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Summary

The development of psychiatry, perhaps even more than other medical disciplines, depends on socioeconomic and cultural factors in the environment in which the discipline is to function. In this article I shall review the impact of some of the trends in society's development, then refer to changes in the form and frequency of mental disorders and finish with a review of paradigms of mental health care which may need to be reexamined and possibly changed.

Key words: social psychiatry, humanities, health services, psychiatry, mental health

Trends of society's development with particular relevance for psychiatry

Commodification

"Commodification", a word that has entered the English language only recently, refers to the trend of measuring all things with economic indicators, as if they were a commodity – like sugar, cotton, timber or iron. This is fine and acceptable for dealing with commodities but becomes profoundly disturbing once it is introduced into fields such as medicine. When this happens economic indicators prevail in the evaluation of performance, in the manner and place of investment and in the mechanisms of control of quality. Thus a hospital will be judged by the profit it makes, not by the numbers of patients who have been treated agreeably and in an effective way. Prescribing the cheapest medication of a class will be allowed: the prescription of any other drug of that class will have to be justified in a sometimes complex manner. Hospital directors will encourage the use of new and often expensive diagnostic procedures in wards housing patients who have a good health insurance contract because their use can give the hospital a handsome profit and sometimes help in making the correct diagnosis. The replacement of the ethical imperative to help those in distress – such as patients – by the economical imperative to make money using medicine affects practice and other components of medicine such as medical education, research and collaboration with other scientific disciplines and social services.

The commoditification trend is particularly harmful to psychiatry. Most of the seriously mentally ill find it very difficult to enter the work force again – partly because of stigma and discrimination, partly because of self-stigmatisation – and it is not easy to make an economic argument for a massive investment into their treatment and rehabilitation. The commodification trend also affects the choice of postgraduate training, which will to a significant degree depend on an assessment of the benefits that a young graduate can expect when selecting a particular discipline for postgraduate training: in this respect psychiatry fares poorly, as witnessed by the continuing reduction in numbers and proportions of those selecting psychiatry as their profession in many countries. Since quality is measured by cost, family members and other non-professional carers will also try to have their relatives treated in the best – and now the most expensive – institution, which will often completely deplete their resources: if the treatment has to continue, they often find themselves unable to continue in the role of carer.

Demographic changes

Demographic changes and trends are also affecting psychiatry. The increasing numbers and proportions of the elderly in the populations increase the probability of an increase of prevalence of comorbidity of mental and physical diseases. The increasing prevalence of comorbidity is also a reflection of medicine's successes in the prolongation of life of people with chronic diseases – people who are at particularly high risk of acquiring mental diseases in addition to their chronic ailment. This represents a major challenge for the health care systems in industrialised countries and soon also in other countries. The health systems are not prepared to deal with the comorbidity of mental and physical illness. Psychiatrists have often not kept abreast with developments in medicine in general and feel incompetent – and in part for that reason also unwilling – to deal with physical illness in people who have mental disorders. The situation is similar with general practitioners and with specialists in various disciplines of medicine, all of whom do not feel confident when it comes to the treatment of mental illness. The tradition of geographic separation of psychiatric and general medical institutions makes things worse.[1]

1 The situation is somewhat different in the instance of depression – many general practitioners and specialists of internal medicine will prescribe antidepressants to their patients who have depressive symptoms – regardless of whether these are part of a depressive disorder or not.

The treatment of a kidney disease in a person with schizophrenia or of obsessional disorders in a person with severe myxoedema – or any other combination of diseases whose management requires solid knowledge of the comorbid diseases and their treatment – is likely to be much less often competently handled by a single physician. The strategy of having two or more specialists participate in the treatment is also not yet a solution – the collaboration between specialists in care often presents difficulties even when there are many of them and easily accessible: the situation is of course worse in countries or regions in which the numbers of specialists is limited.

