS Trust, Hampshire, UK,* [3]*Department of Psychiatry, Zagreb University Hospital Centre, Zagreb, Croatia, and* [4]*Department of Psychiatry, First Faculty of Medicine, Charles University, Prague, Czech Republic*

Abstract

Psychiatry as a discipline will undergo major changes in the coming years. Although changes can be particularly stimulating and challenging from an intellectual, scientific and social viewpoint, the new generations of psychiatrists must be prepared to face these changes and deal with them appropriately. Paradigms which have represented the foundations of psychiatry in the last century now need a major revision. In particular, both trainees in psychiatry and early career psychiatrists need to (1) (re)discover psychopathology, (2) improve mental healthcare through integrated treatments, (3) identify and treat new syndromes, (4) promote an image of psychiatry with patients at the heart of care and as advocates for each other by fighting stigma and promoting the recruitment in psychiatry by medical students. These can be achieved by increasing involvement in institutions and organizations to influence the agenda. In this paper the possible contribution of trainees and early career psychiatrists is discussed and recommendations are made in order to set a new agenda for early career psychiatrists who will still be practising 2–3 decades from now.

Background

The context within which psychiatry is practised is changing rapidly in a variety of ways. From a global perspective, there is a greater recognition of the healthcare resource gap between need and delivery in different countries, and the World Health Organization (WHO) has taken a lead in describing this eloquently (Chisholm et al., 2008). Subsequent policy initiatives have sought to redress this gap but this is yet to translate into satisfactory action (Saxena et al., 2007).

Socioculturally there are significant paradigm shifts in the way in which people relate to each other, both at an interpersonal level but also interculturally. In particular, with changes in ways of communication and the impact of urbanization and globalization, it is inevitable that there will be an increase in individualism and changes in family structure (Bhugra & Fiorillo, 2012). In fact, the usual stereotypical model of husband and wife with two children has given way to same-sex couples having children through surrogacy and adoption. From a cultural viewpoint, whilst on one hand globalization has led to an increased awareness of mental health-related illnesses, on the other hand it has increased migration, both economic and political, and has led to an increase in conventional and new categories of morbidities. These changes have modified communication among people (Luciano et al., 2012) through the development of new ways of web-based social media, such as blogs (e.g. Twitter), social networks (e.g. Facebook) and virtual gaming (Hamm et al., 2013), and the clinical presentation of several mental disorders (Maj, 2012).

Whilst stigma remains an ongoing issue, not only for our patients but also for professionals working within mental health, there is now greater awareness related to stigma and campaigns and guidance are perennially underway to counteract this but this needs to be built upon.

Another by-product of enhancements in communication and travel is the cross-fertilization of professional ideas globally amongst psychiatrists, and the resultant drive to harmonize not only the clinical experience of those suffering from mental illness but also the training curricula of which this experience

Correspondence: Andrea Fiorillo, MD, Department of Psychiatry, University of Naples SUN, Largo Madonna delle Grazie, 1, 80138 Naples, Italy. Tel: 00390815666531. Fax: 00390815666523. E-mail: anfioril@tin.it

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is an outcome. This has led to a decade of development and re-development of psychiatric training curricula (Bhugra, 2008).

New pharmacological and non-pharmacological treatments are continually being developed and researched – in addition to the new care pathways and models of care (Fujisawa et al., 2008) within which these treatments are being delivered, so once again having a significant impact on the experiences of early career psychiatrists. New forms of therapies are being studied and provided in new settings, with psychotherapies provided online (Kessler et al., 2009), information easily reachable through the Internet for everybody (Styra, 2004), and possible targeted psychiatric interventions as a consequence of knowledge of pharmacogenomics (Preskorn & Hatt, 2013). Additionally, with the ethos of personalized healthcare gaining momentum, neuroradiological, genetic and neurophysiological profiling are set to interface with new information technology to revolutionize the manner in which individual patients will be diagnosed and supported.

