

Psychiatry's Future: Biology, Psychology, Legislation, and "The Fierce Urgency of Now"

40 years ago, on 2 April 1979, *Time* magazine published a dramatic cover story titled "psychiatry's depression," arguing that psychiatry was experiencing a life-or-death identity crisis and needed to find new directions in order to survive.^[1] The article documented recruitment difficulties into the profession, a dearth of real knowledge about mental illness, interminable debates about the effectiveness of established psychological therapies, and the emergence of any number of eye-catching pseudo-therapies in the 1960s and 1970s. There was a risqué (and lamentably difficult to forget) photograph of a group of naked people undergoing "rebirthing" at a workshop in California. The *Time* article also noted continued problems with psychiatric hospitals and standards of care but nonetheless concluded that new research in the neurosciences now positioned psychiatry—as ever—on the cusp of a brave new era.

After 20 years, in 1999, Anthony W. Clare, Irish psychiatrist, author and presenter of *In The Psychiatrist's Chair* (BBC Radio 4, 1982–2001), wrote a somewhat similar editorial in the *Journal of Mental Health*, titled "Psychiatry's future: Psychological medicine or biological psychiatry?," touching on many of the same themes.^[2] Clare noted current transitions in psychiatry that were suspiciously similar to those outlined in *Time* two decades earlier and wondered if psychiatry might actually lose its interest in the psychological and social aspects of mental illness and become a kind of reincarnated neuropsychiatry.

If this was the case, Clare was having none of it, as he pointed out that "functional" disorders (e.g., depression) were often treated with physical remedies (e.g., antidepressants, electro-convulsive therapy) and "physical" disorders (e.g., irritable bowel syndrome) were often treated with psychological therapies (e.g., cognitive behavior therapy). The split between psychological and biological aspects of medicine was, he argued, redundant in an era of neuroimaging and molecular genetics, advances in social and psychological psychiatry, and the relocation of psychiatry within general hospitals.

Clare remained worried, however, that, despite apparent advances in understanding and care, both patients and clinicians continued to wrestle with an

apparent distinction between the biological and the psychological. These confusions affected the public understandings of psychiatry and mental illness in a distinctly negative way.

Despite these problems, many of which persist today, Clare advised against an excess of gloom and remained optimistic about the prospects for neuroscience, declaring in 1995 that "there has never been a more exciting or a more demanding time to be in psychiatry."^[3]

But, then, this was *always* considered to be the case in psychiatry. Virtually, every moment in this discipline's history has been heralded as the start of a new era—a recurring rhetorical and cognitive trope of which Clare was only too aware. Indeed, if the history of psychiatry has any consistent theme (and it probably doesn't), it is the idea of therapeutic enthusiasm as new treatments are introduced with great excitement and then discarded in a sorry mix of tragedy and embarrassment (e.g., malaria therapy, insulin coma, lobotomy) and new fields of research emerge with great promise only to disappoint sharply or gradually transform into historical curiosities (e.g., phrenology).^[4]

Nowhere is this endless cycle more apparent than in the field of biological research into the apparent causes of mental illness. In 1982, two of the world's leading and genuinely impressive psychosis researchers, Irving Gottesman and Daniel Hanson, described schizophrenia as an epigenetic puzzle and confidently predicted that it would be solved undoubtedly before the twentieth century ended.^[5] There followed several decades of intensive and costly research into schizophrenia that yielded enormous amounts of scientific data but failed to uncover the definitive causes of the disorder and delivered virtually no demonstrable benefits for patients.

The turn-of-the-century deadline set by Gottesman and Hanson whistled past, and even today, almost two decades later, enormous genetics datasets (using data from over one million people) can identify no substantial genetic difference between schizophrenia, bipolar disorder, major depressive disorder, and attention-deficit hyperactivity disorder.^[6] Interesting but old ideas, such as inflammation-causing



mental illness, are once again being presented as radical and new, and neuroimaging, despite vast numbers of eye-popping costly studies, remains essentially a research tool contributing virtually nothing to clinical psychiatry.^[7]

Notwithstanding these disappointments and this circularity, of course, all of these research areas certainly hold significant promise for the future, but they are neither radical nor new, and they have conspicuously failed to deliver for patients to date. Most depressingly of all, even critics of psychiatry find themselves falling back on extremely tired arguments and highly selected evidence in an effort to present old criticisms as new and unexpected—and then propose arbitrary and seemingly random solutions that are backed by even less systematic evidence than the mainstream practices they purport to criticize.

All of this activity, rhetoric, and clamor are accompanied and possibly underpinned by increasing acceptance that the old questions, upon which much psychiatric research is based (e.g., “What is the cause of schizophrenia?”), were the wrong questions, to begin with. And if, as might be argued, this long-overdue reconsideration of key research questions and the final, welcome deconstruction of the concept of “schizophrenia,” in particular,^[8] reflects the legitimate intellectual evolution of this field, then it reflects an evolution that is too slow, too unwieldy, too costly, and too uncertain of itself to instill much confidence about the future. It also commands considerable opportunity cost in terms of research funds, researchers’ time, and contributions by patients, families, and carers to research from which they personally will almost certainly never benefit.

The irony is that while research into the biology of mental illness remains severely lacking in coherence and

coordination, there are—against all the scientific odds—treatments that work, including biological treatments: Antidepressants are convincingly better than placebo^[9]; psychiatric medications, in general, are no less efficacious than their counterparts in general medicine and, in fact, treatment with an antidepressant is more effective in reducing relapse of depression (relative risk reduction: 58%) than aspirin is in reducing serious cardiovascular events (19%)^[10]; there is ever-growing enthusiasm (and some evidence) for psychological therapies such as cognitive behavior therapy in multiple psychiatric conditions, and antipsychotics not only alleviate symptoms of psychosis but also actually reduce the risk of early death in schizophrenia.^[11] So, while we do not understand the biological underpinnings of most mental illnesses, we still have treatments that help substantially and can even prolong life.

