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1

Bio-Medical Perspectives

Mental Illness as Disease: The Medical Model

Chapter Overview

- The cornerstone of the medical approach to mental health problems is the making of a diagnosis. A diagnosis is only possible if one accepts that there is such a thing as mental illness. The medical approach dominates the practice of psychiatrists.
- The term "mental illness" implies disease. It suggests that there is something wrong and that there has been a fundamental change from normal functioning.
- The medical model is applied to mental health problems in the same way as it is applied to physical health problems. The medical model supposes that psychiatric disorders are diseases with distinct pathologies, courses and outcomes and that psychiatry is a branch of medicine.
- The medical model further supposes that the causes of mental illness are in the last analysis biochemical, though the pathway to such biochemical disturbance may well involve social and psychological factors as well as biological.
- The medical model holds that the making of a diagnosis, and the prescription of medications based on that diagnosis, are reasonably exact sciences.
- The medical model has weaknesses and is open to criticism. Proponents of the medical model counter that there is good, though incomplete, evidence for their approach and that treatments based on the model are demonstrably effective for some individuals with mental health problems.

Introduction

Most psychiatrists argue that psychiatry is a valid branch of medicine with a good evidence base. They are often also aware of the weaknesses inherent in relying on biology alone to explain mental health problems. They thus consciously and actively draw from other disciplines, such as psychology and sociology, both to build the credibility of psychiatry as a scientific discipline and to obtain a greater understanding of the individuals who come to them for help. This eclectic approach is one reason why it is difficult for the uninitiated to come to a full understanding of the basic tenets and day-to-day practice of psychiatry. The main reason for the difficulties which students encounter when they first come to the study of mental health and ill-health is that mental health problems, however conceptualised, are difficult to define. In this chapter we will outline the traditional medical approach to mental health problems.

Disease and Normality

Prominent UK psychiatrist Peter Tyrer has offered the convincing argument that the building of "models" is of key importance in understanding mental health problems. Although medically trained, he makes his case without resorting to a dogmatic defence of any particular model: "In order to explain psychiatry it is necessary to use models that offer the practitioner a consistent approach that justifies treatment or investigation. These models are ingenious, clever and convincing but none of them is comprehensive" (Tyrer and Steinberg, 2005, p. xi). This book explores a number of alternative models of mental health problems, though this chapter necessarily focuses on one.

Most medical doctors approach concepts of health and illness by utilising the "medical model". This approach involves: identifying signs and symptoms; diagnosing a disease; and then prescribing treatment with the aim of easing symptoms or even curing the disease. Those who seek to defend this model with a coherent line of argument suggest that it is better described as the "disease model", and the two terms will be used interchangeably in this chapter. The medical/disease model supposes that psychiatric disorders are diseases with distinct pathologies, courses and outcomes; that psychiatry is a branch of medicine; that the causes of mental illness are primarily biochemical; and that diagnosis and the prescription of medications are reasonably exact sciences. It can be seen easily enough that the disease/medical model is based on an approach that has been successfully established in physical medicine. It is clear even to the uninitiated that such an approach is less easy to apply to mental health problems.

If we consider mental problems to be diseases this poses an immediate question: what is a disease? The defining features of a disease can be reduced to two components: (1) there is a qualitative variation from what is considered to be normal and (2) this variation confers a handicap, or biological disadvantage, on an individual (Scadding, 1967).

Immediately we must then pose a further question: when can we say that any deviation from the normal represents a qualitative variation? Indeed, what is "normal"? In other branches of medicine doctors rely on the "obvious" evidence of complaints of pain or the presence of lumps and bumps, before sending their patient off for increasingly complex "diagnostic" tests, in order to demonstrate abnormality. Psychiatrists too seek out evidence

for abnormality, but are largely dependent on subjective judgements on which to do so. Psychiatrists both in day-to-day practice, and when defending the theoretical basis of their field, are all too aware of the relative absence of objective tests on which to base diagnosis. Indeed, the lack of diagnostic blood tests or scans in all except a few “cases” presenting to mental health services means that psychiatry is not fully accepted as a branch of medicine by some other doctors. Standardised diagnoses, based on a clear assessment of signs and symptoms, are thus particularly important in psychiatry.

Defining Mental Illness

So far, so straightforward you might think. So why is it so difficult to detect deviations from the norm and to define “mental illness”? Well if you think about it, defining “illness” can be difficult in all circumstances. What approaches are available? We could seek to define mental illness as the absence of good mental health. The problem is what exactly does this mean? What is good mental health? Is there so much individual and cultural variation that defining good health is more or less impossible? In any case defining anything by the absence of something else is not easy.

We could define mental illness through the presence of suffering. This is helpful for those who complain but not for those who do not. Many individuals who are considered by wider society (the man or woman in the street) to be acting strangely and who appear to be ill do not complain of anything. For the doctor the denial of obvious problems is sometimes further evidence of illness in itself and they consider the person to lack “insight” or understanding of their own problems. Sometimes the picture is even more complicated. The person in question may not just argue that they are well but that they feel very well indeed. Such a situation arises when a person with bipolar affective disorder (when individuals are troubled by episodes of both mania and depression) is in the midst of a manic episode.

A third possible approach is to define mental illness as the presence of deviant behaviour. The problem with this line of reasoning is obvious – who defines deviant behaviour? There is a real danger of seeing pathology in merely eccentric behaviour or less common lifestyle choices. In the past such an approach led some psychiatrists to see homosexuality as a form of mental illness.

The final option, and the one which dominates other medical fields such as surgery, is that illness is defined by the presence of pathology. In surgery this is uncontroversial. Pathology is demonstrably present in blood tests, X-rays and various scans. Psychiatry must rely on the demonstration of abnormal, or pathological, psychological processes. And demonstrating abnormal psychology is not a simple task.

Signs and Symptoms

So how do we define, and search for abnormal psychology? The answer is that abnormal psychology reveals itself through the presence of defined signs and symptoms. Signs are generally abnormalities which are visible to an observer (such as marked weight loss in someone with anorexia nervosa) and symptoms are what a person complains of (for example, the “fear of fatness” expressed in anorexia nervosa). It is not possible to fully explain the various signs and symptoms that psychiatrists seek here (for a full explanation of this fascinating field read

the book "Sims symptoms in the mind", Obeyade, 2008). To illustrate the diagnostic approach one example of a psychiatric illness will be considered – the assessment of mood and the other symptoms which often accompany depressed mood in depressive illness.