Changes of family structure

The changes of family structure and its functioning are another demographic factor relevant to psychiatry, in at least two major ways. First, the reduction in the numbers of stable and lasting families in many countries weakens the role of the family as provider of care for its members. This change is not yet ubiquitous, but it is likely that it will become universal. Second, the family has been the main transmitter of culture, and growing up in a family was a way of adopting a system of values and becoming a member of a group with shared traditions: entering into the world without that orientation and with an uncertainty about values that should govern action makes maturing into a useful and well-balanced person a much more chancy process.

The latter development is all the more important in view of the changes to the educational system, which in developed countries continues to postpone the placement of responsibility on the shoulders of those growing up. Whereas in a number of countries girls aged 15 years are married and in others boys have to work for their upkeep from an even earlier age the vast majority of youngsters of highly industrialised countries are in schooling and free of any responsibility until they reach the age of 20 or – if they enter university – the age of 26 or more. The long-lasting latency of responsibility of fully grown up young people represents a risk factor for mental disorders and for socially unacceptable behaviour that is often the result of the tendency of youth to seek to overcome challenges. The misbehaving adolescent and adolescents with mental disorders or passing through a crisis – the subject of many a conference and consultation – are clearly an issue for society and health services in the developed world, likely soon to become universal. Handling these problems is made even more difficult because of the lack of an organised transition and of collaborative arrangements between the mental health services offered to children, adolescents and adults.

Urbanisation

The demographic changes are partly due to the now ubiquitous rapid urbanisation. In most countries of the world more than 50% of the population live in towns, and the numbers of urban dwellers are growing. Urbanisation presents some difficulties and some advantages to mental health service. The advantage is that people with mental health problems who, while dwelling in remote villages, could not reach mental health services now can do so. The difficulty is that mental health services in towns are often overburdened by the influx of people with mental illness and that the previously existing communities in towns are losing their cohesion, identity and readiness to help those in need.

Migration and immigration

Rural–urban migration leads to massive changes of society, particularly when it is simultaneous with the immigration of people from other countries. The poorest countries receive by far the greatest numbers of refugees and immigrants, but the numbers of those entering highly industrialised countries has also grown in the past few decades. Immigrants bring with them their ways of being ill, which gradually change so that the ways of expressing their diseases are no longer similar to the way of disease expression of their home country and not yet similar to the way in which diseases are seen in the host country. They are therefore difficult to recognise and treat. This is only one of the problems that immigration creates for health services. Others stem from the sudden increase in needs for services and from the fact that migrants who arrive in developed countries rarely come accompanied by families who could provide them with help if they fall ill. Migration produces even more difficulties for the donor countries. Continuously losing able-bodied and healthy members, the communities in many of the host countries are ailing – they are composed of children, those who could not migrate because of disease (particularly because of mental disorder) and disability, and those who had to return from the richer countries because of illness. The main source of income for such communities is the money sent home by migrants who have found employment abroad or in towns. With time this kind of support is drying up, thus creating problems for which no country has yet found a satisfactory solution.

The changing position of women in society

The changing position of women in society also has consequences for mental health care. Traditionally, in many societies women brought up children, trans-

mitted cultural values, looked after the disabled, diseased and elderly, took care of the home and participated in the work in the fields. The entrance of women into professions meant an extra burden for them because there were no ready candidates to take on the roles that they play in society. Sometimes they break down under the load of responsibilities with conditions such as "exhaustion depression" described by P. Kielholz nearly a century ago. Others reduce their engagement in traditional roles, which means that the need for care for the chronically disabled becomes greater, that the education of children is passed on to the schools (which often refuse to take it on, arguing that they will transmit knowledge but that the education of the child for life is by and large the responsibility of the parents) and that societies begin to lose their cultural identity and adherence to a value system that previously helped the functioning of the society. Some countries seek the solution to this problem by increasing the number of part-time employment opportunities and facilitating the participation of fathers in child upbringing by granting paternal leave after childbirth; others rely more heavily on immigrants (who are sometimes poorly trained and do not speak the language of the parents very well) taking on the rearing of children and other roles traditionally played by women. An equitable solution allowing both women and men to work and share their responsibilities in fulfilling the tasks previously completed by women has yet to be found: meanwhile the problems listed above will continue to present a significant risk for the health of the population.

