Professional relationships and the crisis in psychiatry

Phil Thomas

THE PROFESSION of psychiatry is facing a crisis; one that originates from within. It is reflected by the pharmaceutical industry's disinvestment from new drug development in psychiatry. The prominent psychopharmacologist Christian Fibiger recently wrote '...a massive experiment has failed: despite decades of research and billions of dollars invested, not a single mechanistically novel drug has reached the psychiatric market in more than 30 years (Fibiger, 2012, p.6). Coincidentally, Peter Tyrer, then editor of the *British Journal of Psychiatry*, wrote of '...the end of the psychopharmacological revolution...' (Tyrer, 2012, p.168). This is evidence of a crisis at the scientific heart of psychiatry, related in part to its failure to validate a single psychiatric diagnosis, and to develop effective drug or physical treatments based in scientific knowledge.

In this paper I want to examine how some within the profession have interpreted this crisis through recent special articles published in the *British Journal of Psychiatry*. Their responses are probably not typical of the majority of psychiatrists, but two of these papers represent a powerful and influential body of academic thought within the profession. They promise future insights into psychosis through neuroscience and molecular genetics; a promise they use to justify continuing medical dominance in mental health practice. The promise upon which this justification is based is hollow, given the repeated failure of biological science to validate psychiatric diagnoses. There are good reasons to believe that, in future, neuroscience and molecular genetics will fare no better.

The crisis as a threat to medical authority

Craddock et al. (2008) suggest that psychiatry faces a crisis of authority brought about by a 'downgrading' of core elements of medical care in psychiatry, particularly the belief that the profession offers specific treatments based in diagnosis. They identify a number of factors important in understanding how this happened. These include a broadening of the concept of 'mental illness', which undermines the priority of serious mental illness for those responsible for commissioning mental health services; scepticism within the profession towards the value of scientific studies of mental illness; and interprofessional rivalries between psychiatrists and other professional groups in mental health. They claim that patients have a right to expect more than 'non-specific psychosocial support'. At some future point, advances in molecular genetics and neuroscience will yield new targeted biological treatments for psychosis (Craddocket al., 2008; Bullmore et al., 2009).

...an attack on medical leadership in multidisciplinary teamwork...

Changing interprofessional relationships between psychiatrists and other mental health professionals are a particular threat. For example, Craddock et al. (2008) see *New Ways of Working*, the programme of work undertaken jointly by the Royal College of Psychiatrists and the Department of Health (Department of Health, 2005) as an attack on medical leadership in multidisciplinary teamwork. The traditional relationship between general practitioner (GP) and hospital specialist was based historically in the right of the GP to refer patients to hospital specialists of her or his choice, who then assumed responsibility for the patient's care. The distributed model of care supported by *New Ways of Work-*