Exercise 1.1 Signs and symptoms of depression

Try to identify how you might be able to decide if someone is depressed. Think about: their appearance and behaviour; what they are saying; their mood; what they are thinking about; how they seem to be perceiving the world; how they are coping; and their view of how they are.

The central symptoms of depressive illness are depressed mood, anhedonia (an inability to enjoy life), loss of interest and energy, and guilt or self-blame. Often patients feel hopeless about the future. They may make suicidal plans or carry out suicidal acts. Typically depression is accompanied by a poor appetite and weight loss, and sleep disturbance such as waking very early in the morning and not being able to get back to sleep. Symptoms of depression such as these, and other abnormal psychology is sought firstly through a standardised approach to the psychiatric assessment (see Box 1.1). This commences with taking a psychiatric history and then continues with a "mental state assessment". The mental state assessment (sometimes known as the mental state examination) corresponds to the physical assessment carried out by a general practitioner, a physician or a surgeon. Finally various blood tests and scans may then be ordered in order to check for any underlying physical condition and complete the picture.

Box 1.1 The standard psychiatric assessment

Psychiatric history including:

- Source of and reason for referral*
- Presenting complaint*
- History of presenting complaint*
- Previous medical and psychiatric history*
- Family history*
- Personal history*
- Previous personality*
- Forensic history*
- Mental state assessment*

Investigations:

- Psychological, physical and social*

The Psychiatric History

The components of a basic psychiatric history are outlined below:

Presenting complaint: A brief description of the problem or problems in one or two sentences and in patient's own words. Including an approximate timeframe is helpful (e.g. "Crying all the time" for two weeks).

History of presenting complaint: The symptoms described by the patient and associated symptoms not explicitly described by the patient but picked up through careful questioning. It is important to ask about the length, severity, course of the problem and the extent to which the patient is bothered by symptoms, as well as any precipitating or perpetuating factors.

Medical history: Information is gathered about any medical conditions which may or may not contribute to the illness and influence medication choices. The patient is asked about any previous operations and any history of physical trauma (especially head injury).

Previous psychiatric history: It is important to enquire regarding any prior contact with mental health services (as an outpatient or inpatient). A person may have had no prior contact with mental health services but have received treatment from a GP, in the voluntary sector or privately. Any previous attempts at self-harm must always be asked about.

Family history: Any family history of mental health problems is ascertained, after asking about all close relatives in some detail. The quality of relationships with family members is an important consideration.

Personal history: A full history of the person's life is taken, including: their birth and early development; childhood relationships and important events; education including schools attended, qualifications, whether enjoyed or disliked, relationships with peers and teachers; occupational record; psychosexual history; children.

Current social situation: Current occupation (any problems?); finances including debts and income; housing situation; habits (alcohol, tobacco, drug misuse).

Personality factors: For example, shy or outgoing and other personality traits as appropriate.

The Mental State Assessment

In the mental state assessment the patient's current mental life is evaluated on the basis of systematic enquiry and observation. The reference period for the first assessment is not just the here and now but also includes the month preceding the interview. For example, the doctor may ask the patient: "have you worried a lot during the last month?" or "have you had difficulty relaxing in the last month?"

The main dimensions on which a patient's mental state is assessed are outlined below:

I. *Notable aspects of appearance and behaviour*

- **Appearance and dress:** Unusual dress may give useful clues to the diagnosis. Drabness or self-neglect may be a result of an underlying depression or dementia, for example.
- **Personal hygiene:** Poor hygiene may accompany many conditions, e.g. it may result from self-neglect in severe depression.
- **Build, posture and expressions:** The general build and height of the patient is noted. An example of an important finding in this area would be the loss of weight associated with anorexia, depression or a phobic avoidance of food.

- *Behaviour and activity*: The presence of slowness or under-activity, over-activity or excitement is noted, as is the presence of any abnormal movements.

II. *Abnormalities of speech and thought form*

This dimension focuses on how the patient puts their thoughts together and how they express them (not on what they are talking or thinking about – this is described in the section on thought content). Thought form reflects the patient's thinking processes. To a large extent a patient's thinking processes have to be inferred from the patient's speech.

- *Speed and volume of speech*: Pressure of speech is seen in anxiety or in a more severe form in mania; retardation of speech is seen in depression.
- *Coherence*: This describes how well one can follow what a patient is talking about. Can one follow what is being said?
- *Amount and spontaneity of speech*.
- *Inflexions and intonation in speech*.
- *Poverty of content of speech*: This is about the amount of information conveyed by the patient: sometimes a patient may talk a lot but be vague and woolly.

III. *Abnormalities of mood*

The most common abnormal mood states are anxiety and depression. They often occur together.

- *Anxiety* consists of a mixture of psychological and physical symptoms. Psychological symptoms include worry, hypochondriasis, tension, and anxious foreboding. Physical symptoms include palpitations (a sensation of a fast and/or irregular heartbeat, shortness of breath, dry mouth, sweating).
- *Depressed mood*: The central symptoms of depression are depressed mood, anhedonia, loss of interest and energy, and guilt or self-blame. Suicidal ideas must be asked about – it is an important part of the assessment and it won't provoke a suicide attempt.
- *Elevation of mood*: The central symptom of mania is elevation of mood. This can take the form of excessive happiness or irritability. There may be other associated symptoms such as over-activity and grandiosity (delusions or overvalued ideas of grandiose abilities or self-importance).

IV. *Thought content*

This describes what a patient is thinking about. It includes any themes of the interview and any preoccupations of the patient (such as jobs and finances) as well as clearly abnormal features such as delusional beliefs. Remember the person being interviewed may disguise what they are really thinking about. Most people tend to edit their thoughts before speaking.

- *Pre-occupations*: What does the patient talk about? Is he/she concerned about topics such as bodily health, guilt, how people have treated him/her?
- *Obsessions*: Is there obsessional checking and repeating, such as checking gas taps, doors and switches that the patient knows he/she has already checked? What happens when the patient tries to stop?

- *Abnormal belief:* One should specify the content, mode of onset and degree of fixity of any abnormal beliefs. Fixed, false beliefs out of keeping with social and cultural background are delusions. Remember, a delusional belief isn't simply one that you disagree with. The presence of a delusion always indicates that the patient is suffering from some form of psychotic illness. (See Box 1.2 for an explanation of the key aspects of a person's presentation which a psychiatrist uses to decide when a person has a psychotic illness such as schizophrenia.)

