What is the heartland of psychiatry?

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Summary  Psychiatry has long identified schizophrenia as its defining disorder, its heartland as it has been called. In the past 20 years, this has had a number of negative consequences for psychiatry as a medical specialty, which result from the uncertainty of diagnosis and an increasing emphasis on demedicalising services in an attempt to provide social care outside hospital. These changes have probably increased the stigma attached to psychiatric practice and threaten to deskil doctors. They have also meant that services for other disorders do not meet the needs of patients. To continue to allow schizophrenia to be the paradigm condition is against the interests of psychiatrists and their patients.

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About 20 years ago, it was a commonplace to refer to schizophrenia as the heartland of psychiatry (see Bebbington & McGuffin, 1988). The reason for this curious use of an emotive reference to territory seemed rather odd, but not terribly important, because it was in many ways an exciting time to do research in psychiatry or have a scientific interest in its progress and understanding. Unfortunately, the identification of schizophrenia in this way has had largely negative consequences for the practice of psychiatry as a distinctive medical specialty, the full effects of which are only fully being felt now.

WHY SCHIZOPHRENIA?

Why was schizophrenia so important to the generation that looked to Aubrey Lewis, John Wing, Bob Kendell and others for leadership? It had a lot to do with diagnosis, and perhaps with beds. Schizophrenia’s rich phenomenology and arcane foreign language literature made its diagnosis seem difficult and interesting. Moreover, making the diagnosis of schizophrenia came to seem very important because psychotherapists had indulged in an almost unlimited extension of the ‘schizophrenia’ concept in 1950s’ America, to include most neurotic problems. The US–UK collaborative diagnostic project probably marked the highpoint of confidence and international influence of British psychiatry (Kendell et al, 1971); its focus effectively defined what psychiatry was. It established that psychiatrists could reliably play by operational rules in making a diagnosis and led directly to the DSM and ICD classifications. Furthermore, schizophrenia was restored as a core disorder that trumped other diagnoses in a notional hierarchy of importance. This was fundamental. The prevailing view was that schizophrenia could be reliably recognised on the basis of symptoms such as thought insertion. Thought insertion was taken to have the property that Jaspers required of a true delusion: it can be traced back to an ‘irreducible and non-understandable experience’ (Wing, 1978). It is not an extreme experience of a normal kind. When dominated by such phenomena, a mental state is thus qualitatively different from the normal. Finally, despite appearances to the contrary (comorbid anxiety, depression, mood elevation and cognitive impairment were commonly present), schizophrenia was held to be a unitary diagnosis. Just how unreasonable this was, and remains, seems still to be poorly appreciated.

The first and most obvious problem was that an emphasis on diagnosis delivered psychiatrists into very uncomfortable arguments about the status of schizophrenia. To suppose a qualitatively abnormal mental state is, first, foremost and inevitably, stigmatising. It echoes the sane/insane legal distinction and to this day many psychiatrists are reluctant to tell their patients that their diagnosis is schizophrenia. Second, it throws up a boundary problem: however confident one may be about its more severe forms, schizophrenia has rather friable edges, and the diagnosis at its most friable too often hinges on what people say they do and do not believe, and might or might not do on the basis of such belief. A clinical diagnosis of schizophrenia could, when based on partial delusions alone, be a social construct and the antipsychiatry argument, in all its pompous certainty, proceeds from that. Finally, patients frequently disagree with the psychiatrist’s interpretation of their mental state, and may have to be detained against their will. Historically, English psychiatrists have probably been too enamished in the workings of the Mental Health Act and their diagnosis has been too central in deciding detention of patients with schizophrenia. This is rarely the best basis for a positive therapeutic alliance. So, by clinging to schizophrenia as a heartland, psychiatrists have helped define and strengthen the negative view others have, both of psychiatry and of themselves.