Finally, the core of psychiatry itself is undergoing constant evolution. With the advent of DSM-5 and ICD-11, diagnostic and classification systems will again be transformed significantly, if not radically. In fact, in the DSM-5 some disorders were revised by combining criteria from multiple disorders into a single diagnosis, as in instances where there was a lack of data to support their continued separation, new disorders were included based on a review of existing evidence from neuroscience, clinical need, and public health significance. Moreover, the numbers of specifiers, items that delineate phenomenological variants of a disorder, and subtypes in the DSM-5 have been expanded to account for efforts to dimensionalize disorders, and in some cases the specifiers have been removed, as is the case for the bereavement exclusion for major depressive episodes (Maj, 2013; Regier et al., 2013).

It is in this evolving context that we set out to examine the traditional and current identity of psychiatric trainees and early career psychiatrists and propose a new, future agenda for this dynamic group.

The identity of early career psychiatrists

The professional backgrounds and the identities of early career psychiatrists have already seen a radical shift from the 1960s and 1970s through to the latter part of the last century.

Nowadays, early career psychiatrists and trainees are trained in and often base their clinical practice on rating scales rather than on an in-depth psychopathological analysis of the patient. The risk is that psychiatry as a discipline could lose its own identity if the empathic and subjective approach to psychiatric care is simply disregarded. Psychopathology is at the heart of doctor–patient interaction in psychiatry.

Other major changes that occurred recently include the move of mental healthcare from the hospital to the community, with the consequent burden on families and the need for the implementation of evidence-based psychosocial interventions, the affirmation of brief modern psychotherapeutic approaches which have replaced long-term traditional psychoanalytic therapies, the availability of new pharmacological compounds, which have replaced in many developed countries 'old-fashioned' but effective drugs such as chlorpromazine, tryciclic antidepressants and lithium, which is now considered a 'forgotten drug' (Fieve, 1999). However, the context, outlined above, signifies that trainees and early career psychiatrists will have to once again transform themselves to meet the needs of their patients in the 'new' world: 'The 21st century abounds in social changes, economic upheavals, revolutionary advances of knowledge and many other developments which require a re-examination of the paradigms on which psychiatry and mental health care are based' (Sartorius, 2010, pp.1–6).

Although mental health disorders now have a well-recognized biological basis, by their very nature they reach beyond the brain to involve social, cultural and psychological dimensions. It has been argued that the current paradigm of psychiatry is mainly a technological one, in which genetics, neuroimaging and biological research are the most important elements, and where psychiatry is a medical discipline using the same clinical and research methods of other medical specialities (Bracken et al., 2012). However, this paradigm does not achieve its aim of explaining causes of mental disorders and does not produce a coherent explanation of mental diseases, probably because it does not take into account the interplay of elements underlying a mental disorder (Kingdon & Young, 2007).

The key domains that early career psychiatrists need to consider are reported in Table 1.

Rediscovering psychopathology

Since the transition of DSM-III's utility from purely research purposes to wider clinical applications, it has been assumed that using operational criteria is the only reliable way to arrive at psychiatric diagnoses. There are now two parallel operational criteria that are recognized across the globe in making psychiatric diagnosis: DSM-IV and ICD-10. Both are currently undergoing revisions (although DSM-5 has been launched recently) and it is now acknowledged that using operational criteria for making

Table 1. The new agenda for early career psychiatrists.

1. Rediscovering psychopathology
2. Is psychopharmacotherapy alone sufficient?
3. Psychiatry as a medical discipline
4. From the asylum to the community … Changes in mental health care settings
5. New syndromes and new diagnoses
6. Psychiatrists and the media: how does the public perceive us?
7. Being involved in scientific societies
8. Recruiting young doctors into psychiatry

psychiatric diagnosis presents its own challenges, especially in diagnosing psychiatric co-morbidities (Maj, 2005) and in terms of the utilization by psychiatrists across the world (Maj, 2011). Whilst it is hoped that the revised operational criteria will address some of these challenges, the above evidence also highlights the significance of all psychiatrists having strong grounding in psychopathology, as this will enhance ability to take a holistic view of the patient and validly apply any operational criteria to support their diagnosis.