Box 1.2 Differentiating psychotic illness from non-psychotic illness

Psychotic illnesses are defined by evidence for loss of contact with reality—this is demonstrated by the presence of delusions (abnormal beliefs) and/or hallucinations (a percept without an object).

It is important to remember that a delusional belief isn't simply one that you disagree with and that if a belief is in keeping with the beliefs of a person's social/cultural group it is unlikely to be delusional.

Delusions and hallucinations are often accompanied by lack of insight—that is a person does not accept/believe they are ill/require treatment (insight is often "partial").

In all non-psychotic illnesses there are no delusions or hallucinations—that is, the person is in contact with reality and insight is largely preserved. There are however times when it is difficult to be absolutely certain about the dividing line between psychotic and non-psychotic illness.

V. Perception

Perception relates to how we perceive the world we live in. Mild changes of perception, for example heightened or dulled perception, may occur as secondary phenomena to emotional disturbance such as anxiety. Major perceptual disturbances, such as hallucinations, are usually associated with psychotic disorders or brain disorders (for example temporal lobe epilepsy or a brain tumour).

- *Auditory hallucinations:* Is there evidence of auditory hallucinations? If present, are these based on depression or elation? Are the voices commenting or talking about the patient or are the voices speaking to the patient?
- *Visual hallucinations:* Is there evidence of visual hallucinations?
- *Other hallucinations:* These may also occur in the other sensory modalities – smell, taste and touch.

VI. Cognitive function

- *Ability to cope and social impairment:* The patient's ability to cope at work and at home is highly dependent on intact cognitive skills.
- *Attention, concentration, distractibility:* Is the patient's attention easily aroused and sustained? Is he/she easily distracted?

- *Orientation*: Is he/she well orientated for time (time of day, day of week, date), places and persons?
- *Level of consciousness*: Impairment of consciousness ranges on a continuum from barely perceptible dulling to coma.
- *Memory impairment*: Recent deterioration in memory may be evident from the patient's self-report, or from the discrepancy observed from the patient's account of his/her life and that given by others.
- *Grasp and intellect*: Deterioration of intellect and grasp can be assessed by comparing the patient's previous level of attainment (school record, work record), with his/her present knowledge of current affairs and general knowledge, and his/her understanding of abstract concepts such as the meanings of proverbs (e.g. 'a stitch in time saves nine').

VII. *Insight*

What is the patient's attitude to his/her present state? Does he/she regard it as an illness which needs treatment? What does he/she attribute it to? Can he/she appreciate possible connections between his/her illness and stressful life situations?

Syndromes and Classification

Once the history has been taken and the mental state assessment completed the doctor will try to decide on a diagnosis. An example of a diagnosis based on syndrome diagnosis is that of depressive illness (See Box 1.3).

Box 1.3 Example of a syndromal diagnosis: depressive illness

Depressive illness is the pathological state of sadness – that is, sadness which is deeper and more profound than would be expected in the person's circumstances and/or sadness which has continued for too long.

It is a syndrome, with associated symptoms (including loss of appetite, weight loss, sleep disturbance, suicidal thoughts, and a range of other symptoms).

For example, diagnosis of depressive illness: presence of depressed mood or loss of interest, plus four other symptoms, for at least two weeks.

The description of syndromes is the basis of classification systems in psychiatry. It has been difficult to create sound classification systems for the same reasons as it has been difficult to define health and ill-health. It should be noted however that problems around diagnosis and classification are not confined to psychiatry but are also seen in other branches of medicine and surgery.

Doctors have attempted to create systems of classification for many centuries. All medicine is based on recognising groups of symptoms and signs and then classing them together to make a particular diagnosis recognisable to most medical professionals. Thus if a patient has shortness of breath, peripheral oedema (a build-up of fluid in the tissues causing swelling), lung "crepitations" (abnormal lung sounds caused by excess fluid), raised pressure in the jugular vein (a blood vessel in the neck) and hypotension (low blood pressure), most doctors will start to think of cardiac failure. Systems of classification are attempts to formalise and standardise diagnoses. They allow doctors to communicate clearly with each

other and to be sure that they would make roughly the same diagnosis if faced with the same set of symptoms and signs in different patients or in the same patient at different points in time.

The purpose of diagnosis and classification is to bring together illnesses which have the same characteristics. Ideally diagnoses should identify disorders with the same underlying pathology, same aetiology and same treatment outcomes. Such an outcome is rarely achieved in psychiatry. An example of a condition when a diagnosis does bring such clarity is Huntington's chorea. This neuropsychiatric disorder has a clearly defined underlying cause (genetic inheritance) and an absolutely certain treatment outcome (unfortunately, premature death). A good classification system has treatment implications, prognostic implications, allows communication between professionals and is useful for research purposes and in certain court proceedings.

The modern psychiatric classification systems have evolved over many decades. There were many problems with psychiatric diagnosis pre-1970, with widely differing concepts of mental illness across the globe. In particular the influence of Freudian (psychoanalytical) ideas, especially in the USA, meant that very different ideas were held simultaneously on either side of the Atlantic. By the late 1960s it was becoming increasingly clear that there were major problems. The US-UK Diagnostic Project (Cooper et al., 1972) found that schizophrenia was nearly twice as "common" in New York as in London, whereas manic depression was less "common". However the symptoms with which individuals presented were similar in the two cities. Clearly doctors in the two cities were making different diagnoses when presented with the same types of symptoms. The importance of standardised diagnoses was further illustrated by the controversy surrounding the International Pilot Study of Schizophrenia which was published in 1973. This nine-country international study found higher rates of schizophrenia in the United States and Russia than in the United Kingdom, Denmark, Nigeria, India, Czechoslovakia, Taiwan or Colombia. The differing prevalence of schizophrenia was not due to social, genetic or therapeutic differences but rather to "looser" diagnostic criteria in the US and Russia so that the diagnosis was made more often.

The International Statistical Classification of Diseases and Related Health Problems Tenth Revision (ICD-10, 1992) is the most recent edition of the system of classification devised by the World Health Organisation (ICD-11 is due to appear soon). The ICD-10 is ratified by the 193 WHO member countries and is the main system in the UK and the rest of Europe. It is divided into chapters relating to specific medical "fields" containing diagnoses with criteria agreed by international task-forces of doctors. The ICD-10 is an exhaustive list of diagnoses of sometimes startling detail. For example, there is a code for an "accident involving animal drawn cart leading to injury of occupant of three-wheeled motor vehicle".