Insularisation and globalisation

Two further trends are of significant relevance for mental health and for the organisation of mental health services: "insularisation" and globalisation. The first, "insularisation", refers to the paradox of communication in modern society where – in parallel to the ever greater possibility of being in touch with others with e-mail, iPhones, Internet links and related developments – there is an increasing number of people who feel lonely and miss direct human contacts, old-fashioned friendships and emotional engagement. Loneliness has a variety of psychological consequences, particularly in older age groups, most of them not conducive to good health and quality of life. The other major development is globalisation – a trend that at its beginning was seen as being very positive, promising open borders, a free exchange of goods and ideas and a stronger effort to help the world's poorest – but over time became little more than a one-way transfer of goods and ideas from the highly developed countries to those in the Third World. In addition to the movement of goods, globalisation also contributed to the transfer of value systems and ideals of social organisation from the economically powerful industrialised world to settings where survival depended on other sociocultural rules. An example of this development was the insistence on personal independence as a goal of treatment and rehabilitation of people with mental illness in settings in which interdependence has been a strategy of survival for the sick and the healthy from time immemorial.

Mental disorders and their changes in recent years

Changes of the clinical picture of mental illness

General education in developed countries has reached almost all children and adolescents and it is possible that the disappearance of some of the dramatic forms of schizophrenia (such as its catatonic and hebephrenic forms) and of other psychoses in general is linked to education and increasing capacity to express experiences and inner feelings learned in school and by exposure to ever more present media. The fact that dramatic forms of mental illness are still seen in poor countries and that they seem to be becoming rarer in parallel with the increased coverage of the population by schooling, television and other technological communication innovations might be seen as support for this hypothesis.

In addition to the disappearance of dramatic forms of psychoses (such as extreme megalomaniac delusions), several other changes in the form and severity of mental disorders have also been recorded in recent years. They are not as well described as those that were portrayed in the 19th and 20th century, possibly because their symptoms are still changing. Depression, early onset of bipolar disorder in children and attention deficit hyperactivity disorder (ADHD) are among these, but the list is much longer.

There are also problems that are linked to longer life expectancy, such as in the instance of schizophrenias. Persons with schizophrenia are now, in industrialised countries, often reaching old age and find themselves deprived of the support of their mothers and fathers, who might have died or been struck by dementia and other ailments frequent at older age. Their clinical picture presents a mixture of symptoms of chronic schizophrenia and of signs of accelerated cognitive decline, and their capacity to look after themselves (and sometimes also after their old parents) may be minimal. The reduction of the capacity of mental

hospitals and the disappearance (mainly for economic reasons) of the previously promoted transitional institutions such as day and night hospitals, sheltered housing and foster family accommodation makes the management of problems of this type a major and growing challenge.

The uncertainty about "marginal" states

A variety of psychological conditions including burnout syndromes, malaise, marital problems, child misbehaviour, some posttraumatic states, occasional binge eating, mild cognitive problems of senescence and many others have emerged as candidates for disorders that should be handled by psychiatrists, psychologists or alternative medical practitioners (e.g., those practicing homeopathy, Ayurveda or acupuncture). The evidence of efficacy of methods employed to deal with most of these conditions is feeble or nonexistent but none of the professions listed has until now because of that categorically refused to deal with them. Most of these states are not life-threatening although they are sometimes the "straw that breaks the camel's back", a problem that comes as an addition to other life problems and illnesses and triggers destructive acts such as suicide.

Increasing prevalence of mental illness

The prevalence and the apparent prevalence – the awareness of the presence of disorders – of some of the well-defined psychiatric syndromes such as depression seem to have grown in recent decades. Among the reasons for this increase are the extension of life expectancy of people with mental disorders (although the mortality of people with mental disorders is still higher than the mortality of people without mental disorders), the better recognition of depressive disorders by medical practitioners and by the population, and the changes of the demographic structure with an increase of the numbers of people who survive into the age of increased risk for depressive disorders. Some other disorders have appeared in recent years, thus for example the mental disorders due to acquired immunodeficiency syndrome while others previously major problems such as those related to quaternary syphilis (progressive paresis) and vitamin B deficiency have practically vanished.