The value of phenomenology and psychopathology has long been recognized and current leadership thinking in the area suggests that using operational criteria further highlights the importance of revisiting some of the age-old principles of descriptive psychopathology. Whilst not discounting the values that operational criteria have added to psychiatric diagnosis, the early career psychiatrists (ECP) will make 'rediscovering psychopathology' one of its top priorities for all its trainees. Whilst 20 years ago it was the norm for residents and early career psychiatrists to study philosophy and psychopathology, their focus today is largely on learning to use diagnostic criteria. We aim to redress this balance by encouraging a more balanced approach that encompasses both these aspects of diagnosis.

Is pharmacotherapy alone sufficient?

Early career psychiatrists need to rediscover their therapeutic expertise not only in traditional and contemporary pharmacological modalities, but also in equally important psychosocial interventions.

There are a number of challenges related to this. Firstly, whilst new residents and early career psychiatrists are learning about new drugs, not all of them are as au fait with more traditionally effective medications. For instance, most residents are not adequately trained in the subtleties of lithium treatment. Therefore, on graduation they are poorly equipped and tend to underuse lithium as the first line of treatment. Instead, they begin the new bipolar patient on an antiepileptic, since it is easier to use and requires less knowledge (Fieve, 1999).

Secondly, there is clear research evidence that for a vast majority of our patients, a pharmacological approach alone does not provide the requisite remission and relapse prevention and needs to be combined with evidence-based psychosocial interventions (Table 2). For instance, in a study by the WHO, many institutionalized patients with chronic schizophrenia had a positive response to medication treatment, with significant symptomatic relief. However, the symptom relief alone did not allow for discharge from psychiatric hospitals (Chisholm et al., 2008). That was achieved only when substantial psychosocial and psychotherapeutic treatments were added (Tasman et al., 2007). The newer generation of psychiatrists needs to be aware of the relative effectiveness of all psychosocial interventions and must develop expertise in one or two of these modalities that they are most likely to use.

Finally, it is crucial that early career psychiatrists are engaged in researching, organizing and disseminating the most contemporary of all therapeutic methods. It is vital that new science is developed to overcome the current limitations in the treatment of severe and enduring mental illnesses and it is hoped that new science in the shape of pharmacogenetics will be used to support personalized pharmacopsychiatry. However, it is also imperative that the breadth of current knowledge and expertise is utilized to develop and disseminate treatment algorithms to support more individualized treatment for patients presenting as a therapeutic challenge (Möller, 2011). From the evidence summarized below, it is clear that current care should move towards the pattern of optimal care; that is, towards evidence-based medicine (Table 3) (Andrews et al., 2003).

Psychiatry as a medical discipline

With the recent advances in functional neuroradiology, psychopharmacology and neuropsychiatry in addition to the growing prominence of consultation-liaison psychiatry in acute medical settings, psychiatry's standing as a medical discipline is unambiguous. It is also clearly evident that overall, psychiatric drugs are no less effective than most other medical drugs (Seemüller et al., 2012).

However, there is still a need for psychiatrists to enhance their skills in identifying somatic illnesses in their patients and to be aware of the importance of medical co-morbidity in patients with mental illnesses (Maj, 2008). Additionally, it is also crucial that psychiatrists utilize medical underpinnings in their assessments and management of psychiatric illnesses. This will only enhance patient care and encourage some of the brightest minds in medical schools to choose psychiatry as a career. Also, the psychiatric diagnostic classifications that are

Table 2. Schizophrenia treatment effect size estimates (adapted from Chisholm et al., 2008).

Intervention scenario	Effect size		Disability weight (0 = no disability)	
	Comparator	Value (SD improvement)	(Conversion = ES*0.181)	% improvement over null
Null (no treatment)		–	0.627	–
Placebo	No treatment	0.050	0.618	− 1%
Older antipsychotic drug	Placebo	0.465	0.534	− 15%
Newer antipsychotic drug	Placebo	0.495	0.528	− 16%
Older antipsychotic drug + psychosocial intervention	Older antipsychotic drug	0.390	0.463	− 26%
Newer antipsychotic drug + psychosocial intervention	Older antipsychotic drug	0.390	0.458	− 27%

SD, standard deviation; ES, effect size.

currently being developed are crucial in placing psychiatry at the heart of medicine and it is essential that in addition to these operational criteria, psychiatrists, like any other medical specialism, utilize their key clinical diagnostic skills of psychopathology and phenomenology to support patient care (Gaebel et al., 2010). Finally, psychiatrists must never allow themselves to be stigmatized by colleagues from other medical specialisms – they can achieve this by not only verbalizing their unique competencies, but also having a zero tolerance for any stigmatizing attitudes or behaviours from within the medical fraternity.

