Medicine, affect and mental health services

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History suggests grounds for both optimism and caution about the future of psychiatry (1).

Katschnig demonstrates that public mistrust of psychiatrists reflects the perception of the profession as excessively reliant on the biomedical model. Given uncertainties regarding psychiatric knowledge, this is not entirely unreasonable. What the public may fail to understand is that alternative points of view may have even less evidence in support (2,3) and that the differences between psychiatry and the rest of medicine are less marked than some might wish to believe.

Katschnig also demonstrates that suspicion is founded on the profession's close association with the pharmaceutical industry. The public fears that limitations in our intellectual horizons, coupled with interest in personal gain, may act against patients' best interests (4). What may be more difficult to see is the harm done when psychiatric assessment or treatment is not made available or is delayed (3).

According to Jaspers, the ideal psychiatrist combines scepticism with existential faith and a powerful personality (5). The importance of eclecticism in clinical practice has been underscored recently (6). It is a travesty of the truth that we all adhere to a narrow biomedical model. However, this is more of an overvalued idea than a delusion, because a number of the profession adopt such a view. Kendler (7) has summarised evidence showing that similar phaenomena in health and disease may be partially explained by different models/perspectives. Reductionism, whether biological, psychological or social, is intellectually untenable and practically potentially destructive (1,3,8).

The 17th century philosopher Spinoza argued that matter and spirit are two aspects of one universal substance (9). We may paraphrase: wood and string are essential to make a violin and physics may help understand how sound is produced, but it is of no particular relevance in creating or enjoying Beethoven's Kreutzer sonata. Our contemporary philosopher of mind John Searle makes a similar argument in the light of neuroscience (10). These matters may be of limited concern to neurologists but of much relevance to psychiatrists.

Some psychiatrists are more interested in biology and some in meaning, but both are essential in understanding patients (8). Affect, conceived as feelings, emotions and agitations (11) and manifested in consciousness, behaviour and relationships in family and society, is the distinctive core of psychiatry. Evolutionary theory helps us understand this (12,13). The ability to understand affect in biological (as well as social and psychological) ways in both health and disease is what distinguishes the specialty from sister disciplines, especially cognitive and behavioural psychology and social work. If psychiatry were to disappear, it would have to be reinvented. However, it is imperative that all national psychiatric societies and training programmes ensure the training and practice of psychiatrists across the biological, social and psychological domains, including engaging patients as teachers (8,14,15). We know that the WPA is supporting this (16).

Evidence suggests that, where patients exercise choice, they are more likely to perceive treatment in positive terms and commit to it (17). The concern of psychiatrists should not be whether patients choose other professions but whether to do so is safe and effective (3,8). There is some very preliminary evidence, for

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example, suggesting that perhaps nurses may prescribe more safely than junior doctors in uncomplicated cases of dementia (18).

Paradoxically, moves to allow non-medical prescribing, such as have occured for nurses in the UK recently, could be welcomed, as long as this occurs safely (3,18,19), because they remove envy as a source of stigma against psychiatrists. The ability of other professions to prescribe will always be more limited. A more important worry for psychiatrists should be, as is the case in the English National Health Service, that patients have restricted access to us when they might need and prefer to see us rather than other mental health professionals (3).

Non-specialist health workers can deliver safely and effectively treatments for mental disorders within a functioning primary care system (20). However, collaborative care models, in which specialists play diverse roles of capacity building, consultation, supervision, quality assurance and providing referral pathways, enhance the effectiveness and sustainability of such nonspecialist health worker-led care programs (21). Psychiatrists may be on stronger professional grounds in the future by focusing training more on developing new team leadership and facilitation skills (19,22).

H. Katschnig has cast our relationships with other professions entirely in competitive terms. However, professionalism in psychiatry is enhanced by effective collaboration with others (1). An example of pioneering inter-professional collaboration between mental health professionals at the institutional level is the National Collaborating Centre for Mental Health, run jointly by the British Psychological Society and the Royal College of Psychiatrists and involving extensively other relevant stakeholders, including patients and carers (1).

References

1. Ikkos G. Psychiatry, professionalism and society; a note on past and present. In: Bhugra D, Malik A, Ikkos G (eds). Psychiatry's contract with society. Oxford: Oxford University Press (in press).
2. Nutt DJ, Sharep M. Uncritical positive regard? Issues in the efficacy and safety of psychotherapy. J Psychopharmacol 2008;22:3-6.
3. St. John-Smith P, McQueen D, Michael A et al. The trouble with NHS psychiatry in England. Psychiatr Bull 2009;33:219-25.
4. Carey B, Harris G. Psychiatric group faces scrutiny over drug industry funding ties. New York Times, July 12, 2008.
5. Clare A. Psychiatry in dissent. London: Routledge, 1980.
6. Shah P, Mountain D. The medical model is dead – long live the medical model. Br J Psychiatry 2007;191:375-7.
7. Kendler KS. Explanatory models for psychiatric illness. Am J Psychiatry 2008;165:695-70.
8. McQueen D, Ikkos G, St. John-Smith P et al. Psychiatry's contract with society: what do clinical psychiatrists expect? In: Bhugra D, Malik A, Ikkos G (eds). Psychiatry's contract with society. Oxford: Oxford University Press (in press).
9. Scruton R. Spinoza: a very short introduction. Oxford: Oxford University Press, 2002.
10. Searle JR. Freedom and neurobiology: reflections on free will, language and political power. New York: Columbia University, 2007.
11. Bennett MR, Hacker PMS. The philosophical foundations of neuroscience. London: Blackwell, 2003.
12. Brune M. Textbook of evolutionary psychiatry: the origins of psychopathology. Oxford: Oxford University Press, 2008.
13. Ottesen Kennair LE. Evolutionary psychology and psychopathology. Curr Opin Psychiatry 2003;16:691-9.
14. Ikkos G. Engaging patients/users as teachers of interview skills to new doctors in psychiatry. Psychiatr Bull 2003;27:312-5.
15. Ikkos G. Mental health services users involvement: teaching doctors successfully. Primary Care Mental Health 2005;3:139-44.
16. Maj M. The WPA Action Plan 2008-2011. World Psychiatry 2008;7:129-30.
17. Sugarman P, Ikkos G, Bailey S. Choice in mental health: participation and recovery. The Psychiatrist 2010;34:1-3.
18. Cubbin S. Training and assessing independent nurse prescribers: a model for old age psychiatry. Psychiatr Bull 2009;33:350-3.
19. McQueen D, St. John-Smith P, Ikkos G et al. Psychiatric professionalism, multidisciplinary teams and clinical practice. European Psychiatric Review 2009;2:50-6.
20. World Health Organization and World Organization of Family Doctors. Integrating mental health into primary care: a global perspective. Geneva: World Health Organization and World Organization of Family Doctors, 2008.
21. Patel V. The future of psychiatry in low and middle income countries. Psychol Med 2009;39:1759-62.
22. Bhugra D. Psychiatric training in the UK: the next steps. World Psychiatry 2008;7:117-8.

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