Incidence of mental illness: has it changed?

It is possible, although it has not been demonstrated, that the incidence of mental disorders has also increased. The uncertainty about the changes of incidence of mental disorders is to a large extent due to the lack of evidence about the incidence of mental disorders in the past and to the rarity of well-designed studies of incidence in most parts of the world in our times. The reports about the increasing prevalence and incidence of mental disorders have probably also been influenced by the fact that the development of services for mental illness and the possibility of treating them with medications like other diseases has increased the number of people who come forward asking for psychiatric help.

New forms of mental disorders

Some new forms of mental disorder have also been described and their frequency and consequences are a serious concern for public health authorities. These include behavioural addictions severely damaging individuals who acquire them – such as addiction to gambling, to excessive physical exercise, to the Internet – and a new set of cognitive impairment syndromes. The latter are related to the increasing complexity of the modern world that makes mild cognitive impairment a significant disadvantage and obstacle for normal life and to the aging of populations which brings with it an increase in the number of people with senescent memory difficulties.

Paradigms of mental health service: need for revisions

The principles of mental health service organisation defined in the second part of the 20th century included:

a) a continuous effort to reduce the number of mental hospitals and reduce the size of those that have not been disestablished;
b) the placement of mental health services in the primary health care services in communities which they are to serve;
c) the reliance on the strategy of community care for the mentally ill and impaired (including their reinsertion into communities and rehabilitation);
d) task shifting – the transfer of responsibility for the treatment of mental illness to the general practitioners and other services; and
e) in some low income countries the selection of "priority conditions" disorders such as schizophrenia and epilepsy which will be given priority (concerning funding of care, education about their treatment, etc.).

Recent years have clearly demonstrated that the above principles will have to be amended, adjusted to the current and future situation concerning care and treatment.

Closure of mental hospitals

The consequences of the abrupt closure of mental hospitals have not been as beneficial as it was hoped. The services which were supposed to take on the care of people who were interned in mental hospitals have only rarely been sufficiently strengthened to take on their new task. In some instances the closure of mental hospitals resulted in a major increase of numbers of mentally ill people admitted to prisons. This trans-institutionalisation did not benefit patients and did not decrease the cost of care as was expected: the main changes were that the judicial system now bore the cost that was previously paid by the health system and that the people with mental illness received even less medical care than before. In other instances the mentally ill ejected from hospitals became vagrants and it is likely – although the evidence about their fate is scarce – that their mortality was heightened and that their life was one of misery. The diminution of number of patients treated in mental hospitals did not necessarily lead to a better service, more human contact and more competent care: in some places the buildings previously used to house the patients were left to decay making the mental hospital even more frightening than it was. Where the reduction of size of mental hospitals went hand in hand with better service the patients experienced clear benefits and in instances in which they were located in the community which was well prepared to receive them they reported an improvement of quality of life. Regrettably, in many countries the reduction of the size of mental hospitals did not go hand in hand with an increase of funding for outpatient and community care nor with a development of services in the community.

Placing mental health care into the community

The placement of mental health services in the structure of general health care in the community worked well in some places but not in others. In some instances the communities were strongly opposed to having a mental health facility next door, near to them. It was clear that time and money should have been invested to make members of the community learn more about mental illness and to take other measures that can reduce the stigma of mental illness, yet it was rare that the budget of the institutions that were to be placed in the community included funds that could be used to prepare for the move of service into the new setting. Stigma of mental illness also affected the use of services in the community: people with a mental illness often avoided going to a psychiatric service in their neighbourhood and sought help far away, so as to avoid stigmatisation that would have followed treatment and recognition that they are in treatment for mental illness in their own setting.