From the asylum to the community – changes in mental healthcare settings

Psychiatry as a medical specialism has led the way in developing community-based care in a way that can be a model for other medical specialisms (Killaspy, 2006).

As we move towards a more community-based model of care, it is evident that some patients, particularly those with higher levels of need, may remain supported at home for longer with the input of more intensive forms of treatment (Killaspy et al., 2006). As an implication, a greater proportion of psychiatric interventions are moving to other settings of care (school, workplace, jail, etc.). Additionally, strategies for prevention and early detection of major mental disorders have become key to supporting greater levels of outpatient care.

Early career psychiatrists, with the benefit of openness and flexibility, can provide leadership in these novel models of care. In order to do so, however, they will require not only the experience and training to work in diverse community-based settings, but also the confidence and risk-management ability to support high quality patient care in these less 'controlled' settings.

Additionally, working in this more dynamic environment with experienced multi-professional teams will require greater leadership skills, and early career psychiatrists should utilize their training and early part of their substantive careers to enhance these.

New syndromes and new diagnoses

Whilst the specialism is going through an exciting phase with the rewrite of both the DSM and ICD, these, for very good reasons, are refreshed every 20 years or so. Additionally, these and most other classification systems are still symptom-cluster approaches, and we are still a long way from an aetiologically based categorization of illnesses. Unfortunately, the many civil wars and international conflicts of recent years have drawn attention to the effect of trauma, starvation, torture and forced migration. Rarely these events are taken into account in current classification systems when explaining the aetiopathogenesis of psychiatric symptoms. These gaps can present as both diagnostic and therapeutic challenges for young psychiatrists and trainees (Maj, 2005).

Table 3. Evidence-based treatments and clinical practice (adapted from Andrews et al., 2003). Comparative efficiency, in cost per year lived with disability (YLD) averted, of current and optimal treatment for schizophrenia and schizoaffective disorder.

Treatment	N	Efficacy (YLDs averted)			Total cost of treatment (AUS$ million)		Efficiency (AUS$ per YLDs averted)	
		Point estimate	95%CI	% Burden averted	Point estimate	95%CI	Point estimate	95%CI
Current	39,048	3774	2908–4691	13	740.0	484.7–1020.0	196,070	123,827–297,516
Optimal	39,048	6217	4326–8362	22	668.2	408.5–1133.3	107,482	59,714–205,418

CI, confidence interval.

In contexts where new syndromes are being recognized with increasing frequency, early career psychiatrists need to take up this challenge on both an individual and organizational level. Individually, early career psychiatrists need to make sure that they are well informed and educated on the new syndromes based on all the evidence that is available and if there is an evidence gap, leadership should be shown by early career psychiatrists in helping fill this evidence gap through research and epidemiological studies. Organizationally, early career psychiatrists should highlight the changing morbidity trends through the organizations they work for, their national societies, as well as international diagnostic groups and fora that they might be involved with.

Psychiatrists and the media: how does the public perceive us?

The image of psychiatry and psychiatrists in the media, and by extension its opinion with the general public, is still depressingly negative. Stereotypical images of psychiatric inpatient settings and ill-founded misconceptions of various therapeutic modalities continue to perpetuate the stigmatization of not only the specialism and the specialists practising it, but also of mental illness itself, thus dangerously impeding access to care and treatment that patients need and deserve.

The specific skills needed to interact effectively with families, administrators, journalists and the legal system should become a formal component of post-graduate training and continuing medical education (Tasman et al., 2007).