ICD-10 has attracted criticism, as it requires individual cases to be fitted into categories which may not reflect the full complexity of the patient's life story. Another criticism levelled at ICD-10 is that it is by necessity a compromise. It requires different doctors from different cultural backgrounds in different countries speaking different languages to agree. This may lead to over-inclusive or unclear diagnoses. Similarly, its medical task-forces have been accused of a bias towards Western medicine and belief systems, leading to controversy over a variety of culture-bound syndromes. A trance state in the ICD-10 is diagnosed as a "conversion disorder" but would be perfectly acceptable in a Buddhist monk.

The Diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association and currently in its fifth edition (hence DSM-V). It is the main system used in the United States, New Zealand, Canada and Japan and there is ongoing debate about whether it is useful to have two parallel systems. Early versions of DSM were largely based on psychoanalytical or psychodynamic models of mental illness. DSM III, IV and V however (published in 1980, 1994 and 2013 respectively) are essentially based on the medical model, and this represented a major change in diagnostic practice. DSM-V is a multi-axial system with five axes for the clinical disorder, any personality problems or relevant defence mechanisms (a Freudian concept), physical disorders, psychosocial or environmental problems and an assessment of the patient's Global Assessment of Functioning (rated by the GAF scale – an assessment of how well the person is functioning in all areas of their life) respectively. Advocates of DSM-V point out that the multi-axial approach helps to form a full appreciation for a person's condition and the breadth of treatment required.

So, in the case of a depressed alcoholic male who suffers from hypothyroidism (deficient activity of the thyroid gland), denies a drink problem, has been neglecting his family and is threatened with redundancy, a multi-axial rating (see Table 1.1) would look like this:

Axis	Code	Diagnosis
I (Clinical Disorder)	296.23 305.00	Major Depressive Disorder. Single Episode. Severe. No Psychosis. Alcohol Abuse
II (Personality/ Defence mechanisms)	301.6	Denial (of alcohol problem)
III (Physical disorders)	244.9	Hypothyroidism
IV (Psychosocial/ Environmental problems)		Threat of job loss
V (GAF scale)	35	Score of 35 on Global Assessment of Functioning Scale (this scale has a maximum score of 100 for perfect health and a minimum of 0)

Table 1.1 An Example of a Multi-axial Rating Applied

Criticisms of Psychiatric Diagnosis and Classification

The critics of the disease/medical model argue that mental illness is merely a medical term for problems in social relationships; that the sick role is socially defined; treatment is an art rather than a science; and that drugs and ECT merely suppress distress.

During the 1960s the very business of psychiatry was challenged, often from within the profession. Among the critics who collectively, though unwillingly, attracted the label of the "Anti-Psychiatrists" were the American professor of psychiatry Thomas Szasz (1961) and Scottish psychiatrist R. D. Laing (1960). The diagnostic process in psychiatry was criticised by Scheff (1966) when he argued that individuals do not fit neatly into categories and that categories are thus merely a form of "labelling". Allocation to a category distracts from

understanding the need to understand the unique difficulties of a person. Critics further argue that diagnoses provide little information about aetiology and have low levels of reliability and validity.

A furore ensued in the aftermath of what became known as the "Rosenhan Experiment" in 1973. David Rosenhan, an American psychologist, organised for himself and eight friends, all perfectly well, to present to different ER departments. They claimed to have heard a voice saying "echo" or "thud" but if admitted to hospital were under instructions to act normally and deny all other symptoms. The outcome was that all were admitted, all were diagnosed and all were treated. When the results were published in the prestigious journal *Science* US psychiatrists could do little but react with embarrassed defensiveness.

Psychiatrists in fact accept much of this criticism. Whilst for many years the "medical" model has been counterposed to the "social" model in sharp debates and polemics, it would be a mistake to suppose that there are two camps at permanent war. In more recent times the two models have been partly merged and today most medical practitioners adopt a "bio-psycho-social" approach, taking biological, psychological and social factors into consideration when assessing any patient or client. For some psychiatrists, however, the bio-psycho-social approach is acceptable, but they believe at heart that mental illness is essentially no different from any other illness and whilst psychological and social factors are important biology is more important.

The Historical Roots of Biological Psychiatry

An examination of the history of the medical approach to psychiatry is instructive at this point. It is important to set our work in its historical context. In particular it is important to grasp that psychiatry developed alongside physical medicine over several millennia basically following the same road map: in order to understand and treat we must firstly describe the clinical syndrome, then identify the underlying pathology and natural history (or course) of the syndrome, before seeking to match diagnosis to treatment. This path led to the development of modern biological psychiatry. The medical historian Roy Porter has published a number of wonderful and intriguing books on the history of psychiatry.

Doctors see themselves, and are indeed seen by most of wider society, as experts. They are experts of course but the long prehistory of medicine in general, and psychiatry in particular, should give pause for thought. Chance findings were as important as a careful measured approach for most of medical history, and certainly superior to many of the attempts to form theoretical models for mental health problems. The chaotic and sometimes stomach churning "treatments" employed over the centuries should open all our eyes to the importance of the placebo effect and of therapeutic optimism, the usual actual reason for any supposed "cures". Doctors ought to keep a cheerful sense of perspective and a healthy dollop of humility. And all mental health practitioners, from whatever discipline and whatever perspective, should keep in mind the lessons of the much longer professional history of the doctor and consider: "What will future clinicians think of today's treatments?"

In prehistoric times there was no division between health care, magic, and religion and of course no understanding of why diseases occur in the first place. Abnormal behaviour was attributed to supernatural forces. Those who developed mental health problems might find themselves undergoing various ceremonies designed to drive out evil spirits, or forms

of “trepanning” (or “trephination”). This, the earliest known form of surgery appears to have been practised from about 8000 BC to 500 BC, and involved boring a hole in the skull with the presumed aim of releasing evil spirits. Such a procedure, performed without anaesthetic, must have been gruesome to undergo, and often fatal, but sometimes seems to have worked – the archeological evidence demonstrates that many individuals survived their surgery by years.

The millennium between 500 BC and 500 AD saw advances in science across the Ancient Greek and Roman world which were unsurpassed until the Renaissance. In that period a number of mental disorders were identified (including melancholia or depression, mania, dementia and hysteria) and symptoms such as delusions and hallucinations were described. In the 5th century BC Hippocrates believed that all illness, including mental illness, had natural origins. Such enlightened ideas appeared to result in humane treatment. Hippocrates advocated rest, bathing, exercise, and dieting.

