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The future of psychiatry

Predictions about the future are nearly always wrong since unexpected and unforeseen developments may bring about the greatest changes. This was true for psychiatry and our knowledge of mental illnesses in the past. It is probably equally true for any forecasts made today. This chapter extrapolates from current trends and make some guesses. The College will change too.

Having spent some time reviewing the Psychiatry of the past two centuries I should like to end by summarising what I think I have learned. Psychiatry is a branch of medicine which should be based on science even though diagnosis can be uncertain.. Mental illnesses still attract stigma and treatment options are limited and symptomatic. Bizarre illnesses attracted bizarre treatments in the past. Even now, psychiatric illnesses can show such stubbornness to treatment that they can expose ignorance of their pathology and aetiology and can arouse aggressive reactions in baffled and frustrated therapists, good coping skills are needed. Some treatments are ineffective and placebo responses can be effective. The education and training of all who work with the mentally ill must seek to achieve a humane kindly but sceptical and scientific approach. The asylum tradition endeavoured to carry out humane treatment for an outcast group. Shaftesbury was the paragon for the nineteenth century. Rational psychiatrists at the hospital that bears Maudsley's name were the most important influences in the UK in the twentieth century. Psychoanalysis may be leaving science and medicine but affects the way we all think. The twenty-first century has started with the Health Service undergoing ever more rapid reorganisations and pressures to reach targets. Psychiatrists in all their manifestations in the twenty-first century should follow in the footsteps of giants such

as Shaftesbury, Crichton-Browne and Maudsley in the nineteenth century and Mapother, Lewis and their followers in the twentieth.

THE FUTURE OF PSYCHIATRY

It is risky to make predictions about the future. Past experience suggests that the further one looks ahead the more likely one is to be wrong. The founders of the Association in 1841 expected that the development of asylums with a new approach to the treatment of the mentally ill would lead to cures, but this did not occur. It is as difficult today as it was for them to forecast future developments. Few of the advances which have occurred in the past 200 years were foreseen, whether it was the use of malaria and then penicillin to treat cerebral syphilis, the accidental discoveries of drugs which could modify some of the more disabling symptoms of severe forms of mental illness or the development of measures to evaluate psychotherapeutic and other treatments. There have been gains in our understanding of mental ill health, but they have not yet been of a kind to justify hopes of a 'breakthrough' which would provide a cure for schizophrenia, an effective means of preventing severe depressive illnesses nor a quick remedy for severe obsessional neuroses. There is no reliable or effective way of dealing with the least explicable behaviours (such as serial sexual murder of children). Research must remain the first concern, though there is room for more extensive application of present knowledge.

Twenty years ago Sir Aubrey Lewis gave his views about the future of Psychiatry and they remain cogent today. Psychiatry benefits from advances in other fields of science and medicine. It is reasonable to expect that as general paralysis of the insane (GPI) has

become a rarity other forms of mental illness which are expressions of cerebral disease will similarly fade away, with relevant advances in therapeutics. Much research will be concentrated on the study of metabolic anomalies underlying some mental illnesses; the range of some ‘functional’ disorders will doubtless continue to be subject to attrition should their somatic pathology be uncovered. The advances in genetics, which have cast light on Downs Syndrome and the inborn enzyme deficiencies associated with defect such as phenylketonuria, will be carried further. The application of increased knowledge of the genetic code whereby particular syndromes are transmitted, and ways of altering it, will possibly some day permit more radical prevention. The psychological elements in the causation and treatment of illnesses that have a physical pathology should become better understood. Further steps should have been taken towards a unitary description and interpretation of vital phenomena in place of distinguishing between ‘organic’ and ‘functional’, or ‘somatic’ and ‘psychological’. The concepts and terms of psychology should move closer to those of neurophysiology, and more will be known about the chemical and electrical happenings in the nervous system which are responsible for wakefulness, awareness of hunger, memory, sexual behaviour, and many other psychological phenomena.

There needs to be more selective use of drugs. The present enthusiasm for drugs credited with anti-depressant, anti-schizophrenic, or tension reducing effects will probably have been succeeded by a more sober appraisal of drugs for the administration of which the indications will be narrow and precise. The computer should lead to further developments in the production and use of powerful methods of statistical analysis which, in competent hands, should advance abnormal psychology. There should be

further changes in psychopathology and psychotherapy. The ambiguities of psychoanalytic theory and its interpretations will have been checked by experiment, and its details and concepts brought into line with the findings of experimental and comparative psychology on the one hand and neurophysiology on the other. Psychopathology should continue to be more tightly expressed and more directly related to systematic observation. Sociological studies should continue to contribute to better understanding of the social causes and manifestations of mental illness, as well as to its treatment. Better methods of prenatal and natal care and upbringing may have manifest preventive value. Psychotherapy will continue to move towards attainment of its aims – a solid theoretical foundation, and communicable methods and techniques which have a well-documented efficacy, well-understood indications for use, and practical applicability to the majority of those who need them. We should expect more shorter methods of treatment, less comprehensive optimism, and better experimental underpinning.

