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シンポジウム

Hoped Horizon of Psychiatry

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Chairpersons Sir and dear friends, first of all I would like to convey my thanks to the Japanese Society of Psychiatry and Neurology and Japanese Young Psychiatrist's Organization for inviting us to this symposium. I would also like to thank the organizers for their hospitality and making our stay comfortable. With the permission of chair, may I start my presentation?

When we talk about the future, there is a need to look in the past and analyze the present. The future stems from the present and present is based upon the past achievements. So we will make an attempt to see and analyze what we have achieved so far; right from the inception of psychiatry as a medical branch.

The history of modern psychiatry dates back to emergence of great thinkers like Sigmand Freud, Jean Piaget etc. They all were medical persons (physicians), but at the same time they were very keen observers and analysts of behavior. Their observations resulted in development of various theories to explain human behavior. No doubt that the theories proposed by them were purely psychological, but still, even after nearly hundred years they are useful guides in therapeutic management of many psychiatric disorders. However, these theories were very fluid and they were antagonistic at a number of points owing to absence of any objective evidence and variability in the behavior. Then a number of so called objective tests were developed to analyze the human behavior e.g., Thematic Apperception Test, Inkblot test etc. No matter how rigourously the assessment criteria were laid for them, still these tests were not free of fallacies and many a times provided conflicting responses in the subjects with same category of symptoms.

With these techniques in hand, psychiatrists started their practice. The patient was provided with a couch during free association and psychotherapies and soon it had almost become an emblem for the psychiatrists. During that time, psychiatrists used to spend long hours with their patients on these couches, listening to their patients and trying to disentangle their patient's unconscious wishes. The couches were not only the place for the diagnosis, but also for the management of illnesses. The whole process was divided into a number of sessions spanning over months.

While the couches were the place for the "neurotic" or non-violent patients, psychotic patients were detained in the asylums to protect the society. Along with the detention, such patients were subjected to the electroconvulsive therapy become effective medicines were not available at that time. This had given psychiatrists a new name, the shock doctor. Even

though it was an effective treatment, yet it appeared brutal as the modified ECT was not available and patient used to convulse for a very long time. This had contributed a lot to the stigmatization of psychiatry, the psychiatrists and even psychiatric patients.

Finally, in 1952 a molecule was introduced in the market. Chlorpromazine which appeared very effective in management of violent patients and psychiatry for the first time tried to portray itself similar to any other medical branch. This was a turning point in the history of psychiatry, where the focus was shifted from the psychological basis of illnesses to the neurotransmitters. The biological, and more precise to say, neurobiological studies started to solve the mystery of neurotransmitters implicated in psychiatric illnesses. As our understanding for neurotransmitters improved and by serendipity too, a plethora of new pharmacological molecules were introduced in the market. If memory serves me right approximately forty new molecules appeared in the market in the past ten years. These drugs were claimed to be more selective, more effective and had lesser side effects than their predecessors. Therefore, the psychiatric illnesses could be controlled in a better manner ; their prognosis improved and the development so far helped in de-stigmatization of psychiatry.

But wait a minute, stop and think, is the picture that we are seeing real or is it just a mirage ? Have we really succeeded in establishing the psychiatry as a truly medical branch ? Well, if you ask for my opinion, I don't think we are. Psychiatry is still stigmatized and a number of people criticize the existence of psychiatry as a medical branch. Dr Thomas Szaz, who himself is a professor in psychiatry, had argued a lot against psychiatry. This happened despite the fact that use of newer psychotropic drug resulted in better control of symptoms, produced lesser adverse effects, and the number of wandering lunatics decreased, and that they decreased the burden onto asylums and improved quality of life of patients and their caregivers.

I think, as psychiatrists, we must work for the wholesome improvement of psychiatry, that includes academic, clinical, social development as well as progress in the field of research. This is a difficult but achievable task, provided we try to understand the reasons for stigma, accept the facts and work hard to change the picture. In my opinion, a number of different factors associated with psychiatric illnesses contribute to their stigmatization. These include- (i) nature of symptoms which are purely behavioral ; (ii) diagnostic techniques applied which is unfortunately purely phenomenological ; (iii) in a good number of cases, permanent cure is not available ; (iv) existence of lunacy acts or mental health acts in many countries ; (v) failure to develop sub-specialties ; (vi) derogatory media portrayal of psychiatric patients and psychiatrists and lastly, (vii) issues related to research. Now we will discuss each of these issues one by one.

