

COMMENTARY

Is psychiatry working?

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Horatio Clare, a broadcast journalist and writer, and I jointly presented a six-episode series ‘Is Psychiatry Working?’ for BBC Radio 4 in early 2023. The series focused on six aspects of psychiatry, namely access to care in crisis, the role of mental health legislation and detention in psychiatric care, the place of diagnosis in clinical practice, medical treatments, psychological therapies and recovery. Our method was to have the lived experience of psychiatric patients centre stage and to augment this with interviews and conversations with practitioners and experts. I think what was distinctive about the series was that Horatio Clare and I then had an ongoing dialogue throughout which, on reflection, listeners found informative and enriching.

The series itself grew out of Horatio Clare’s personal experience of psychosis, which is wonderfully and openly described in his book *Heavy Light* [1], and the format of the series followed the clinical journey of Clare through what is commonly termed the psychiatric system. There is little doubt that there is much debate about, even disdain for, psychiatric practice, certainly in North America and Western Europe. The reasons for this are multifold, but probably most prominent is the widely held belief that psychiatric disorders are not like other medical diseases, as they have no readily identifiable independent markers and therefore ought not to be treated as medical conditions and not by doctors. This, I believe, is the central plank of the so-called antipsychiatry movement or critical psychiatry.

In this article, I will follow the format of the series, discussing access to care in crisis, mental health legislation, diagnostic practice, medical treatment, psychological therapies and recovery. Gaining access to psychiatric care, the world over is difficult, determined as much by limited resources as by stigma and the associated reluctance to being identified as mentally ill.

Access to care

The burden of mental illness to overall well-being is enormous. Mental disorders alongside other noncommunicable diseases, such as cancer, cardiovascular disease and diabetes, cause 70% of deaths globally. Depression, probably the most common mental disorder, is currently among the 10 leading causes of disability adjusted life

years (DALYs) and is projected to be among the top three by 2030 [2]. Estimates of years lived with disability in 2017 confirmed that low back pain, headache disorders and depression were the top three conditions in both males and females, globally [3]. The direct human effect of these facts is exemplified by suicide figures: suicide is the leading cause of death in young people aged 15–29 years and is in the top three leading causes of death among those aged 15–44 years. In 2016, 79% of suicides occurred in low- and middle-income countries [4]. The extent of the burden of mental disorders is not met by the provision of services.

The domains of the World Health Organization’s Project Atlas [5] include governance, policies, plans, laws, financing and payment systems, services and resources. There are immense disparities between low-, lower middle- and upper middle-income countries on the one hand and high-income countries on the other. The differences are as great as 1.3 hospital beds per 100,000 population and to 30.9 beds per 100,000, for example, in the provision of hospital beds for mental disorders. These differences are matched by that of the funds allocated to healthcare. Nigeria, for example, spends \$97 per head of population per annum compared with the United Kingdom which spends \$4,192 and the United States’ expenditure of \$9,892. The proportion of these sums allocated to mental health is always paltry.

Therefore, this is the background of the gross problems in accessing care during crisis and compounded by the manner in which culture frames the values and policies that undervalue mental disorders in society. In the United Kingdom, since the COVID-19 pandemic, there are long waiting times to access care in child and adolescent mental health services and in eating disorder services, and well before the pandemic, accessing adult psychiatric services has been difficult and remains in crisis. Partly this is due to the marked reduction in psychiatric hospital beds: between 1998 and 2014, there was a reduction in beds from 100/100,000 to 45/100,000, the fastest reduction of any OECD country. To amplify this point, mental illness accounts for 22% of health burden but receives only 11% of health funding. The problems in accessing care are therefore unsurprising.

Mental health legislation

Mental health care, compared to physical health care, is uniquely governed by specific legislation in most countries. There are several reasons for this, principally, because mental illnesses such as schizophrenia and bipolar disorder can adversely influence the capacity both to recognise that one is ill and also to seek and accept treatment. Legislation codifies the processes and the circumstances where detention and treatment against the patient's wishes are permissible. This is not the place to discuss the different approaches that the law takes in the different jurisdictions. It is accepted that deprivation of liberty, no matter how justifiable, is regrettable and traumatising for patients and their families. The importance of legislation is underscored by the attendant risks to dignity and safety in the absence of legislation. We know that in many countries, mentally ill people are incarcerated without due process, physically abused and shackled without any treatment being offered. This further aggravates mental disturbance and exacerbates stigma. Nonetheless, even in countries where legislation exists, there is a need to continue to monitor the use of detention and to examine whether there are disparities attributable to discrimination and prejudice. In England and Wales, in the year 2020–2021, there were 53,239 new detentions under the Mental Health Act (MHA) 1983, which was an increase of 4.5% from the previous year. Black or Black British group were over 4 times more likely to be detained than the White group, and for community treatment orders (CTOs), Black people were 10 times more likely than White people to be subject to these Orders [6]. It is worth noting that once age, gender, diagnosis, assessed level of risk and availability of social support are taken into account, ethnicity ceases to be an independent predictor of detention under MHA 1983 [7].