Then there was the matter of beds. The system of large asylums may have originally been a humane innovation, but by the 1960s it had come to be an increasing cause for scandal. The institutions mirrored the chronicity of schizophrenia and seemed to amplify rather than correct the disabilities in everyday living that so many sufferers experience. Far too many patients languished in long-stay beds with minimal dignity and very little medical attention. However, the reaffirmation of the status of schizophrenia seemed to impede rather than facilitate the creation of really new services, as radicals of the time such as William Sargant had argued were needed in general hospitals to treat affective disorder (see Sargant, 1967). Possession of beds was also a perverse measure of a doctor’s individual power within the existing administrative structure, and the mentality of many psychiatrists was undesirably too hospital orientated. So, although the possession of some in-patient beds for acute treatment or respite remained and remains essential for good care, there was a failure...
to distinguish between this need and the
cushion of longer-stay facilities.

MODERNITY: SCHIZOPHRENIA PLUS
SOCIOLGY

The shape of the ‘modern’ psychiatric ser-
vice has, therefore, been defined as much
by what it was against, as by what it was
for. As a corrective to the hospital-based
 treatment of schizophrenia, there had to be
a transfer of resources away from in-patient
services. Although this was reasonable
in the age of the physically remote
asylum, it has continued well after long-
stay beds have disappeared, with pre-
dictably dire consequences for the quality
of acute in-patient care. Moreover, avoid-
ing hospital admission irrespective of illness
outcome has, almost unthinkingly, become
an objective for psychiatric services – and
highly inappropriate if the patient actually
needs hospital care.

Just as beds defined what was to be
avoided, so the emphasis on diagnosis has
acquired an unwanted flavour. The prob-
lems that patients with schizophrenia face
were reformulated as ‘social’. So what the
patients need is ‘social care’; this remains
the Department of Health’s ‘big idea’ for
the future of psychiatry and the socio-
logically correct answers were formulated
in the National Service Framework for
Mental Health (Department of Health,
1999). This formalised and extended in a
surprisingly concrete way the services re-
quired for severe mental illness in England.
Psychiatrists were notable only by their
exclusion from the process whereby the
Framework was developed. Bipolar
disorder was not mentioned at all, and the
National Service Framework, largely un-
modified, remains the dogmatic top-down
blueprint against which targets managers
continue to measure themselves today.

The idea that there might be specific condi-
tions that require specific effective treat-
ments obviously echoes in a ghostly way
through proliferating guidance from the
National Institute for Health and Clinical
Excellence (NICE), but something is lost
in translation to the block contract of
psychiatric care. The policy guarantees only
a mass of non-specific caring measures for
people whose severity of ‘mental health
problem’ is largely measured by their
disinclination to engage with the services
provided.

AN ALTERNATIVE PERSPECTIVE

Might things have been different? Bipolar
disorder was usually misdiagnosed as
schizophrenia before it was also rescued
from the diagnostic shambles by the US–UK
collaborative diagnostic project. What
if it had been the dominant paradigm –
the heartland condition? Bipolar disorder
is no less debilitating, on comparable mea-
sures of morbidity and mortality, than
schizophrenia (Clement et al, 2003) and is
much more common. Moreover, in almost
every respect it would have afforded psy-
chiatry a model within which the medical
role is easier to define. The development
of this model could have informed psychi-
atric services in general with a greater
balance between medical, psychological
and social care.

First, the diagnosis of bipolar I disorder
characterised by mania is largely uncontro-
versial because it is based on observable
and obvious changes in behaviour. At least,
we have yet to hear anyone claim that
mania does not exist. Second, bipolar
disorder is, exactly like schizophrenia, a
complex phenotype that can include virt-
ually all the key phenomenological entities
we recognise in psychiatry – depression,
mania, psychosis, anxiety, substance mis-
use, cognitive impairment, neuroendocrine
abnormality, sleep disturbance and distinc-
tively variable illness course. The difference
is that we do not pretend otherwise, and the
fact that these apparently independent di-
mensions cluster within the single diagnosis
of bipolar disorder is accepted as very
challenging. Does it mean that the dimen-
sions are themselves related to each other
and severity in one will entail severity in
the other – perhaps because of common
developmental variations in biology or the
cumulative effects of illness? Or are cases
of bipolar disorder simply represented by
those people who sit on the wrong end of
these multiple domains, all of which can
behave relatively independently? Can diag-
nosis usefully continue to be categorical
without measuring the dimensions that
characterise the disease? These are inter-
esting questions that could also reasonably
be asked of schizophrenia, but seldom are.
Finally, we are not embarrassed to tell
patients they have bipolar disorder. They
are often grateful to have a diagnosis that
explains more than it obscures.