No doubt, symptoms are primarily behavioral in psychiatric illnesses, but these are not the only illnesses which manifest as change in behavior. If we look impartially, almost all medical illnesses produce behavioral symptoms, and a number of so called "medical disorder" produce only behavioral symptoms- e.g., delirium, Alzheimer's dementia, Dementia with Lewy Bodies, Irritable Bowel Syndrome, Nutcracker esophagus etc. Besides these illnesses, all painful conditions induce a change in behavior. However, contrary to the other medical

illnesses, psychiatric illnesses usually affect caregivers more as compared to sufferers. In addition, many of the psychiatric illnesses run relapsing-remitting or chronic course, which in turn increases the burden on the caregivers. This is an important reason for the stigmatization of psychiatric illnesses.

Another reason, which I feel plays a part in stigmatization is phenomenological nature of the diagnosis of illnesses. This usually gives a feeling to the medical fraternity and to the patients and their caregivers that nothing is wrong with the body. A number of other medical illnesses e.g., Parkinson's Disease, Dementia, Epilepsy, Angina, Asthma, Appendicitis, Fibromyalgia, Chronic fatigue syndrome etc are diagnosed based upon clinical picture only and laboratory investigations rarely demonstrate any pathology, even than physicians investigate the disorders and earn the patient's faith that illness is purely physical. On the other hand, we psychiatrists usually refrain from ordering the laboratory investigations, and this gives a feeling that illness is psychological rather than neurobiological.

To make the situation worse, the diagnostic criteria keeps on changing with every new edition of ICD-10 or DSM-IV, without any contribution from neurobiological studies, resulting in a doubt towards the existence of psychiatric illnesses. This culminates in a situation where in one edition of diagnostic criteria a given person is placed in the diseased category and subsequent edition may refer same behavior as "normal". This fluidity in diagnosis poses the difficulty in providing a concrete ground to psychiatric illnesses. Although, the diagnostic criteria for many non-psychiatric illnesses also keep on changing with time, the changes are usually supported by objective evidences, and anything that is once declared as pathological is rarely reclassified as normal condition/variant.

Thirdly, for a number of psychiatric illnesses, permanent cure is not possible even with the rigorous efforts. This is owing to our poor understanding in the pathophysiology of psychiatric illnesses and to the fact that environmental factors especially the behavior of surrounding people play an important role in deciding the course of illness. It is sometimes easy to make the patient learn to change their dysfunctional behavior, but it is often a Herculean task to request the surrounding persons/caregivers to change their behavior in favor of patient. This raises a question; is behavioral change unique to psychiatric illness? Well, my answer is "No". Akin to psychiatric disorders a number of different medical problems require change in behavior, e.g., diabetic patients are supposed to increase physical work and have to refrain themselves from sweets; cardiac patients have to improve physical working and lessen their fat intake and so on! The list may be endless! However, in these illnesses, behavioral change is required at a gross level and usually in form of habit-change, without any need to change the perception and expression of emotions. In addition, these illnesses do not require behavioral change of the surrounding persons, making it easy to control the condition.

Another concern is the chronic or relapsing remitting course of psychiatric illnesses. For this, there is a need to educate the people that many of the prevalent medical illnesses run a relapsing-remitting or chronic course viz., osteoarthritis, hypertension, coronary artery disease, Parkinson's Disease, CVA, diabetes, hypothyroidism to name a few. Now let us

think, what can we do to reduce the chronicity in psychiatry? We, the psychiatrists must understand that symptom remission is not the goal of treatment. Rather, the aim is to bring out a permanent change in behavior to prevent relapses. However, such change cannot be achieved by pharmacotherapy only and psychotherapy plays an important role in these circumstances. Psychotherapies are time consuming but they have a definite biological basis and work on learning principle. A number of functional neuroimaging studies have shown that psychotherapies change the functional network in brain. Therefore, I advocate use of these techniques during the treatment.