More specifically, it is the role of all early career psychiatrists to enhance the public image of psychiatry and psychiatrists. They can do this by undertaking media training themselves and enhancing their media presence within their local communities. Additionally, professionals should work in partnership with patients and patient groups to present a more realistic image of mental illness and its experience. Finally, targeting specific groups such as high school students and medical students themselves, raising their level of awareness regarding mental illnesses and their treatments to an appropriate level will create more evolved communities that are less accepting of stigmatizing attitudes towards mental illnesses – either at an individual level or in the media (Saxena et al., 2007).

Involvement in scientific societies

> The future of psychiatry depends greatly upon its leaders, especially its academic leaders. Their beliefs and commitment will, to a considerable extent, determine the future of specialty. (Guze, 1993).

Psychiatric societies are useful fora that bring professionals together with the broad common goal of enhancing the experience of those suffering from mental illnesses (Fiorillo et al., 2010, 2011a). Some of these are regional or national whilst others within Europe cross international political borders. Additionally, some of these cater to the interests of early career psychiatrists as a key component of their agenda.

These societies can serve a range of functions including:

1. Enhancing the training and professional experience of psychiatrists.
2. Cross-fertilization of concepts regarding patient care.
3. Developing an international supportive network that can open access to hitherto inaccessible experiences.
4. Developing a broader benchmark for quality and standards of training and patient care.
5. Carrying surveys and studies which may be useful for trainees and early career psychiatrists (Fiorillo et al., 2011b; Nawka et al., 2012; Riese et al., 2013).
6. Providing opportunities to develop professional skills including presentation skills, leadership and negotiations – all indispensable competencies for a successful European psychiatrist.
7. Opportunities for mentorship – both as a mentor and a mentee.

Early career psychiatrists should actively participate and become leaders of their national bodies and these international psychiatric societies – both to realize the above benefits but also to further the profession's interests as a whole. These experiences can be used to improve the recruitment process into psychiatry. Engaging medical students to participate and start being active in societies brings additional benefits.

Recruitment into psychiatry

Doctors and medical students consistently show low rates of interest in psychiatry as a career choice, with the percentage of doctors or students choosing psychiatry as their first choice of career being lower than previous years (Budd et al., 2011). In order to increase recruitment into psychiatry, medical students' attitudes towards psychiatry and the factors that influence their career choices need to be understood. Stigma towards mental health professionals, the tendency of the media to depict psychiatry as a non-medical specialism and the stressful working conditions of psychiatric settings are only some of the causes of the reduced number of medical doctors entering psychiatry (Brockington et al., 2002). Moreover, it has also been suggested that a negative

perception of psychiatry is related to the lack of intellectual challenge, doubts about the effectiveness of psychiatric treatments, low prestige of psychiatry within medicine and the lack of a coherent theoretical basis, which all together may play a relevant role to explain the decision of medical students not to choose psychiatry as a specialism, or the early dropout from a psychiatric specialist training career (Maj, 2010; Katschnig, 2010). Indeed, international psychiatric societies play a significant role to promote the image of psychiatry and therefore the choice of medical students to enter psychiatry (Bhugra et al., 2013). On their part, early career psychiatrists can contribute to this by building a new identity for the modern psychiatrist.

Building a new identity for the modern psychiatrist

Sharfstein (1999) has proposed that in the future psychiatrists will have to choose to take one of four subspecializations: (1) neuroscience, which will include the techniques of neuroimaging, genetics and prenatal prevention, (2) medical psychiatry, which will include the knowledge of the close relationships between mental and physical disorders, (3) psychotherapy, which will include the study and treatment of the psychological aspects of mental disorders, and (4) social psychiatry, which will have to deal with the new problems raised by the society. In their book *The perspectives of psychiatry*, McHugh and Slavney (1998) have outlined four different perspectives that psychiatrists should adopt in order to have a complete understanding of mental disorders: (1) the categorical perspective, according to which the psychiatric patient is identified with his or her 'illness', (2) the 'dimensional' approach, which provides an understanding of the cognitive and affective structure of the patient, rather than its disorders, (3) the behavioural perspective, according to which the psychiatrist must focus on issues related to the behaviour of patients, and (4) the narrative perspective, which aims to give meaning to mental disorders as responses to life events. We believe that only a real integration of these different perspectives of psychiatry will allow us to get a comprehensive view of patients and their disorders and to avoid unnecessary and dangerous biological, psychological or social reductionism.

