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Editorial

The future of academic psychiatry may be social

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Summary
The past 30 years have produced no discoveries leading to major changes in psychiatric practice. The rules regulating research and a dominant neurobiological paradigm may both have stifled creativity. Embracing a social paradigm could generate real progress and, simultaneously, make the profession more attractive.

Declaration of interest
None.

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The current recruitment problems in psychiatry have reopened the question of whether the profession is in crisis and where its future lies.[1,2] A hard, honest look at how we have fared for the past 30 or so years might help us to understand our current predicament and to plan for the future.

Progress

Overall it seems clear that the quality of psychiatric care has improved. Unequivocal evidence for this is hard to obtain as changes over time vary for different patient groups and different localities. However, compared with 1982 there is substantially more overall funding, the built environment and staffing of most in-patient units is very much better, and a range of community-based services have been established. More mental health professionals treat more patients, and many are arguably better trained. More treatments are routinely available, and practice is undoubtedly more consistent. Clinical governance and quality management ensure that clinicians actually do what they are contracted to do. So, overall things have become better, and this applies to practically all high-income countries. Academic psychiatry has contributed rigorous trials of interventions, reviews and meta-analyses consolidating knowledge on interventions summarised in guidelines to inform practice. So far so good.

The role of research discoveries

The steady improvement in clinical services and rolling out of research evidence have given an impression of substantial progress in psychiatry. This impression may have obscured the real rate of recent scientific advances. It can be questioned whether the past 30 years have witnessed any scientific discoveries that have led to major improvements of practice.

The common service models, including day hospitals and community mental health teams, had all been introduced 30 years ago. There have been no new antipsychotics, antidepressants or mood stabilisers that are clearly more effective than the drugs available at that time.[3] All current major psychotherapy schools had already outlined their models including psychodynamic therapies, behavioural therapy, cognitive therapy, solution-focused therapy, client-centred therapy and various forms of family therapies. Randomised controlled trials were firmly established as the gold standard for evaluating treatments, and psychometric principles were in place for the development of assessment instruments.

Progress in fundamental research in subjects adjacent to psychiatry, such as genetics and neuroscience, has been considerable and their applications to practice are regularly presented as imminent. However, as of now, these achievements in fundamental research have led to no obvious breakthrough in better treatments.

Process and paradigms

Why has the enormous volume of increasingly well-funded and high-quality psychiatric research produced so little? Two potential reasons are the rules that regulate research activity and the models that guide its content, in short, process and paradigm.

Process

Increasingly, academic medicine is dominated by rigid rules that define success and failure with short cycles for the evaluation of performance. There is intense pressure to publish in high-impact-factor journals and to be cited by others. This, in combination with the peer-review process of publications and grant applications, leads to a narrowing focus on what is mainstream and in fashion. Consequently, research groups across the world conduct studies in the same areas that will generate funding and impact-factor points here and now.

Such pressure to comply with mainstream expectations and the resulting opportunism and short-term planning may not necessarily provide the best conditions for creativity and innovation. Psychiatry shares this academic environment and funding rules with other medical specialties but the nature of our specialty means that their impact has been more profound.

Dominant paradigm

We must also question whether the right paradigms have been used. Mental disorders have a neurobiological, a psychological and a social dimension. The prevailing paradigm in psychiatric research assumes a hierarchy between these dimensions. It regards neurobiological aspects as the basis of disorders, which are then expressed in psychological symptoms influenced and managed within a social context. Neurobiological findings tend to be taken as the explanations for disorders. Neurobiological processes have been proposed as explanations for how and why interventions work, including psychotherapy.[4]

Adopted enthusiastically by the pharmaceutical industry, this paradigm has resulted in a criteria-based diagnostic system generating an ever increasing number of disorders. These frequently occur as comorbid disorders in the same person at the same time. This approach attempts to disentangle the complex and holistic experience of an individual in their biographical and social context.

Paradigms are neither true nor false, simply more or less useful for generating testable hypotheses and fostering progress. There are good historical reasons for the current paradigm and for operationalised diagnostic systems. But surely the recent lack of progress is reason to pause and consider alternative paradigms rather than simply pressing on with 'more of the same'.

