

## Psychiatry in decline

Francis J Dunne

### What is Psychiatry?

*"The mind is its own place, and in itself can make a heaven of hell, a hell of heaven"* John Milton

The word 'psychiatry' is derived from the Greek for "doctor of the soul" and was first coined in the early 19th century by the German physician and anatomist, Johann Reil (1759-1813), although the treatment of mental disturbances dates back hundreds of years prior to this. The specialty of Psychiatry is regarded as dealing with the prevention, assessment, diagnosis, treatment, and rehabilitation of 'mind' illnesses or mental disorders. Diseases of the brain itself, for example encephalitis, tumours, and so forth, fall within the realm of neurology, generally. There are, of course, many overlapping disorders which cause neurological symptoms (paresis, slurred speech, ataxia, to cite a few) and 'mind' symptoms (depression, anxiety, psychosis). Disorders which affect several organ systems, for example, the autoimmune diseases, often cause multiple, bewildering neurological and mental symptoms. The primary goal of the psychiatrist is relief of suffering associated with 'psychiatric' disorders which include inappropriate anxiety, clinical depression, and psychotic disorders. Attempts have also been made to categorize and 'treat' different types of personality disorder. The latter is a contentious issue (perhaps with the exception of antisocial and borderline types) sometimes based on value judgments rather than clear scientific evidence. Treatment for mental health problems nowadays is usually community-orientated for less severe conditions and often hospital-based for more intractable disorders. The vast majority of patients are treated on a voluntary basis, whether in hospital or the community.

### Medical, biological, social or psychological?

*" I think we ought always to entertain our opinions with some measure of doubt. I shouldn't wish people to dogmatically believe any philosophy, not even mine."* Bertrand Russell

Psychiatry is sometimes criticized for adopting a 'too' medical or biological approach, despite the fact that many physical conditions masquerade initially with 'mental' symptoms. It would seem strange, if not irresponsible, were a psychiatrist, who is after all, a qualified medical doctor, not to enquire about a patient's physical history. What is conveniently overlooked is that in everyday practice psychiatry uses a holistic approach to

the patient, taking social and cultural backgrounds into account, as well as the general medical status. Treatment may thus involve medication, various forms of psychotherapy, or both, in addition to practical measures such as help with family problems, debts, housing, residential placements and so forth. In recent years, particularly in the UK, there has been a much greater emphasis on psychological treatments and social interventions. The 'medical' approach has taken a definitive back seat. Psychotropic drugs are frowned upon because of their side-effects, or perceived as a form of control used by psychiatrists towards their patients. Sweeping statements are made about their lack of efficacy and selective abstraction of the research is used to support such statements. Psychiatrists are denigrated for being in the grip of Big Pharma and are further demoralized by the being perceived as 'drug pushers'. They are perceived by mostly non-medical 'therapists' as not being in touch with the psychological and sociological issues which are cited as underlying and perpetuating psychiatric disorders. Electroconvulsive therapy is considered barbaric; it is banned in some states in the USA. Complementary or 'alternative' therapies, regardless of whether or not they stand up to scientific scrutiny, are proliferating, and prescribed drugs are being replaced by 'natural' herbal products, despite the inherent dangers of the latter (1). Psychiatry is in decline and is becoming obsolete, a victim of its own psychobabble and increasingly mind-numbing research, understandable to the elite few. The profession is in danger of being 'psychologised' in order to appear acceptable and user-friendly, advocating therapies which in themselves do not stand up to scientific scrutiny. Outcome studies are quoted as favourable, when the very tenet of their foundations is very shaky, to say the least.

Perhaps there is not much reason for surprise when one considers not very long ago psychiatry advocated behaviour therapy for the treatment of homosexuality, orgone energy accumulators for neuroses, and insulin coma for schizophrenia. In hindsight such practices were totally unsound, unacceptable, and in the case of insulin coma therapy, dangerous; fortunately, they are now obsolete. Yet the history medicine is replete with such 'cures': mercury was once used to treat syphilis, and in surgery trepanation was widely used in ancient times for the treatment of seizures. In retrospect these procedures could be also be considered outrageous and barbaric, though with the development of scientific knowledge it is easy now to understand, reflect, and accept, that no other effective

treatments were available at the time. Not so the case for psychiatry. Psychiatrists and other mental health professionals, who by and large genuinely have empathy and sympathy for their patients and want them to get better quickly, discharge them from hospital or outpatient clinics, and reunite them with their families whenever possible, are still unjustly accused of wanting to exert social control. There is no doubt that abuse of psychiatric practice does occur in some institutions and that political regimes throughout the world have used and still use powerful neurotropic drugs to subdue and control individuals who challenge the authority of the State. It is common knowledge that psychiatry was used by some totalitarian regimes as part of a system to enforce political control, for example in Nazi Germany, the Soviet Union, and the apartheid system in South Africa. Whether such abusive practices, which no doubt still exist, will ever be abolished will depend on the will of Governments and pressure from Human Rights campaigners such as Amnesty International.