Conclusions

The work carried out in the last few years by the Early Career Psychiatrists Committee of the European Psychiatric Association has ultimately resulted in the proposal of this new agenda. We think it can be particularly useful for the new generations of psychiatrists, who now have the chance to build up their own future, provided that the actions listed in this agenda are taken urgently and responsibly. Psychiatry will continue to play a major role in modern medicine, and trainees and early career psychiatrists will have to be the actors, and not mere witnesses of this process.

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References

Andrews, G., Sanderson, K., Corry, J., Issakidis, C. & Lapsley, H. (2003). Cost-effectiveness of current and optimal treatment of schizophrenia. *British Journal of Psychiatry, 183,* 427–435.

Bhugra, D. (2008). Psychiatric training in the UK: The next steps. *World Psychiatry*, 7, 117–118.

Bhugra, D., Steering Group, Farooq, K., Lydall, G., Malik, A. & Howard, R. (2013). The International Study on Career Choice in Psychiatry: A preliminary report. *World Psychiatry, 3,* 181.

Bhugra, D. & Fiorillo, A. (2012). Families, functioning and therapies. *International Review of Psychiatry, 24,* 79–80.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., ... Yeomans, D. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry, 201,* 430–434.

Brockington, I. & Mumford, D. (2002). Recruitment into psychiatry. *British Journal of Psychiatry, 180,* 307–312.

Budd, S., Kelley, R., Day, R., Variend, H. & Dogra, N. (2011). Student attitudes to psychiatry and their clinical placements. *Medical Teacher, 33*, e586–592.

Chisholm, D., Gureje, O., Saldivia, S., Villalón Calderón, M., Wickremasinghe,R., Mendis, N., … Saxena S. (2008). Schizophrenia treatment in the developing world: An interregional and multinational cost-effectiveness analysis. *Bulletin of the World Health Organization, 86*, 542–551.

Fieve, R.R. (1999). Lithium therapy at the millennium: A revolutionary drug used for 50 years faces competing options and possible demise. *Bipolar Disorders, 2*, 67–70.

Fiorillo, A., Brahmbhatt, P., Elkholy, H., Lattova, Z. & Picon, F. (2011a). Activities of the WPA Early Career Psychiatrists Council: The Action Plan is in progress. *World Psychiatry, 10,* 159.

Fiorillo, A., Lattova, Z., Brahmbhatt, P., El Kholy, H. & Picon, F. (2010). The Action Plan 2010 of the WPA Early Career Psychiatrists Council. *World Psychiatry, 9*, 62–63.

Fiorillo, A., Luciano, M., Giacco, D., Del Vecchio, V., Baldass, N., De Vriendt, N., … Oakley, C. (2011b). Training and practice of psychotherapy in Europe: Results of a survey. *World Psychiatry, 10*, 328.

Fujisawa, D., Hashimoto, N., Masamune-Koizumi,Y., Otsuka, K., Tateno, M., Okugawa, G. … Sartorius, N. (2008). Pathway to psychiatric care in Japan: A multicenter observational study. *International Journal of Mental Health System*, 26, 14.

Gaebel, W., Zielasek, J. & Cleveland, H.R. (2010). Psychiatry as a medical speciality: Challenges and opportunities. *World Psychiatry, 9*, 36–38.

Guze, S.B. (1993). The future of psychiatry and the medical model. *Journal of Nervous and Mental Disease, 181,* 593.

Hamm, M.P., Chisholm, A., Shulhan, J., Milne, A., Scott, S.D., Given, L.M., … Hartling, L. (2013). Social media use among patients and caregivers: A scoping review. *British Medical Journal Open, 9*, 3.

Katschnig, H. (2010). Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. *World Psychiatry, 1*, 21–28.