So, what next for psychiatry? 40 years on from *Time’s* sobering analysis of psychiatry’s existential crisis and 20 years after Clare’s comments about psychiatry’s future (at least he believed it had one), what is the future of psychiatry today? Are we—as usual—on the brink of a brave new era of marvelous scientific advances that will rescue us from our terminal *ennui*, or is it time to call time on psychiatry’s recurrent (and occasionally desperate) infatuation with shiny objects?

In the first instance, it is important not to throw the baby out with the bathwater because fields such as psychiatric genetics, neuroimaging, and studies of inflammation hold genuine promise for the future. But that future is ever-receding, and the principle of research justice requires that patients, families, and carers who contribute to research today should have at least the prospect of some benefit for their time and contribution. The ostensibly reasonable promise that their involvement will benefit others at some distant future date is starting to wear thin, especially if psychiatry continues to cling doggedly to unpromising research paradigms that are well past their sell-by dates. As a result, while research in psychiatric genetics, neuroimaging, inflammation, and so forth should certainly continue, it should be commissioned and conducted with a heightened awareness that sometimes there is no baby in the bathwater—only suds and bubbles. It is, perhaps, time to rebalance.

Objective, critical thought is vital. Too often, small sample sizes undermine the reliability of much-touted neuroscientific findings.^[12] Selective outcome reporting and selective analysis of neuroimaging studies are particular issues: All that glitters is not gold, even in the utopian other-world of brain imaging.^[13] Mindless forms of neuroscience often command a seductive appeal that they do not merit, especially when colored

images of “brain scans” accompany press releases and media reports about underpowered studies, fuelling a public discourse about neuroscience and psychiatry that is as bereft of truth as it is rich in rhetoric, and that does essentially nothing except instill false hope in people with mental illness, psychological problems, and various other forms of distress.^[14]

The disappointing facts are that the treatment of, for example, schizophrenia remains in many ways the same today as when Clare wrote his paper in 1999; there has been virtually no neuroscientific advance with a significant impact on day-to-day mental health care since before the *Time* article in 1979; and, if anything, the over-zealous closure of psychiatric hospitals over the intervening decades has seen the experiences of many people with schizophrenia increasingly resemble those of their counterparts in the early 1800s, before the asylums were built, with increased rates of homelessness, imprisonment, and early death: Even today, men with schizophrenia die 15 years earlier, and women 12 years earlier, than the general population.^[4,11] Antipsychotic treatment can reduce this elevated mortality, but, as the World Health Organization (WHO) points out, most of the people affected by mental, neurological, and substance use disorders—75% in many low-income countries—simply cannot access the treatment they need.^[15]

And this, undoubtedly, is the key clinical, bioethical, political, and existential issue that psychiatry faces today: Gross and deadly inequity of access to effective care. How psychiatry responds to this situation should and will be the greatest single factor shaping psychiatry's future.

The current state of biological research suggests that solutions to this dilemma will not be forthcoming from that quarter any time soon, although they will likely appear in the future with better, cheaper, more scalable, or more targeted treatments or improved overall treatment paradigms. For now, however, solutions for today's patients and their families are far more likely to lie in the realms of mental health service delivery, law, and politics.

In this light, the most interesting development for the mentally ill for several decades occurred on 29 May 2018 when the Indian Mental Healthcare Act, 2017, was commenced.^[16] The Indian legislation is highly innovative in that it provides a justiciable, legally binding right to mental health care to over 1.3 billion people, one-sixth of the planet's population.^[17] More specifically, the Act states that “every person shall have a right to access mental health care and treatment from mental health services run or funded by the

appropriate Government” (Section 18(1)). This is a highly ambitious provision by any standards.

While Indian mental health services, like those in many other countries, are substantially under-resourced and this commitment to a “right” to mental healthcare would present an enormous challenge in any jurisdiction, the Indian initiative is nonetheless a bold and exciting one, clearly reflecting the “vital role” that the WHO accords to law in advancing the “right to health.”^[18] It is, of course, impossible to know at this early stage precisely to what extent the Indian legislation will achieve its aims or even whether it might have some paradoxical negative effects, but the new legislation is, at least, an innovative and imaginative development in a field that is largely bereft of them, and it points to an important new direction for the future of psychiatry: The assertive use of law to improve clinical care.^[19]

Most of all, the new Indian legislation, through its focus on *today's* patients, reflects what American civil rights leader Martin Luther King called “the fierce urgency of *now*,”^[20] balancing the future prospects offered by biological research with an assertive focus on the patients of *today*, as opposed to the patients of some ever-receding future that is full of eternal promise, eternally unfulfilled.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

Brendan D. Kelly

Department of Psychiatry, Trinity College Dublin, Trinity Centre for Health Sciences, Tallaght University Hospital, Tallaght, Dublin, Ireland

Address for correspondence: Prof. Brendan D. Kelly
Department of Psychiatry, Trinity College Dublin, Trinity Centre for Health Sciences, Tallaght University Hospital, Dublin - D24 NR0A, Ireland.
E-mail: brendan.kelly@tcd.ie

Submitted: 21-Nov-2019

Accepted: 15-Jan-2020


Published: 09-Mar-2020

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Access this article online	
Website: www.ijpm.info	Quick Response Code 
DOI: 10.4103/IJPSYM.IJPSYM_492_19	

How to cite this article: Kelly BD. Psychiatry's future: Biology, psychology, legislation, and "The fierce urgency of Now". *Indian J Psychol Med* 2020;42:189-92.