A social perspective

One possible alternative paradigm is a social one. This goes beyond the established impact of poverty, wars, social inequality and unemployment on mental health. We hardly need more research to demonstrate their importance, but ensuring peace, social equality and full employment are political tasks. A social perspective in psychiatry and psychiatric research encompasses the social nature of human life. Mental disorders are defined as constructs in a social debate (which is why they are endlessly controversial). Our definitions reflect a consensus and this has been shifting over time, as with the declassification of homosexuality as a mental disorder in 1973.

Mental disorders are expressed in social interactions. People with mental disorders talk about their experience to someone else or they display behaviour that has to be interpreted in the given social context to be understood as a symptom. Whether someone walking alone and talking loudly in the street is a cause for concern will mainly depend on whether they have a mobile telephone in their hand. Psychiatric research cannot directly observe processes in the mind, and neurobiological phenomena are ultimately meaningless unless they are linked to the real lives of people in their social reality. Observations of behaviour in a social context allow us to conclude what may be going on in the mind and what may possibly be correlated to neurobiological processes.

Finally, mental disorders are diagnosed and treated in interactions with health professionals, whether face to face or using modern communication technologies. They are at the centre of what psychiatrists do and how they apply their professional skills.

Even the hardest sceptic must acknowledge the abundant evidence of the importance of personal relationships in shaping both cause and cure of disorders. Earlier relationship breakdown is implicated in the causal pathway of adult disorders by how it shapes interpersonal trust and the stability of relationships (the 'conveyor belt' of adversity).

Implications

A social paradigm requires research to study what happens between people rather than what is wrong with an individual wholly detached from a social context. This has conceptual and methodological implications. It would not ignore the neurobiological and psychological dimensions of mental disorders, but link them to social phenomena in the patient's life and in treatment. Methodologically, much improved assessment approaches are required in a number of domains. First, to assess how patients live in their various roles, for example as partners, neighbours, friends, professionals, and how psychiatric treatment may have an impact on these. Second, to assess how patients may interact in natural and therapeutic groups, and how these interactions are associated with symptoms expressed in other contexts. Last, to assess how relationships and interactions with mental health professionals and non-professionals may be helpful, reduce distress and bring about positive change. This may lead to a focus on treatment factors that are commonly regarded as non-specific without, in any way, diluting the core medical responsibilities.

This approach challenges the accepted distinction between basic and applied sciences, which assumes that discoveries are first made in basic sciences and then 'translated' into practice. Basic research on mental disorders as social phenomena would have to be conducted in the 'real world'. A fuller appreciation of the social contribution to disorders and their treatment would not only be of theoretical interest but have direct practical implications.

Service models such as the therapeutic community and day care were formulated largely with an understanding of the therapeutic potential of social interaction. These models have been in decline as psychiatry has shifted towards a focus on the individual. At the same time, community care has been established, with services that work in the community, but rarely with the community. Few services actively work at increasing social cohesion and social capital in their community to improve the mental health of local individuals. In an increasingly fragmented society, work with the community would help patients establish and maintain relationships with relatives, friends and wider social networks.

Finally, a focus on the social perspective would emphasise the role of psychiatrists as agents in a social context. As Jaspers wrote in 1913, 'Psychiatrists function primarily as living, comprehending and acting persons'.[5] This requires a focus on skills and not just on knowledge. These skills may be related to, but are not identical with, what is required in conventional psychotherapeutic settings. They include an ability to use personal strengths in communicating with people with different mental disorders and influencing groups. We believe that such a focus in training and practice has a potential to strengthen our identity, give psychiatrists more societal relevance and make psychiatry more attractive as a profession.

Outlook

A tension between a neurobiological and a social model has characterised psychiatry since the establishment of academic psychiatry in the mid-nineteenth century. This tension has been productive and moved psychiatry forward. However, psychiatry may have been at its most attractive as a profession and most productive at times when the social perspective was fully embraced as central to it.

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