Diagnosis

Modern psychiatric classification systems owe much to Emil Kraepelin (1856–1926). Kraepelin in the 5th edition of his textbook *Psychiatry* [8] demarcated manic-depressive psychosis (bipolar affective disorder) from dementia praecox (schizophrenia) based on their clinical features and their clinical outcomes. He combined *démence précoce*, *hebeprenia*, *catatonia* and *dementia paranoides* into *dementia praecox*. Eugen Bleuler (1857–1939) later changed the term *dementia praecox* to schizophrenia.

These terms and other diagnostic terms that are included in the International Classification of Diseases (ICD-11) and the Diagnostic and Statistical Manual (DSM-5) are controversial and problematic for many reasons, but not least, because there are yet to be identified independent biological markers that can confirm these diseases. In other words, psychiatric disorders rely upon clinical symptoms, observed behaviours and

demonstrable abnormal phenomena. They are diagnosed at a syndromal level. The irony is that once independent markers are discovered for psychiatric disorders, the care and management of these disorders move to neurology. Neurosyphilis is a case in point. Once the causative agent *Treponema pallidum* was identified in 1921, what was originally termed general paralysis of the insane came to be recognised as cerebral syphilis, and once there was available treatment in the form of penicillin, the management devolved to general medicine.

There are other objections to the application of the so-called medical model to psychiatry. Some people argue that psychiatric disorders do not exist as the notion of mind is conceptual and not physical, hence that diseases of a conceptual realm cannot by definition occur. This is, of course, a spurious argument but some people are persuaded by it. Others argue that psychiatric classification is stigmatising, and that whilst the terms may be reliable there is little reason to believe that they refer to underlying mechanisms. Finally, many patients feel that these labels are unhelpful and find them dehumanising and unduly reductive.

Treatment

Chlorpromazine was manufactured by Laborit and marketed by Rhone-Poulenc from 1951 onwards. It was introduced as a treatment in 1952 and termed a neuroleptic by Jean Delay and Pierre Deniker because of its effects including emotional neutrality, slowing of movement and other motor activity and emotional apathy. One of the earlier reported cases was 47-year-old Giovanni A., a manual labourer who had mania with psychotic symptoms and was well known on the streets of Paris where he gave improvised political speeches, got into fights with strangers and wore a cracked pot on his head. Chlorpromazine was shown to be effective and Giovanni was able to converse normally and was discharged after 3 weeks of treatment at Sainte-Anne Hospital, Paris [9]. In 1957, Roland Kuhn published the results of the use of imipramine on 40 patients with vital depression, demonstrating that these patients responded well to treatment [10].

These two drugs, chlorpromazine and imipramine, became the prototypes for subsequent psychotropic agents used in psychiatry to date. The concern is that in over 70 years, no drug treatments relying on truly novel mechanisms have been introduced into psychiatry. Furthermore, there continues to be controversy over the use of these drugs, including over their efficacy, their mechanisms of action and the prudence of long-term use. There is a reluctance to accept that mood disturbance, for example, can arise solely from abnormalities of neurotransmitter systems without any meaningful social or stressful precursors. This plays into the pervasive idea that drug

treatments are not working on fundamental causes, rather they are merely altering superficial chemical anomalies. The drug induced side effects such as extrapyramidal effects, including parkinsonism, and tardive dyskinesia is also a cause of concern, and with newer antipsychotic agents, the associated metabolic side effects, including induced obesity, hyperlipidaemia and hyperglycaemia, have drawn much criticism. There is therefore widespread reluctance to accept these drugs and significant crisis of confidence in their utility and relevance.

Therapy

The two main forms of psychotherapy include psychodynamic psychotherapy, which derives from psychoanalysis, and cognitive behavioural therapy, which is an advance on behavioural therapy. Psychodynamic psychotherapy works on the broad assumption that early childhood experiences continue to have force in adult life and that traumatic childhood experiences are responsible for much of the distress that presents to clinicians in adult life. There is the additional understanding provided by attachment theory, a well-developed account of the role of parenting style and the characteristic attachment of a child to its primary care on personality development and adult well-being. Cognitive behavioural therapy on the other hand is firstly based on learning theory, incorporating both classical behaviourism and operant conditioning, and subsequently further developed by the work of Aaron Beck, in which cognitions come centre stage.