### What is madness?

*“Madness is rare in individuals - but in groups, parties, nations, and ages it is the rule”* Friedrich Nietzsche

It is not possible to delineate the boundary between sanity and insanity. Broad definitions of mental disorder have been attempted and an individual might be said to be ‘mentally disordered’, or as formerly described, ‘of unsound mind’, when there is a more than temporary impairment of cognitive functions such as memory, orientation and comprehension, an alteration of mood leading to a delusional appraisal of one’s situation, abnormal perceptions and disordered thinking. However, this concept is criticised for being overinclusive and precise definitions of mental illness remain elusive. It is probably easier to envisage mental health problems as being on a continuum from normal to abnormal for example, from a relative sense of well-being and contentment to a state of distress and unhappiness. Further exacerbations or stressors lead to a disintegration of oneself and that sense of oneness with the environment. Loss of reality ensues with further anxiety and perplexity, disordered and confused thinking or delusions, and perceptual disturbances (usually auditory hallucinations), in some cases. The same symptoms can be caused by drugs such as cocaine or amphetamines. It is known that these drugs alter the effects of dopamine, serotonin, noradrenaline, and perhaps other transmitters, leading to the assumption that anxiety, depression and psychoses are biologically driven, the often cited chemical imbalance approach. In the case of dopamine, implicating this neurotransmitter as a sole trigger factor in psychoses is simplistic and naïve. Likewise, depression and anxiety may have other biological causes such as hormone irregularities or fluctuating glucose levels. The dopamine hypothesis alone has largely been discredited in the aetiology of psychoses. Dopamine as a causative factor is only one small part of a much wider as yet unknown picture: for example,

psychosis occurs in Parkinson’s disease where dopamine is actually deficient.

### The ‘psychologised’ individual

*“Common sense is not so common”* Voltaire

One major criticism of psychiatry concerns the endless diagnostic categories or disorders which set out to describe and define the whole range of normal human expression, from the histrionic to the shy. No wonder then that psychiatry and allied specialties, for example, psychology and sociology, are accused of a sweeping disregard for the extraordinary complexity and richness of human behaviour. Whole subsets of psychiatric specialties have mushroomed over the last 30 or more years, to include substance misuse, forensic issues, autistic spectrum disorders and many others(2). Many disorders have variants, for example schizoaffective or schizomanic subtypes for schizophrenia, without any real scientific basis for such assertions. The eccentric individual becomes ‘schizotypal’; the individual who is detached from others and prefers his/her own company, is labelled ‘schizoid personality disorder’. Some would question whether many psychiatric descriptions are indeed ‘disorders’. There are very few ‘mental’ conditions which really could be regarded as disorders, save for example, severe clinical depression, bipolar disorder, obsessive compulsive states, and the psychoses, the latter often drug-induced. The diagnostic categories become bewildering and meaningless when subtypes are used, for example schizoaffective, bipolar I and bipolar II, depression with or without psychotic symptoms, and so forth; all have their supporters and detractors. Objectively, the symptoms are merely variations on a theme and cannot be accurately rated scientifically, unlike the gradings of say, Hodgkins or non-Hodgkins lymphoma. The distinction between normal and abnormal is blurred and varies among cultures. This is particularly pertinent when describing or defining personality disorder. For example, when does narcissistic behaviour become an illness? Why should it be seen as a disorder? Indeed, high self-esteem is encouraged in today’s climate and we are told to ‘love themselves more’. The usual response to the questioning of such behaviour is that it is ‘inappropriate’ or ‘out of proportion’ to the individual’s circumstances, or that ‘the patient is suffering’. Yet the entire media business, arts and entertainment, modelling and fashion industry is engaged in a narcissistic mind set, and the public love it! In other scenarios words are used interchangeably such that a psychopath, say, is perceived as a cold-blooded killer without conscience or feeling for his victim, or considered a creative genius, or indeed admired as a successful politician. The list of descriptions in the psychiatric disorders classification is wearisome and meaningless in many respects.