There is also a need to spend more energy in exploring the objective diagnostic techniques and develop new therapeutic technique which can replace the stigmatizing previous therapeutic options like physical restrain and electro-convulsive therapy. In the past ten years, a number of articles proposed the gene therapy for psychiatric disorders, although it is yet in infantile stage. Similarly, trans-cranial magnetic stimulation is now under investigation for a number of psychiatric disorders, and with such progress, future appears bright.

Fourthly, I feel that lunacy acts or mental health acts have done harm rather than protecting rights of psychiatric patients. A plethora of news reports confirm that these acts are often used to ruin the psychiatric patients from exercising their rights. Consider a hypothetical situation: a male of around 50 years is brought to the emergency room of a psychiatric hospital for behaving abnormally and committing violent acts for ten days by his relatives. The man is tied with the ropes and he is abusing his relatives, pleads that he is not insane and trying to hit them for bringing him there. He also says that relatives are against him and wants to snatch his property. In such condition, how do we decide whether the person is sane or not? Should we give him antipsychotics/sedatives to control his motor activity? Should we label him with any psychiatric diagnosis? And above all, should we admit/detain him in the hospital even for the observation? Remember, admission for even few hours can be used as plea against him in the court of law by his relatives to get rid of him. In such a case, he would lose his share from his property and other assets. This is just one example how these acts can be misused.

In my opinion, subjects with HIV infection or open pulmonary tuberculosis or hepatitis B infection are more dangerous to the society than a violent psychiatric patient as many of them do not have overt symptoms and yet they are infectious. Such a spread of infection may be at times life threatening. Likewise, can we prevent the smoking and alcoholism by any act? Many countries have forbidden smoking at public places, but it is a well known fact that smokers keep on releasing the carcinogens even hours after their last smoke, known as passive smoking. Similarly, drunken drivers him a number of people every year. Despite such a huge problem, there is no law to control their movement in the society and to bind them for adequate treatment. I feel this is the right time to reconsider importance and need of mental health acts in the management of psychiatric patients which provide power to the mental health workers to detain the psychiatric patients against their will in certain circumstances.

Fifthly, I feel that we ourselves are also responsible for the stigmatization. We do not talk about the neurobiological or medical basis

of psychiatric illnesses and often there is a gross discrepancy in explanation of illness and its treatment. Many of us explain the pathogenesis based on (abandoned) psychological theories or talk non-specifically about the change in neurotransmitters in brain as the cause of psychiatric illness. When it comes to treatment, we often prescribe pills and do not use non-pharmacological management. This creates a doubt in the patient's and care-giver's mind regarding psychiatric illnesses and stigmatize. Despite so much progress most of the psychiatrists feel more comfortable with Schizophrenia, Mood disorders or substance abuse patients. A number of psychiatrists are not efficient in dealing with dementia, delirium, neuropsychiatric illnesses, sleep disorders, primary headaches, eating disorders and neuro-developmental disorders. Same is the case with sub-specialties like child psychiatry, geriatric psychiatry, neuropsychiatry, CL psychiatry etc.

Next, the media is also responsible for stigmatization. Media portrays a negative or derogatory image of psychiatric patients and even of psychiatrists. Patients are often posed violent, destructive and psychiatrists as jokers. There is a strong need for invoking the sense of responsibility in the media persons so that they work towards de-stigmatization. Lastly, as I have already discussed there is a need to increase the research, particularly neuro-biological research in developing countries. An article published in British Journal of Psychiatry by Saxena throws more light on this issue and discusses the 10/90 divide in the field of research. The article categorically mentions the need of more research in developing countries as they (we) contribute approximately 10% to total research despite catering more than 90% of world population. Moreover, a number of articles consider the pharmaco-genomics and suggest that pharmacological research data from developed countries cannot be applied to other countries.

In the end, I would like to state that psychiatry as a specialty has bright future and will be of utmost importance, providing we try to remove stigma attached with it, work hard on new frontiers and develop the sub-specialties.