The concern is that contemporary psychiatric practice is over-reliant on drug treatment to the detriment of psychotherapy, the so-called talk therapies. This privileging of drug treatment is seen as a fundamental flaw in the ways that psychiatric practice not only conceptualises mental disorder but also frames its responses. In this regard, there is a concern that psychiatrists see pathology where they ought to see distress and that drugs are prescribed in preference to psychotherapy, further confirming what is believed to be the inhumane response to human distress.

Recovery

Traditionally, doctors have regarded symptomatic improvement as the basis for determining the nature and quality of clinical recovery. But as the predominant medical conditions in society have become chronic and not amenable to cure, this traditional approach has become unacceptable for most patients, as it focuses on deficits and handicaps, and leaves a sense of failure and incapacity in the patient. This has resulted in a change in patient discourse such that there has been a redefinition of what it means to recover from a disease or disorder, and what it is like to live with a disorder rather than to suffer with it.

This is the basis of the recovery movement in psychiatry. Anthony [11] is credited with the most widely accepted

contemporary definition of recovery. He argues that the *person* with a mental illness can recover even when the *illness* is not cured, and that the process of recovery can proceed in the presence of continuing symptoms and disabilities. From this point of view, ‘wellness’ and ‘illness’ may be considered as independent variables. Thus, recovery involves:

‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness’.

There are dangers to this approach, as I have argued elsewhere:

‘There is a limit, I think, to how far language and the concepts that it embodies can be stretched to accommodate our desires not to accept what is negative and emotionally intolerable. But life has much that is painful, discomforting, demeaning and plain bad. Renaming these events or denying their obdurate reality is perhaps unhelpful to those who suffer. In any case, as doctors we have a fiduciary duty to be truthful that transcends the wish to please all’. [12]

Conclusion

The BBC Radio 4 programme ‘Is Psychiatry Working?’ was an opportunity to evaluate where we are with psychiatric practice in the 21st century. It showed how much more there is to do for patients, but because there was not much of a focus on history, it failed to demonstrate clearly how far things have come. There is no easy answer to the question, ‘What do we need to do in order either to improve or change the current state of psychiatric practice?’ No doubt, proper funding of psychiatric services worldwide would help, and here the slogan ‘There is no health without mental health’ is worth repeating and the demand for parity of esteem between physical and mental health services is of course a demand for justice. Stigma is an important factor, particularly in the reluctance to access services but it also frames public discussions about mental disorders and their treatments. This is another way of saying that public education is important. Finally, allocation of funding for research into causes and treatments, not only into the biological underpinnings of psychiatric disorders but also into the roles of adversity, social economic disadvantage, income disparities and access to social amenities, must be a priority for all policymakers and governments. The disease burden of mental disorders

is such that no country can afford not to heed the call for greater investment.

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References

1. Clare H. Heavy light: A journey through madness, mania and healing. London: Vintage; 2021.
 2. Mathers CD, Loncar D. Projections of global mortality and burden of disease from 2002–2030. *PLoS Med* 2006; 3(11): e442. doi: 10.1371/journal.pmed.0030442
 3. GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. Global health metrics. *Lancet* 2018; 392: 1789–858.
 4. World Health Organisation. Depression fact sheet. 2020. Available from: www.who.int/news-room/fact-sheets/detail/depression [cited 30 April 2023].
 5. World Health Organization. Mental Health Atlas 2017. Geneva: WHO; 2018.
 6. NHS Digital (2022) Mental Health Act Statistics, Annual Figures, 2021–22. <https://digital.nhs.uk/data-and-information/publications/>
- [AQ1]

7. Singh SP, Burns T, Tyrer P, Islam Z, Parsons H, Crawford MJ. Ethnicity as a predictor of detention under the Mental Health Act. *Psychol Med* 2014; 44: 997–1004. doi: 10.1017/S003329171300086X
8. Kraepelin E. *Psychiatrie* (5th edition). Leipzig: J.A. Barth; 1896.
9. Ibrahim M. Chlorpromazine: The delay of Laborit. *Newsletter of the Royal College of Psychiatrists' History of Psychiatry Special Interest Group*, 12, 14–16. 2021.
10. Healy D. *The psychopharmacologists II*. London: Altman; 1998.
11. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehabil J* 1999; 16: 11–23. doi: 10.1037/h0095655
12. Oyebo F. The rediscovery of discovery [commentary]. *Adv Psychiatr Treat*. 2004; 10: 48–9. doi: 10.1192/apt.10.1.48

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