There was little real understanding of course. The “humoral theory”, under which personalities were classified based on the four humours (phlegm, black bile, yellow bile, and blood), was widely held. Plato (400 BC) viewed the soul as an allegorical chariot with the psyche as the charioteer driving two horses (one noble and the other impelled by animalistic desires). The charioteer’s role is to balance these impulses.

After the collapse of the Roman Empire the accumulated knowledge of Ancient Greece and Rome was lost for many centuries. During this period the Islamic world was at the forefront of science and compassionate treatment of the mentally ill was emphasised. Medical historian Roy Porter (2002) cautions against idealising the role of hospitals in medieval Islam, however, stating that “They were a drop in the ocean for the vast population that they had to serve, and their true function lay in highlighting ideals of compassion and bringing together the activities of the medical profession.”

In Europe the Middle Ages (about 500–1500 AD) saw the regression of both knowledge and understanding. In the 15th and 16th centuries witch hunts swept Europe. In 1486 the notorious *Malleus Maleficarum* (“The Witches’ Hammer”) was published. This text provided a guide for witch-hunters and “proof” that witches were mostly women. The presence of deviant (usually sexual) behaviour was a key for the witch-hunters and insanity was held to be caused by possession by the devil. Salvation of the immortal soul was more important than the comforts of the possessed body and thus physical punishments were used to make the body an intolerable refuge for the devil. An important turning point (for the better) was the publication of physician Robert Burton’s *Anatomy of Melancholy* in 1621. This text was written from Burton’s own experience of profound depression. He proposed a therapeutic programme of exercise, music, drugs, and diet and stressed the importance of discussing problems with a close friend or doctor.

In time, treatments became less obsessed with the spirit world and increasingly followed a cathartic approach – seeking to induce a crisis in the individual through deliberate bleeding, the use of flogging, forcible rotation, ice baths, shocks with eels, induction of vomiting, the induction of fevers with rats and malarial mosquitoes, and endless other techniques. The elegantly named “douche ascendante”, for example, was in fact the very inelegant procedure whereby a sudden stream of cold water was directed at the anus of the patient without warning. Bleeding was not without significant risks – 18th-century records show that a young woman in a manic state was bled 30 times in 10 days and subsequently died. The

residues in popular memory of the usefulness of a "shock to the system" are still to be heard in common parlance. Many of us have uttered the phrases "Why don't you snap out of it?" or "I could shake him!"

The Rise of the Asylums

Prior to the 19th century most patients were cared for in their local community, or left to roam the countryside uncared for. A few were admitted to madhouses such as the Bethlem Hospital in London (the famous Bedlam) or St Patrick's in Dublin (founded by Dean Jonathan Swift). It is reasonable to assume that the lives of those with more serious forms of mental illness were "nasty, brutish and short" and that many ended up incarcerated in prisons and poor houses. In the 18th and 19th centuries a system of state built and run asylums was created in countries such as the United Kingdom and the United States, with the aim of housing people with mental health problems separately from prisons and poor houses. It has been convincingly postulated that this process was less benign than it might initially appear and was more a form of social control precipitated by the turmoil and chaos of the early industrial revolution.

Inspired by the profound social changes ushered in by the French Revolution, Philippe Pinel and Jean-Baptiste Pussin introduced more humane methods into the treatment of the mentally ill when they removed the chains from the inmates of the Asylum de Bicêtre in Paris in the 1790s. Pussin and Pinel can be credited with beginning what became known as "moral treatment". Around the same time as they were adopting their revolutionary methods, the Quaker William Tuke pioneered a similar enlightened approach at the York Retreat in England (opened in 1796). The Retreat promoted "moral responsibility" and forms of occupational therapy. The environment was held to play a vital role in the treatment of the mentally ill, and in order to aid recovery, conditions and surroundings resembling the comfort of home were introduced with beds, pictures and decorations replacing shackles, chains and cold, stone cells.

The second half of the 19th century saw many significant advances. Pioneering German psychiatrist Emil Kraepelin published his landmark psychiatry textbook which began to tease out the different conditions with which patients present in a way that doctors would understand today. "General paresis of the insane" became one of the first of these conditions to be linked to a physical cause (in this case, syphilis). The possible psychological mechanisms underlying mental health problems were explored and elucidated through the work of Mesmer, Breuer, Charcot and Freud concurrently with these advances. At the same time asylums became more widespread both in the USA and Europe, and ever more crowded. This overcrowding meant that old procedures were re-introduced and the more humane approaches associated with moral treatment were increasingly neglected.

By the first years of the 20th century therapeutic optimism was non-existent. There were few asylum doctors and a widespread sense that admission to an asylum was admission for a lifetime. Bizarre treatments came and went. Some of these were brutal and irreversible, for example the extraction of all of a patient's teeth, a colectomy (removal of the entire colon or large bowel), or hysterectomy in order to treat imagined chronic infection. It was not a pretty picture.

Physical Treatments in Psychiatry

Against this pessimistic background a series of radical physical therapies were developed in central and continental Europe in the late 1910s, the 1920s and, most particularly, in the 1930s. In 1917 Austrian psychiatrist Julius Wagner-Jauregg (1857–1940) began using malarial therapy for general paresis of the insane (or neurosyphilis), which at the time was a terminal disease. He deliberately caused patients to become infected with malaria, seeking the spikes in body temperature associated with the disease which would kill the temperature-sensitive infective agent. Although this radical approach also killed about 15% of patients it worked well for the majority who would otherwise have died from neurosyphilis, and mental hospitals kept colonies of infected mosquitoes in order to treat their patients.

Malarial therapy was quickly superseded by the discovery of penicillin in the 1940s (as penicillin is an effective treatment for the infective agent which causes syphilis) but the idea that cure was possible was now established. This was the beginning of a radical and experimental era in psychiatric medicine that broke with the culture of therapeutic nihilism in the treatment of chronic psychiatric disorders, most particularly schizophrenia. Such disorders were until then typically regarded as hereditary and degenerative and therefore un-amenable to any therapeutic intervention.

In 1920 barbiturate-induced "deep sleep therapy" was introduced as a treatment for schizophrenia by the Swiss psychiatrist Jakob Klaesi. Soon afterwards insulin was isolated by Frederick Banting and Charles Best and in 1923 it was noted that depression cleared up in some insulin-treated diabetics. In 1928 the Viennese psychiatrist Manfred Sakel (1900–1957) used insulin to relieve symptoms of morphine withdrawal and then as a treatment for schizophrenia. "Insulin coma therapy" became an established treatment for two decades. It appeared to work (in retrospect it is clear that it did not – any benefits were due to the placebo effect and it was very dangerous).