Much research in psychiatric journals nowadays is organic-based with ever intensive searches for newer receptors or transmitters, with increasing emphasis on the neurological basis for psychiatric conditions. In the past, emphasis was placed on

the positive outcomes of drug trials, though this, fortunately, is now changing and reputable medical journals are now prepared to publish the results of negative findings. On the other hand, other researchers attempt to prove one type of psychotherapy is more effective than drug therapy, or that both together are better than either alone. Psychiatry has become polarized, with the 'organic camp' advocating a neurobiological basis and reductionist paradigm for psychiatric disorders, while the 'psychotherapy model' emphasizes the individual's part in his/her illness with the development of strategies to defeat and overcome irrational beliefs and counterproductive emotions. There are problems with both approaches. A great deal of criticism is now being targeted against the psychology industry with its claims of treating serious illnesses through talking cures, and using labels to categorize almost every aspect of human behaviour (3). For example, how does one account for biological symptoms which are pervasive in severe depression without considering the role of neurotransmitters and regulatory hormones? How does one measure the complexity of suffering in any one individual and translate that into a rating scale for myriads of others whose problems have different origins? Whole books are written on the use of rating scales for research into psychological/psychiatric disorders. Yet there are over 250 different psychotherapy treatment approaches, which inevitably leads one to question the overall value of psychotherapy (4). In Epstein's view, the whole field of psychotherapy is 'pseudoscientific, an elaborate mysticism only differentiated from religion by a seemingly modern orientation and the cant of science' (5). Research in psychotherapy is in any event notoriously difficult because of sample sizes, control groups, placebo effects and the nature of the therapeutic intervention itself (cognitive therapy, family therapy, psychoanalytic therapy). Besides, even when some patients show a moderate improvement, nonspecific factors are always operating in the period between therapy sessions and follow-up. Patients may have had a better social adjustment because of a new job, an increase in salary, or a change in a relationship and so forth, while others may have had a general decrease in life stresses, for example, through improved physical health (recovery from surgery, better control of diabetes). Some patients will deteriorate, despite 'cognitive restructuring', because of redundancy from a job, or ending of a relationship and so forth.

### What next?

*"Just trust yourself and you'll learn the art of living"* Goethe

Although many of the psychological treatments available nowadays were initially propounded by psychiatrists, psychotherapy and behavioural management are now more often carried out by psychologists, nurse practitioners and counsellors. Psychiatrists tend to deal with more severely affected individuals, ironically, those deemed to need

psychotropic medication or where 'counselling' has failed. It could be argued that talking to a stranger for a fixed number of sessions (ranging from 10–12 one-hour slots) actually impedes the normal process of recovery and that a patient would benefit more from using his/her own social networks including family, friends, general practitioner and others, who are better placed to view the patient's problems in context. Research claiming that depressed people are most likely to benefit from cognitive therapy, or that the majority of people suffering from panic attacks will recover with anxiety management, is deceptive and naively optimistic. The notion that a Psychologist /counsellor/ psychiatrist could turn a patient's life around in 10 hours or so (10 sessions) is difficult to sustain when such problems have accumulated over that person's lifetime, no matter how long or short-lived. The human mind is too complex and the human condition too intricate to be hoodwinked into such quick-fix solutions. Perhaps the best way forward is, ironically, to revert to an holistic approach with better education and training of both psychiatrists and psychologists. The former need further training in neurology (they already receive extensive training in psychology) and time spent in GP surgeries, the latter should be required to gain more experience of patients with severe types of psychiatric disorders (many hospital-affiliated psychologists already do), and general exposure to medicine via an acute emergency department or at a GP surgery (say, one year in total), preferably both, in order to broaden their horizons. The author appreciates the inherent, perhaps, unfortunately, insurmountable difficulties in setting up such a system involving the various disciplines. All 'therapists' should have a grounding in philosophy and sociology. It needs to be made clear that many patients simply feel better by talking to someone, though this 'feeling better' is not often sustained, and that knowing the cause of one's problems does not equate with 'cure'. Many patients have intractable conditions which are not amenable to 'talking therapies', and such individuals do not fit the category of the 'worried well', the usual 'clients' of counsellors and other therapists.

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