Kessler, D., Lewis, G., Kaur, S., Wiles, N., King, M., Weich, S. … Peters, T.J. (2009). Therapist-delivered Internet psychotherapy for depression in primary care: A randomised controlled trial. *Lancet*, *22*, 628–634.

Killaspy, H. (2006). From the asylum to community care: Learning from experience. *British Medical Bulletin, 80,* 245–258.

Killaspy, H., Bebbington, P., Blizard, R., Johnson, S., Nolan, F., Pilling, S., .. King, M. (2006). The REACT study: Randomised evaluation of assertive community treatment in north London. *British Medical Journal, 332*, 815.

Kingdon, D. & Young, A.H. (2007). Research into putative biological mechanisms of mental disorders has been of no value to clinical psychiatry. *British Journal of Psychiatry, 191*, 285–290.

Luciano, M., Sampogna, G., Del Vecchio, V., Giacco, D., Mulè, A., De Rosa, C., … Maj, M. (2012). The family in Italy: Cultural changes and implications for treatment. *International Review of Psychiatry, 24*, 149–156.

Maj, M. (2005). 'Psychiatric comorbidity': An artefact of current diagnostic systems? *British Journal of Psychiatry*, *186*, 182–184.

Maj, M. (2008). WPA Action Plan (2008–2011). *World Psychiatry, 7,* 129–130.

Maj, M. (2010). Are psychiatrists an endangered species? *World Psychiatry, 9,* 1–2.

Maj, M. (2011). Psychiatric diagnosis: Pros and cons of prototypes vs operational criteria. *World Psychiatry, 10,* 81–82.

Maj M. (2012). From 'madness' to 'mental health problems': Reflections on the evolving target of psychiatry. *World Psychiatry, 11*, 137–138.

Maj, M. (2013). 'Clinical judgment' and the DSM-5 diagnosis of major depression. *World Psychiatry, 12*, 89–91.

McHugh, P.R. & Slavney, P.R. (1998). *The Perspective of Psychiatry,* 2nd ed. Baltimore, MD: Johns Hopkins University Press.

Möller, H.J. (2011). Effectiveness studies: Advantages and disadvantages. *Dialogues in Clinical Neuroscience, 13,*199–207.

Nawka, A., Raszka, M., Pacherová, L., Lattová, Z., Kmoch, V., Nawková, L., … Novák, T. (2012). Report from the congress: Future of psychiatry and psychiatric training – 19th European Federation of Psychiatric Trainees forum in Prague. *Prague Medical Report, 113*, 66–71.

Preskorn, S.H. & Hatt, C.R. (2013). How pharmacogenomics (PG) are changing practice: Implications for prescribers, their patients, and the healthcare system (PG series part I). *Journal of Psychiatric Practice*, *19*, 142–149.

Regier, D.A., Kuhl, E.A. & Kupfer, D.J. (2013). The DSM-5: Classification and criteria changes. *World Psychiatry, 12*, 92–98.

Riese, F. Oakley, C., Bendix, M., Piir, P. & Fiorillo, A. (2013). Transition from psychiatric training to independent practice: A survey on the situation of early career psychiatrists in 35 countries. *World Psychiatry*, *12*, 82–83.

Sartorius, N. (2010). Revision of the classification of mental disorders in ICD–11 and DSM–V: Work in progress. *Advances in Psychiatric Treatment, 16*, 2–9.

Saxena, S., Thornicroft, G., Knapp, M. & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity and inefficiency. *Lancet, 370*, 878–889.

Seemüller, F., Möller, H.J., Dittmann, S. & Musil, R. (2012). | Is the efficacy of psychopharmacological drugs comparable to the efficacy of general medicine medication? *BMC Medicine, 10*, 17.

Sharfstein, S.S. (1999). In the year 2099. *Archives of General Psychiatry, 56,* 1151–1152.

Styra, R. (2004). The Internet's impact on the practice of psychiatry. *Canadian Journal of Psychiatry, 49,* 5–11.

Tasman, A., Kay, J., Lieberman, J.A., First, M.B. & Maj, M. (2007). *Psychiatry.* London: Wiley.