In 1934 Ladislav Meduna, a Hungarian neuropathologist and psychiatrist, introduced Cardiazol shock therapy, the first convulsive or seizure therapy for a psychiatric disorder. Shock therapy was founded on the theoretical (and entirely erroneous) notion that there existed a biological antagonism between schizophrenia and epilepsy and that therefore inducing seizures in people with schizophrenia might effect a cure. After several years of experimentation electro-convulsive therapy (ECT) was introduced by the Italian neurologist Ugo Cerletti in 1938 and it quickly became the established mode for inducing such seizures. It is actually relatively ineffective for schizophrenia but effective for severe depression and remains in use today, though now modified by the use of anaesthetics and muscle relaxants. It is quite literally a life-saver in very severe cases of depression when individuals refuse to eat or drink.

The idea that operating on the brain might alter behaviour, thoughts and feelings in a favourable direction was established when John Fulton and Carlyle Jacobsen reported on operations on chimpanzees in 1928. In 1935 the Portuguese neurologist Egas Moniz devised the "leucotomy" (from the Greek words for white and cutting), a surgical procedure targeting the brain's frontal lobes. This appeared to result in patients forgetting their depressing or discouraging feelings. The "leucotomy" procedure was very delicate and time-consuming and required great skill and training from the surgeon. As it appeared to be effective, efforts were made to develop a more practical and easy-to-perform procedure with similar desired results.

Soon Walter Freeman and James W. Watts developed the transorbital lobotomy, using a device akin to an ice-pick. This was an "office" procedure which did not have to be performed in a surgical theatre and took as little as 15 minutes to complete. In 1949, 5,074 lobotomies were carried out in the United States and by 1951 18,608 people had undergone the procedure in that country alone. Freeman himself became known as "the traveling lobotomist" and performed over 3,000 lobotomies. There was considerable public interest in the procedure and the press ran many articles about its "success". From the outset some health professionals opposed Freeman's "euthanasia of the mind" however, and the sceptics were absolutely correct – there is no evidence of any genuine therapeutic benefit from frontal lobotomies and they caused severe harm to many.

The Beginnings of Modern Therapeutics

After the Second World War a long and slow process of "de-institutionalisation" began across most of the industrialised world. The number of inpatient beds in the UK and USA peaked in the mid-1950s. The introduction of antipsychotic medication around that time is held by many to be the key driver of this process, but the process of change was influenced by a number of factors which predated the pharmacological developments. Those factors included: increasing concerns about the loss of liberty involved in institutional care; international debate about how community mental health services could be provided; and more progressive approaches being developed. One factor in these more progressive ideas was the impact of the return from war duty of young psychiatrists who now had a sense that change was possible. At the front they were expected to patch up traumatised soldiers quickly and return them to the ranks and thus were open to the idea that a positive therapeutic outcome was possible.

Governmental policy changed too – illustrated best by Enoch Powell's "water towers" speech in 1961 (he called for the eventual closure of the asylums with their iconic water towers) and US President John F. Kennedy's legislative drive for a more humane approach. Institutions began to change their procedures in ways that resembled the moral treatment approach of an earlier age. There was a greater emphasis on protecting the human rights of patients and on individualised treatments. Outpatient services were developed. There were undoubted benefits, but also negative consequences. There was significant relocation trauma and whilst many patients were discharged to independent living or to the care of their families, the homeless population (in the USA in particular) soared, as did the population of the prisons (Lamb and Bachrach, 2001).

Modern psychiatric medications appeared in a decade of rapid discovery in the 1950s, often discovered by chance. The first of these new, and relatively effective, medications was lithium, introduced as a treatment for bipolar affective disorder by John Cade in Australia in 1949. The first antipsychotic, chlorpromazine, was introduced in the early 1950s and the first antidepressant, imipramine, in 1956. Soon afterwards the first benzodiazepine (medications which counteract anxiety) appeared. Each first was followed by a number of other similar medications, the so-called "me-toos".

Unfortunately since the 1950s there have been few real breakthroughs, though there have been important developments. Imipramine and similar medications, which collectively became known as the tricyclics because of their common three-ring chemical structure,

were eventually largely supplanted by the serotonin selective reuptake inhibitor (SSRI) antidepressants, not because they are more effective but because they have more tolerable side-effects and are safer in overdose.

The "first generation" or "typical" antipsychotics remain in use today but the "second generation", or "atypical", antipsychotics are now the treatment of choice, and again this is largely because of an improved side-effect profile. The advent of a group of anti-dementia drugs has given some hope to sufferers, but only some, as the medications in question do not reverse the pathological process of Alzheimer's dementia but merely slow its progress.

Many pharmaceutical companies have all but abandoned the search for breakthrough drugs in this field. Perhaps medications lie around the corner which will transform the lives of millions, but at this point in time it is not clear where they will come from. Effectiveness and side-effects remain problematic issues for many people. Perhaps a Nobel Prize will yet be awarded to a psychiatric researcher for a proven and long-lasting treatment. To date only three Nobel Prizes have been awarded in the field of mental health. Wagner-Jauregg was the winner in 1927 – "for his discovery of the therapeutic value of malaria inoculation in the treatment of dementia paralytica" and Moniz won in 1949 – "for the discovery of the therapeutic value of leucotomy in certain psychoses". Whilst the neurochemists Arvid Carlsson, Paul Greengard and Eric Kandel won a Nobel Prize in the year 2000 for a genuine breakthrough – "discoveries concerning signal transduction in the nervous system" – the fact that the prize has never been awarded to a psychiatrist is disappointing.

Do the Drugs Work?

Today psychiatrists treat a number of conditions with medication, including depression, bipolar affective disorder, anxiety, obsessive-compulsive disorder (OCD), schizophrenia and other psychotic illnesses, dementia and various addictions. Often however it is symptoms that are treated rather than illnesses. Hence combinations of medications are often used, which presents a confusing picture. Indeed, some of the medications may be prescribed to counter the side-effects of other medications. Not surprisingly there is much debate as to whether there is under-prescribing or over-prescribing of psychiatric medications (or perhaps we have it just right?). When should medication be used? What is the correct balance between psychological therapies, medication and doing nothing?

The general principle for most psychiatric medications is to increase levels of whatever brain chemical (or neurotransmitter) is thought to be low or lacking. In depression this is held to be serotonin and norepinephrine, in psychosis, dopamine, and in dementia, acetylcholine. The main groups of drugs mirror the main illness groups which psychiatrists encounter: antidepressants, antipsychotics, anti-dementia drugs, benzodiazepines, mood stabilisers and medications which are useful in addiction.