Whether psychiatrists will have extended or narrowed their scope in dealing with social deviation remains arguable. If the course of events in the last half-century is a guide, they will be asked more and more to deal with criminals, turbulent and disturbed adolescents, and other people who offend against the social canons. Unless psychiatrists can demonstrate that the psychiatric approach to ‘psychopathic disorder’ and kindred troubles is more efficacious than that of any other professional discipline, it is possible that sociologists (pure and applied) will hold the field, rather than psychiatrists or, for that matter, psychologists. There will be continuing efforts to combat the fear and misunderstanding which colour people’s notions of mental illness. In this, and other

measures that are still experimental, it should eventually be an accepted requirement that means of evaluating the efficacy of any new procedure should be built-in when the project is planned. What is appropriate today for new drugs might become appropriate for new laws bearing on mental illness and defect, and for new social arrangements designed to ameliorate or lessen psychological troubles, and for attempts to reduce the effects of stigmatisation.

I would like to be able to hope that there will be an increasing recognition, by the general public, politicians and the media, of the high prevalence and disabling consequences of mental illness because the ground has been laid by epidemiological research will also be brought about by personal experience, that is by the recognition by thousands of ordinary people that some form of mental illness is a serious burden and a source of anxiety to their own family: depressive illnesses, alcohol dependence or phobic anxiety in a sibling or a spouse, or perhaps in themselves, Alzheimer's disease in an aged parent, or anorexia nervosa in a teenage daughter. This recognition should go hand in hand with a slow reduction in the stigma of mental illness, and each should reinforce the other. A lessening of the stigma would make it easier for people to admit to, and eventually to talk about, the disorders that they have observed in their friends, their relatives and in themselves. The increasingly public recognition of the ubiquity of mental disorders might further reduce stigma, because the psychological processes on which stigma is based are founded on the assumption that the stigmatised condition – whether it be cowardice, homosexuality, being born out of wedlock, or having a mental illness – is restricted to an unfortunate minority. If there is a reduction in the associated stigma, and I cannot be hopeful about this, it might eventually result in an increasing

willingness, by politicians and the general public, to devote a higher proportion of health-care spending to the treatment of psychiatric disorders. There is no doubt that the symptoms and illnesses that people complain of always attract more resources than those that they are reluctant to admit to. But stigma has more subtle effects on funding as well. When competition for funds is intense, as it usually is, the lion's share will always tend to go to the most 'deserving' patients and illnesses. And when budgets have to be cut in order to balance the books – a recurring feature of the NHS – one of the easiest budgets to cut has been, until now, the mental health budget, because fewer people protest. And fewer people protest because they do not regard psychiatric facilities as relevant to the needs of their own family, or if they do they do not admit it. Unfortunately the desire to lock up anyone believed to be dangerous may also lead to increased stigma for the mentally ill.

We can expect to see further advances in our understanding of the aetiology and pathogenesis of mental disorders. The volume and sophistication of clinical and epidemiological research have been increasing. So too have the scale and sophistication of basic research into the human brain, and the willingness to fund such research. Nowadays, many of the most able young biochemists, pharmacologists and physiologists find that brain research is challenging, fascinating and potentially rewarding territory to work in. Understanding of fundamental psychological processes such as memory, speech and perception should increase slowly. The major disorders that cause the most disability are fundamentally disorders of cerebral functions. Progress, however, is likely to be slow since the schizophrenias are still more complex than we like to admit. It is unlikely that we will fully understand them until scientific

research into the chemical processes within single cells and the mechanisms of transmission of information within the cell are fully understood. It will also be necessary to understand the complex interaction of all the factors that are involved in the cause of this illness. These will include genetic, biochemical, sociological and psychological inputs as well as developmental studies from foetal to adult life.

In the 1950s psychiatry acquired a series of effective therapies that were all chance discoveries. The therapeutic effects of phenothiazines, tricyclic antidepressants, monoamine oxidase inhibitors and lithium were all discovered fortuitously within a few years of one another by researchers who were looking for something quite different, and our understanding of how these drugs work remains incomplete. We may, of course, acquire other effective and novel therapies in equally fortuitous ways in the future. Hopefully we will eventually acquire potent new therapies, not by luck, but by a rational process of development based on a better understanding of aetiology. The cholinesterase inhibitors currently used for the treatment of Alzheimer's disease may be the harbingers of such developments. Although these cholinesterase inhibitors appear to be only modestly and temporarily effective, Alzheimer's disease seems closer to yielding some of its secrets than other major psychiatric disorders. Drug companies continue to develop amyloid protease inhibitors or amyloid precursor protein antagonists, and it is possible that a means will be found to prevent or delay the deposition of amyloid. If this happens, with a prevention of the development of the symptoms of this disease, the consequences for the image of the psychiatry of old age should be as profound as those for patients, their families and the nursing home industry.