The insistence on community care as the main form of mental health service provision hit two other problems as well. First, in many places the communities of the type that the originators of the community care strategy had in mind when composing the strategy have vanished from many countries and are likely to vanish from others. Rapid urbanisation and high-rise dwelling meant that neighbours do not know each other and are unlikely to offer help or accept a person with mental illness as one of their community. The diminution of the size of families, with a predominance of nuclear families in which both adults are out to work and the children are in school, further reduced the creation of ties and connections among people living on the same territory. The second problem was that of staff attitudes. Most of those employed in mental health services entered the profession with the expectation of working in an institution, possibly and probably next to departments of other specialties. The notion that the service will be outside of institutions and far from colleagues who could offer help and advice if necessary is not particularly attractive to staff who therefore often tried to slow down the move out of the facilities to areas – sometimes slums – presenting danger to those working there or just being far from other medical services and colleagues.

Task shifting

The strategy of task shifting is not a recent invention. The notion that general practitioners should be invited to participate in the treatment of mental illness or to take full responsibility for it was voiced in the late 19th century by Ray, Griesinger and others. Research in the 20th century demonstrated that general practitioners are often the first point of contact for mental disorders such as depression and a variety of studies showed that they can provide treatment to those patients if given some additional training. Even personnel with shorter education such as nurses and medical assistants, who carry most of the primary health care in many countries, can adequately deal with many mental disorders if properly trained. It therefore seemed logical that the lack of psychiatrists should be compensated for by shifting many of the tasks involved in the treatment of mental illness to primary care agents. There are, however, problems with this strategy. Many general health care agents do not wish to be responsible for the treatment of mental illness. Sometimes this is because they have not been adequately trained to do so during their medical or nursing training. Sometimes the stigma of

mental illness makes them feel that they cannot make the mentally ill better and that, in addition, when treating them they might be exposed to aggression. Sometimes they just felt that dealing with mental illness would hugely increase their workload, which is often heavy. In recent years the notion that all general practitioners should be trained in psychiatry has been replaced by a different strategy, characterised by three tenets: first, that only those family physicians who volunteer should be given the training; second, that the training should be provided by a general practitioner experienced in the treatment of mental illness (who is a more credible teacher for GPs) with the psychiatrist serving as a resource person rather than as the main teacher; and third, that the training should be focused on problems most frequently seen in general health care. It was also stressed that the training should be of a duration that is compatible with the obligations of general health care agents, and thus take the form of a spaced out series of short training courses lasting no longer than a few hours or an afternoon.

The use of new technology and other desirable changes to improve mental health care

Medical training before and after graduation is clearly an important avenue for the introduction of changes of the health system necessary to reflect the revision of paradigms mentioned above as well as of the sociocultural and technological changes characterising our times. The latter include the use of new technology – e.g., Internet and mobile phones that make it possible to strengthen the self-help arsenal of treatment in psychiatry – as well as the need to recognise that patients and families must be seen and treated as partners in the provision of treatment, in rehabilitation and in planning of health services. Improved medical education is also of central importance in dealing with problems related to the fast increase of prevalence of comorbidity of mental and physical disorders which must be seen as a major challenge to medicine of our century.

Prevention and reduction of stigmatisation and its consequences

Among the many other paradigms of care that will have to be reviewed and updated if mental health care is to be provided to all those who need it is also the imperative need to include the fight against the stigma of mental illness among the routine tasks of the health system rather than attempt destigmatisation by occasional campaigns or by the organisation of special events. Major international studies demonstrated that it is possible to reduce stigma or prevent it if the action against stigma is permanently among the priorities of the health care and educational system.

The relevance of local conditions

All of the above will have to be considered in light of the realisation that policies and plans that are imposed on all parts of the world or a country will fail. While a few general principles are valid for all health care, the way to success is the adaptation of health care strategies to the local situation, a wise use and combination of elements of service based on evidence and experience in the context of the setting in which care is to be provided.

Conclusion and coda

Research and experience acquired during the past century provided evidence about the huge magnitude and severity of mental health problems and about effective ways of dealing with them. The vast social, ecological, economic and cultural development of recent years confirmed the importance of dealing with mental health problems and underlined the need to update paradigms of mental health care developed in the past.

The time to act is now and it is of crucial importance that psychiatrists and others knowledgeable about mental health and mental health problems take an active role in shaping new strategies of promoting mental health, preventing mental illness and mental health problems and providing care to those who are affected by them.

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