To answer the simple question "do the drugs work?", it is instructive to consider the treatment of depression. Put simply all the antidepressants have been shown to be effective in depressive illness, but there are a number of "buts". The more minor forms of illness are less responsive. The antidepressants are more likely to help if a person has an episode of depression which is deemed to be moderate or severe in severity. There are problems with the antidepressants – they can take several weeks to work and have many side-effects (they are not, as is commonly believed, addictive, however). The choice of antidepressant depends on

the side-effect profile of each, the risk of overdose, previous response and safety in relation to age and health.

The side-effects of the tricyclics are particularly problematic, and include sedation, often with a hangover, postural hypotension (with a risk of fainting), a fast heart rate (with a risk of arrhythmias), a dry mouth, a tremor, headache, blurred vision, constipation and urinary retention (and this is not a complete list). The SSRI antidepressants (the most well-known example of which is fluoxetine/Prozac) are much easier to tolerate. They are safe in overdose with no significant cardiac side-effects. They may cause weight loss, nausea, headaches, and sexual difficulties but most patients can tolerate these side-effects and persevere.

Similarly, whilst the evidence for their effectiveness is not absolutely conclusive, it is reasonably strong for other medications. The mood stabilisers act to suppress swings between mania and depression in bipolar affective disorder. Examples include lithium (there are several preparations – Priadel is the most commonly used) carbamazepine (Tegretol), gabapentin (Neurontin) and valproic acid (Depakote and Epilim). Lithium remains the most widely used of these. It is an effective drug but its narrow therapeutic range (too low a level in the blood is ineffective, too high a level is potentially toxic, even fatal) means that great care must be taken. Lithium is excreted exclusively through the kidneys and may cause kidney damage, though this is relatively uncommon. A significant proportion of patients who take lithium develop hypothyroidism (decreased thyroid gland function), though if such a problem develops the deficient hormone can be artificially replaced and usually return to normal after stopping lithium. Nausea, gastrointestinal upset, fatigue, muscle weakness, polydipsia (drinking excessive quantities of fluids), polyuria (passing excessive quantities of urine), tremor and weight gain are also seen.

Antipsychotic medications certainly work: they reduce psychotic symptoms in a manner not reproduced by any other type of medication. The effect is independent of any sedative effects and there is no clouding of consciousness. They bring with them many side-effects however, sometimes particularly unpleasant and sometimes permanent. The typical antipsychotics have been around since the 1950s and include chlorpromazine, trifluoperazine and haloperidol. The atypical antipsychotics appeared in the 1990s. Important atypicals are olanzapine, risperidone and clozapine. The typical antipsychotics in particular can have dramatic and unpleasant side-effects. Acute dystonias are abnormal movements which are alarming, distressing and dramatic in onset, classically presenting with what is known as an "oculogyric crisis". This can last for several hours if not treated and results from spasms of the muscles of the lips, tongue, face and throat resulting in facial grimacing.

Antipsychotic medication can result in side-effects that are more or less indistinguishable from Parkinson's disease. These side-effects include a decrease in active, planned movement, muscle rigidity and tremor. Such side-effects typically appear in one third of patients on typicals. Akathisia occurs in up to 50% of patients on typicals, sometimes within a few days of commencement and sometimes after many weeks. It results in restlessness, agitation, intolerance of inactivity and is occasionally associated with suicide. Tardive dyskinesia appears in about 40–50% of patients who have been treated with long-term antipsychotic medication (hence "tardive" or late). It is a serious, disfiguring, often permanent disorder. Classically it presents with involuntary movements of the mouth and face – the affected individual may appear as if they are a cow "chewing the cud". Other abnormal movements of the upper and lower limbs, or indeed any part of the body may appear, resulting in various

rare and bizarre variations, for example "rabbit syndrome." The second-generation anti-psychotics are much less likely to cause these side-effects but they are not side-effect free. The most significant problem is weight gain, and the possibility of developing diabetes in the long term.

One of the most controversial groups of medications used by doctors is the benzodiazepines, such as diazepam or temazepam. They are prescribed for anxiety and can also be used as sleeping tablets (though increasingly they are being replaced as first line sleeping tablets by the "Z" drugs—such as zopiclone and zolpidem). When broken down in the body the benzodiazepines result in active metabolites causing prolonged effects, for example hang-over effects when used as sleeping tablets. Tolerance to the beneficial effects develops and hence it is necessary to increase the dose again and again. And both psychological dependence and physical dependence can occur. For these reasons they should be reserved for more severe symptoms, used at the lowest effective dose and ideally for only two to four weeks. Patients must be warned about the possibility of dependence.

As mentioned, there are now some anti-dementia drugs though these slow rather than reverse the impact of the disease. Dementia is a global term which refers to a set of symptoms with evidence of decline in memory and thinking which is of a degree sufficient to impair functioning in daily living and is present for six months or more. It is associated with changes in behaviour, motivation and personality. Patients lose the ability to do more complex tasks, for example looking after their finances. Eventually there is loss of ability to perform basic activities of daily living, mobility is affected and patients become dependent. There are a number of types of dementia and there are treatments which slow the progress of the most common form, Alzheimer's disease (the cholinesterase inhibitors, for example donepezil and rivastigmine).

□ Case study 1.1 Mrs Watson

It is constructive to consider how a General Practitioner would apply his/her psychiatric training (based on the medical/disease model) to a specific individual and situation.

A 62-year-old woman, Mrs Watson, calls her GP because she has become frightened in her flat. She describes being intimidated by two men who come into her house at various times of the day, though most often at night. She says they sit in her living room and watch the TV, occasionally passing comments which she thinks may be about her, though she is unable to clearly make out what they say. She thinks one of these men may be the Dalai Lama and she believes that he wishes to take over her house and evict her. She says that this has only been occurring for about 10 days. She has no previous history of psychiatric problems.

The GP will speak to this woman and consider the three principal symptoms that this woman appears to describe. These are:

- Visual hallucinations
- Auditory hallucinations
- Delusions of persecution

Based on the GP's overall assessment, and the presence of these important symptoms, four possible diagnoses need to be considered.

- An alcohol-induced state
- An acute organic psychosis, e.g. due to infection or recently prescribed drug or a stroke
- Dementia
- Schizophrenia of late onset

The GP would concentrate on important issues in his/her examination of this woman and her environment:

- An assessment of her cognitive function.
- Is there evidence of acute physical illness, such as an infection?
- Is there evidence of excessive alcohol use?
- How well does she keep her flat? Is there evidence of neglect?
- Is there a possible informant available or does she live alone?