Therapeutic advances in the future will not all be pharmacological. In the past few years there has been the development, mainly by clinical psychologists, of more effective psychological therapies for the treatment of anxiety states, for drug-resistant hallucinations and delusions and, perhaps, for reducing the risk of relapse in bipolar disorder. Other effective psychological and social therapies will presumably continue to be developed and deployed. Mental health and social services may become more closely aligned.

Psychiatry may become more 'biological' and less conceptually isolated from the rest of medicine. It has been a backward branch of medicine in the sense that the aetiology and pathogenesis of the conditions treated are less well understood than many other medical specialities. It is still forced to define most of its disorders by their clinical syndromes. This is an inevitable consequence of the complexity of the structure and functions, and experimental inaccessibility, of the human brain compared with those of, for example, the heart, the kidney or the skin. The perceived differences between mental and physical disorders should narrow as psychiatry acquires the technological trappings of internal medicine.

The rest of medicine should become more aware of and interested in psychological and social influences on morbidity and mortality. The evidence that simple psychological treatments can alleviate symptoms and reduce the treatment-seeking behaviour of many patients with somatic symptoms and the demand from patients themselves for a different doctor-patient relationship may impel physicians and surgeons to think more about psychological therapies. There may be a general recognition, by informed laymen

as well as by the rest of the medical profession, that there is no fundamental difference between mental and physical illness and that arguments about whether the chronic fatigue and irritable bowel syndromes are ‘organic’ or ‘psychiatric disorders’ are devoid of meaning.

There will be other changes that will affect psychiatry. Three of the main social or economic changes that will almost certainly have a major impact, not just on psychiatry but on the whole of medicine, are: the rise of consumerism and changing public attitudes to doctors; the increasing determination of governments to limit expenditure on health care; and increasing competition between different health-care professions.

Organisations representing people whom psychiatrists regard as patients, but who regard themselves as clients, users or even as survivors, should become better organised, more confident and more influential in the future. Increasingly, these user organisations will demand a greater voice in policy decisions at all levels (national and local), in clinical governance, and in the training of psychiatrists. Some psychiatrists find this uncomfortable, as some user representatives are strident, and deeply critical of their own experiences of psychiatric services. Psychiatrists have a common interest with such consumer groups in combating the stigma of mental illness and in persuading health departments and purchasing authorities to devote more resources to mental health.

Public attitudes to doctors are changing. This ‘death of deference’, affects all authority figures and all experts, from the Archbishop of Canterbury to nuclear physicists. Attitudes to doctors, and particularly to NHS consultants, have changed in response to

repeated revelations of consultant incompetence. Such revelations have damaged public trust in doctors and damaged the prestige of medicine. This has happened at a time when the average competence of British doctors is probably higher than it has ever been before. The balance of power between psychiatrists and both the Government and their patients has been permanently changed. Doctors are faced with a progressive loss of clinical autonomy as well as of prestige in all industrial countries. It is likely that this change will continue. The prescribing of expensive medicines and the introduction of expensive technologies, and the National Institute for Clinical Excellence (NICE) will be one of the mechanisms for achieving this aim. Future governments are likely to share this determination even if they use different means. The College has been a strong proponent of evidence-based medicine and the use of evidence-based guidelines and may be expected to continue both to develop these and promote their use. There is a risk that future governments, desperate to control health-care costs, will start to suborn the process of guideline development and transform what ought to be a distillation of all relevant clinical evidence as an aid to clinical decision-making into a management protocol based largely on financial considerations. Management protocols recently imposed by some American health maintenance organisations are not an encouraging precedent.

In the short term it is reasonable to expect a continuation of present trends in psychiatry. Advances in the understanding of brain function and malfunction will inevitably have implications for psychiatry, though all mental disorders will not be reducible to organic causes in terms of brain cell or brain system pathology. There are many changes in somatic structure and function that are brought about by experiences. In time, more

meaningful diagnoses will supersede current ones which are descriptive terms attached to clusters of symptoms. The relationship between psychiatrists and other doctors, to one another and their patients will continue to change.

THE FUTURE OF THE COLLEGE

It is difficult to predict the future of all medical colleges. Increasing specialisation in medicine has led to the development in the last century of many more than the colleges of physicians and surgeons. They may all at some future date coalesce into an Academy of Medicine representing academic medicine in parallel, with the BMA representing the Trades Union side. If this happens the College as it is today will surrender some of its autonomy.

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