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Editorial

Rebalancing academic psychiatry: why it needs to happen – and soon†

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Summary
Academic psychiatry is in trouble, becoming the narrowest of biological research approaches of decreasing relevance to clinical practice and global health. What is required is a rebalancing of the psychiatric academy to include greater support for researchers conducting social, clinical and community studies within a broad, more humanistic biosocial framework.

Declaration of interest
None.

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There is a distortion in academic psychiatry. It seems that a younger generation of psychiatrists is more willing than their senior colleagues to join the chorus of critics outside and inside the broader mental health field to name it and offer a correction. Academic psychiatry has become more or less irrelevant to clinical practice and to the major developments in the mental health field. After decades of investment in biological psychiatric research, there are many intriguing and potentially significant findings, yet still not a single biological test that can be routinely used in the clinic to determine whether someone has a particular mental disorder. Brain science has advanced impressively for neurological conditions, and for our general knowledge of how the brain works, but it has not determined what causes schizophrenia, depressive disorder or anxiety diseases. For all the efforts going into neuroimaging, genetic research, neurophysiology and cognitive neuroscience, which have contributed importantly to our understanding of the brain, we still do not understand the pathophysiology of these mental illnesses or of other psychiatric conditions, from eating disorders to autism.

This should count as an extraordinary failure – one that is apprehended by the pharmaceutical industry, which is clearly moving away from mental disorders to treatment for neurodegenerative diseases and other seemingly more tractable problems. And yet academic psychiatry and the funders of research still proceed as if the great breakthrough is just around the corner. Perhaps the senior generation of researchers has simply become far too comfortable with the financial and media support it has enjoyed over the years. Entrapped by the unlikely prospect of an imminent breakthrough, and the alluring publicity of the latest candidate finding, no matter how shaky, they and the media continue to make immodest claims of causality, inured it seems to the sad embarrassment of having to resort to the difficult-to-say-with-a-straight-face chestnut, 'It's all terribly complicated'. Surely, the lesson to be learnt is that biological psychiatry research is necessary but insufficient for a robust academic psychiatry oriented to understanding and treating serious mental illness. Psychosocial, cultural, clinical, health services and policy studies are just as essential as biology in addressing problems that are also social, moral and economic in their genesis and alleviation.

The cascading evidence from treatment outcome studies is that the effects of standard psychopharmacological medications, now many years old, seem less and less impressive. It is perplexing, therefore, how little interest the psychiatric academy seems to show in researching caregiving, psychotherapy, clinical work and community treatment systems or in the study of mental health policy and programme development more generally. Perhaps this is not all that surprising, inasmuch as entire generations of psychiatrists committed to psychosocial research have been lost through marginalisation and inadequate support. Academic psychiatry has painted itself into the narrowest corner, with limited relevance and an intellectual agenda that lacks excitement outside its small purview. It has failed to attract students and the broad intellectual interest that the field once held. It has lost sight of the human faces and social crucibles of mental illness. It has hollowed out psychiatric research's spirit and humanity. Academic psychiatry has poorly served the profession and the mentally ill.

What is to be done?

Look around to see what is exciting the rest of medicine. Global health is now squarely on the agenda of students, researchers and funders. Implementation research that mobilises and evaluates community services and social and behavioural research to improve healthcare systems' efficiency and effectiveness are at the forefront. The advances for HIV/AIDS, multidrug-resistant tuberculosis and, increasingly, non-communicable disease treatment in resource-poor settings are impressive. These include community models for delivering mental healthcare for the very poor and socially disadvantaged. Some of the latter approaches are new. However, the lineaments for most community-based practices derive from community mental healthcare models for the integration of clinical care with psychosocial and psychopharmacological methods developed over decades and across nations.[1] Medical students who seem largely uninterested in academic psychiatric research are flocking to programmes like those developed in the Partners In Health international network, or to projects inspired by other models of community care such as those initiated by Vikram Patel and colleagues (see www.sangath.com; www.centreforglobalmentalhealth.org).[2–4] Among many others, these approaches appeal to those health professionals and students for whom social justice and care for the suffering of the poor are central, and have moral force.

These other faces of academic psychiatry offer not only a chance at rebalancing psychiatric research, but a way out of the *cul de sac* psychiatric research has found itself in. Moreover, what

†See pp. 430–434, this issue.

is most surprising about clinical psychiatry today, as opposed to its overly narrowly focused academic cousin, is how mainstream psychiatric practice has become. Using a blend of pharmacological and psychosocial practice (with their strengths and limits), consulting psychiatrists have found useful and effective ways of taking care of ordinary patients in primary care and specialty settings. Here practising psychiatrists also frequently bring to medicine a more inclusive assessment and greater attention to emotional and social issues that help counter the waning humanism in caregiving generally. This is especially true of psychiatrists in consultation–liaison systems. Hence, in my view, what will save the profession is not biological research but its expertise, experience and success in clinical care and global health.[5]

It is the psychiatry of the academy, then, not clinical psychiatry, that needs help. What needs to be done is to complement the best of the biological research effort with equally strong and well-supported research in global mental health and clinical psychiatric practice, involving the community as well as the clinic. We need greater attention to implementation of research in global mental health, to community programmes, consultation–liaison activities, the routine conundrums of the practising consultant and primary care worker and to the questions of coping and caregiving facing patients and families, in order to develop a more practically useful biosocial framework.

To accomplish this rebalancing, the ties between psychiatry and public health need to be strengthened, as should those between our discipline and the social and behavioural sciences. It is telling that most of the MD and PhD students whom I have trained in medical anthropology have chosen to work in the infectious disease field and other subdisciplines of internal medicine. When I began to combine psychiatry and anthropology in the 1970s, academic psychiatry was the most open of the academic medical specialties to its social context, cultural patterning and therapeutic relationships, and to the insights of the social and behavioural sciences. Now it seems that psychiatry is more indifferent and less welcoming to the contributions of social science research than is internal medicine or public health.

What saves psychiatry is its clinical utility and its potential for improving caregiving generally, combined with innovative efforts to make it a leading edge of global healthcare delivery. And what just might make a difference for academic psychiatry is to recast the dominant framework as a biosocial model that marries biological and psychosocial/cultural research in applied research collaborations that address the most salient issues for caregiving.[6] That will require fostering of a new generation of psychosocial researchers and much greater support for global mental health researchers and practitioners and health services and policy researchers.

In an age of funding retrenchment for research, it will not be easy to rebalance the research agenda. But if this is not done, we continue on the current pathway. And if by, say, 2030 we still have no clinically useful biological test for mental disorders and little in the way of new therapeutic agents, academic psychiatry will, I believe, be consigned to irrelevancy that will be ruinous to the profession. In the meantime, every sign suggests that young clinicians and researchers will increasingly be drawn to the fields of global mental health and practical clinical mental healthcare.

Will the psychiatric academy rise to this challenge? Much as I hope so, as a realist I doubt this will happen until such time as the entire academic enterprise in psychiatry is clearly in jeopardy. By 2030, there definitely will be a profession of clinical and community psychiatry, but perhaps there will no longer be many academic researchers in psychiatry. I hope I am proven wrong, but if I am not contradicted by history it will be a sad denouement for a field that could and should not just promise much, but actually deliver on that promise.

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