There are other contrasts with the
schizophrenia model which are equally
important to clinical practice. The course
of illness in bipolar disorder allows a much
more meaningful distinction between the
needs of patients for sympathetic in-patient
respite care when acutely ill and for out-
patient-based interventions when compara-
tively well. The treatment of bipolar disorder
is also much less amenable to one-size-fits-all
social care, which, like most such provision
for dependent groups, tends with time and
inattention more to reflect the needs of staff
than patients: staff become rather more
willing to assess patients’ needs than to
try and satisfy them. Bipolar disorder is
more likely to challenge clinicians to under-
stand the illness and its treatment in relation
to individual and autonomous patients.

Finally, treatment of bipolar disorder
demonstrably requires the medical expertise
which we should take a pride in. The med-
ications that we have available seem often
to require use in combination, which prob-
ably reflects the complexity of the pheno-
type. Therefore, prescribing for patients
with bipolar disorder requires knowledge,
skill and experience. We make a distinction
between acute and long-term medication
and seek active involvement by patients in
managing acute exacerbations of symp-
toms. Psychological treatments comple-
ment the medical approach, and enhanced
care is an objective for all patients
(Goodwin, 2003). Psychological interven-
tions can reduce the risk of relapse when
added to treatment as usual, and have a
pragmatic emphasis on self-monitoring,
self-management and education about the
illness. Moreover, the indication for the
content and the timing of treatment is being
rationally defined and refined in controlled
trials (Vieta & Colom, 2004). The confu-
sion around whether cognitive–behavioural
therapy (CBT) is really useful for schizo-
phrenia is telling (Turkington & McKenna,
2003; Durham et al, 2005). Moreover,
although being adopted by NICE, as one
might say, for the nation, the relevance of
CBT for psychosis has been wildly ampli-
fied at grass roots level in a way that could
never have occurred for bipolar disorder –
common sense would prevail when the
greatest therapeutic optimist met their first
patient with florid mania.

DO PSYCHIATRISTS
HAVE A FUTURE
AS MEDICAL SPECIALISTS?

These differences illustrate what can occur in
psychiatry when modern medical treatments
are allowed to develop unhampered by ideology, compared with what happens when they are not. The social model of schizophrenia was the minority, left-wing, ‘show biz’ cause of the 1960s, a formative time for our middle-aged policy makers, who have their own curious heartlands. Its current dominance is neither measured, nor moderate. It essentially totalitarian spirit has even required a new language – an Orwellian ‘newspeak’ where no one must be said to have an illness, comply with treatment or be a patient. The only possible surprise is that the use of the word schizophrenia has not yet been banned from the National Health Service.

Other losses have been more subtle. Can it be sensible to invest a tenth of what we do on schizophrenia on research in bipolar disorder (Neurosciences and Mental Health Board Strategy and Portfolio Overview Group, 2005)? Why do so many junior doctors leave psychiatry because of the role it currently offers them (Lambert et al, 2006)? Most doctors may feel marginalised by managers with regard to resource allocation: psychiatry appears to us unusual in the extent to which managers literally think they know how we should do our jobs. Doctors have a training that brings scientific rigour to what they observe and how they treat. As doctors we also have a broader base in general medicine than most other disciplines involved in psychiatry. A good doctor must be able to make a difference to an individual patient. However, our assumptions and allegiances – our heartland – must be fruitful, not a barren wilderness of good intentions.

We could still develop a more interesting role for doctors in psychiatry because there are effective evidence-based treatments for a wide range of specific conditions, not just bipolar disorder. We happen to know bipolar disorder best and we have been appalled by the difficulties faced by people with bipolar disorder in the current model of secondary services. However, little seems likely to change if schizophrenia continues to occupy such a central and distorting position in our thinking. Why should one condition continue to be so dominant? In general medicine, it would seem ludicrous if the decision was made by the Department of Health to restructure all care around the model of diabetes. To continue to make schizophrenia the paradigm condition in psychiatry is against the interests of psychiatrists and, more importantly, of our patients.

REFERENCES


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References
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