Her GP would focus on important aspects of Mrs Watson's mental state.

- Orientation.
- Short-term memory.
- Awareness of current events.
- Level of consciousness.
- Presence/absence/type of hallucinations.
- Presence/absence/type of delusions.

A neighbour then appears who tells the GP that on a number of occasions recently she has found Mrs Watson having difficulty climbing the stairs to her flat, seeming to be unsteady on her feet and to be somewhat incoherent in her conversation. On other occasions she appears to be able to walk and talk normally.

The GP looks for clinical signs on physical examination of this lady and finds the following.

- Tremor
- Sweating
- Tachycardia (a fast heartbeat)
- Muscle weakness
- Poor co-ordination of movement
- Nystagmus (involuntary eye movement)

These clinical signs suggest an alcohol problem. Indeed on examination of this woman's flat the GP finds a lot of empty gin bottles which confirms his/her suspicions that her symptoms may be alcohol related. He/she decides that Mrs Watson would best be treated in hospital and asks her if she will agree to admission. She refuses to be admitted to hospital or to attend a psychiatric outpatient clinic.

Certain physical investigations are appropriate in this case.

- Liver function tests
- Chest X-ray
- Urine sample
- Renal function tests
- CT scan of brain

And various options are then considered.

- Institute an alcohol withdrawal regime in the community with support from a member of the Community Addiction Team; perhaps provide additional support through Crisis or Home Treatment services; offer voluntary admission; or, if the relevant grounds were met, detain into an acute psychiatric admission ward under mental health legislation.

Points to consider include:

- Problem of ensuring adherence to prescribed medication whilst at home.
- How much staff time will be available for monitoring her?
- Concern about her physical state if she develops severe alcohol withdrawal symptoms.
- Is it legally possible to detain her in hospital against her will?
- The GP may lose his/her good relationship with the patient if she is detained.
- It may be possible to persuade her to come into hospital eventually if attempts are first made to keep her at home.

The Future of Psychiatry

Where is psychiatry today and what is its future? In the 1970s psychiatry was consciously "re-medicalised" after the many years when Freudian ideas were dominant in the USA and prominent in most other places. The DSM-III (1980) was focused on symptoms not causes. Psychotherapy became much less in vogue and psychopharmacology (the use of medication to treat mental illness) became the cornerstone of medical practice. For a generation the psychiatry research effort has been less focused on environmental factors and much more on biology.

Succeeding editions of the DSM have expanded the range of conditions which come under the remit of psychiatrists: DSM-I (1952) contained 106 diagnoses and was 130 pages long, DSM-II (1968) contained 182 diagnoses and was 134 pages long and DSM III (1980) contained 265 diagnoses and was 494 pages long. The process of expansion has continued since.

This process is derided by many, and a debate over so-called "cosmetic psychopharmacology" has ensued. Diagnoses such as dysthymia, ADHD (attention deficit and hyperactivity disorder), OCD (obsessive-compulsive disorder), social anxiety disorder and post-traumatic stress disorder (PTSD) are not without critics.

The psychiatric profession is under assault on two fronts. Organic brain disorders lie at one end of the spectrum of the conditions that psychiatrists treat. When a patient presents in a confused state as a result of a brain tumour, or with a depressive state which clearly and demonstrably results from a physical illness such as hypothyroidism, then as far as other mental health professionals are concerned such conditions belong properly within the domain of the psychiatrist. The psychiatrist still has a problem however – other medical doctors such as neurologists, neurosurgeons and physicians may well consider these conditions to properly belong to them!

This is the concern of some psychiatrists – on one wing they lose work to psychologists and others who pull away those clients who have problems which are best understood as

psychological, and on the other side their medical colleagues detach individuals who are considered to display symptoms which result from a physical health problem. Psychiatrists certainly see illnesses such as schizophrenia (and related conditions such as schizoaffective disorder and persistent delusional disorders) as their territory. Such a claim depends on a robust defence of the concept of schizophrenia as a distinct illness, of course. A similar “claim” is made for depressive illness, bipolar disorder, anxiety disorders, panic disorder, phobias and obsessive-compulsive disorder. In addition psychiatrists see the problems relating to drug and alcohol abuse as their preserve. A range of other conditions broadly bracketed under the headings of maladaptive behaviour or abnormal illness behaviour are also claimed.

In a rather contradictory fashion psychiatrists see the personality disorders (for example, psychopathy, dependent, borderline and narcissistic personalities) as within their remit whilst simultaneously seeking to avoid any responsibility for the behaviour of individuals with such a diagnosis. This is because by definition a personality disorder is said to be present when a person’s personality causes the person themselves to suffer, others to suffer and/or society to suffer. This suggests no change from a previous level of functioning, as personality is relatively fixed from early adulthood, and thus it is not a question of symptoms appearing with the onset of illness. A person with a personality disorder is not “ill” as such and consequently not easy to treat or change. Critics might argue that psychiatrists want it both ways. Looking after people with a diagnosis of a personality disorder gives them a role, but they eschew any accompanying responsibility.

Despite all the criticisms and caveats, there is a place for clinical psychiatry in the early 21st century (See Professor Tom Burn’s recent lucid and humane defence of the profession and its practices (2013)). Psychiatry has been at the centre of developing our understanding of mental health over the past 200 years and many of the most important challenges to the dominant ideas at any one time have come from within that profession. The Royal College of Psychiatrists, for example, has recently produced important and progressive guidance on spirituality (2013) and sexual orientation (2014). Psychiatrists help many people in distress every day. How psychiatry develops, with other disciplines in the field of mental health, from here is the subject of a later chapter of this book.

FURTHER READING

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- Oyeboode, F. (2008) *Sims’ symptoms in the mind: an introduction to descriptive psychopathology* (Philadelphia, PA: Elsevier Health Sciences). An intriguing text which outlines the rich variety of psychopathology.
- Porter, R. (2002) *Madness: A brief history* (Oxford: Oxford University Press). The definitive history of psychiatry written by the foremost historian in the field. Illuminating and eye-opening.
- Rosenhan, D. L. (1973) ‘On being sane in insane places’, *Science*, 179 (4070), 250–258. An account of the experiment that revealed the weaknesses of psychiatric practice above all others. All psychiatrists, and all other professionals, should read this paper and ponder its lessons.

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