

Interview with Professor Allan H. YOUNG

Professor Allan H. YOUNG – M. B., Ch. B., M. Phil., Ph. D., FRCPC, FRCPsych

Ranked as one of the world's leading scientific minds in the field of Psychiatry and Psychology, Professor Allan H. Young is Director of the Centre for Affective Disorders in the Department of Psychological Medicine in the Institute of Psychiatry at King's College London, United Kingdom and holds the Chair of Mood Disorders. He has held academic appointments at some of the most prestigious universities in UK and Canada.

Professor Allan H. Young has conducted research in the cause and treatments for severe psychiatric illnesses, particularly mood disorders.

He has had over 300 referred scientific full publications and authored a number of books dealing with psychopharmacology and affective disorders including *Bipolar Disorders: Basic Mechanisms and Therapeutic Implications* with J. C. Soares, and *Practical management of Bipolar Disorder* with I. N. Ferrier and E. Michalak.

Professor Allan H. Young is President of the International Society for Affective Disorders and Chair of the Psychopharmacology Committee of the Royal College of Psychiatrists.

You are a well known personality in the European and International Psychiatry and we are honoured to have you as our guest to deliver your lecture at "Socola" Hospital in Iași.

1. How do you see the development of psychiatry in the future?

Firstly, thank you very much for inviting me here and it has been fascinating to come and see your hospital and see how

active and vigorous psychiatry is in Romania. I think the future of Psychiatry really lies within medicine. I think it is very important that we remember that we are medical specialty, we deal with a large part of medicine and we interface with many specialties, including family practice and so on and so forth. If one looks at the other common complex disorders, such as diabetes and heart diseases, in many ways, in terms of the genetics, the epidemiology,

for example, they are very similar to our psychiatric disorders. So, although there is a belief, that somehow, the psychiatry is different from the rest of medicine, I actually don't think it is. I actually think the rest of medicine could learn things from psychiatry, some of our psychotherapeutic approaches and our tendency to work together with teams of other disciplines and also to look at the whole patient; all these could well be taken as a model for the use in the other areas of medicine.

However, in psychiatry, we should always be aware that fundamentally our common complex disorders are similar to other common complex disorders in medicine. It should also be pointed out, that our patients not only to have mental ill health, but also to have physical ill health. So, the most vulnerable people have a sort of double hit from both, mental ill health and physical ill health and, this is why they, die earlier. The figures vary, but for people that suffer for schizophrenia, bipolar disorder and severe depression, they die between ten and twenty years earlier than the rest of the population, so they do, of course, have an excess death rate from suicide, but that is a small percentage of the overall deaths. Most of the deaths are from the same things that kill everyone else: heart disease and cancer and so on. So, this means that we have to be looking at the physical health needs of our patients as well. It is also notable that our patients actually don't get the physical health care they need, so in terms of the preventative measures, they fare far worse than people who don't have mental ill health. So, for all these reasons, I think, the future is for psychiatry to really return to its medical

roots and to make full advantages of that, whilst not giving up the things that we do particularly well, such as psychological treatments and psycho-social considerations of disease.

2. Do you think that DSM-V has its contribution based on evidence or, on the contrary, it creates barriers in the development of psychiatry in the 21st century?

Well, that's a very interesting question. It should always be remembered that DSM-V is the American Diagnostic Manual; the rest of the world has the International Classification of Diseases which is also being revised. Furthermore, it should also be remembered that the International Classification of Diseases also applies to the United States, because it is a WHO or United Nations enterprise. So, for example, the government in the United States codes mental illness by ICD not by DSM, and that will become increasingly important because of the health and social CARE ACT passed by President Obama, where people with psychiatric illness are going to get more care. I think the most important DSM is DSM-III, which came out in 1980. And that was the real revolution that was the break with the past, that's when the diagnostic criteria were introduced, so that, if we talked about major depression, a psychiatrist in Romania, a psychiatrist in the UK, a psychiatrist in New Zealand or Chile would all know that they were talking about the same thing. That was a very, very important advance. Of course, there were details which were wrong and things which weren't particularly good, but DSM-V is essentially an evolution from DSM-III. There are lots of people who have

been critical with DSM-V, in the UK where a lot of people are basically critical of psychiatry and the very notion of the psychiatric diagnoses. If one looks at the Mood chapters for DSM-V, related to bipolar disorder and depression, I think they are very much an advance. I think they are on the whole very sensible. They reflect much more the dimensional nature of these illnesses. So, it's not just depression or mania, you can have mixed states which incorporate both and these are very frequent. Before, if you used DSM-IV, you were supposed to have a very *yes* or *no*, *black* or *white* approach to mania and depression. This new change is important, because much of the research, that we do, is done into new treatments, is done by the pharmaceutical industry (and I showed some of them in my lecture) and the pharmaceutical industry will use the DSM-V for new treatments for depression and mania, because their first market that they go to is the United States, which is still by far the biggest market. That the FDA require DSM-V to be used and that means that things like the mixed features specifier will be applied when someone has depression and we will know that they have depression either with or without maniac features. That's important information. So, we might have a better understanding about when to use antidepressants for example. Overall, I think there are lots of issues by DSM-V, but I'm quite positive about it for Mood disorders. I think it's quite sensible.

3. Can you give us some comparative considerations regarding DSM-V-ICD 10 (ICD-11)?

The first thing to say is that ICD is much more an international enterprise. It's done by people from all over the world, whereas DSM is really very much focused on the United States. So ICD has to apply to Cuba as much as to Florida, for example. The ICD committees have people from all over the world and I think this is very important. ICD is also very focused on a clinical utility which means making it useful for clinicians. For DSM that wasn't a major consideration really. So, I think that ICD may turn out to be the better document. There is also an attempt to harmonize the two which would be an attempt to make the two as much in harmony as possible such that they don't contradict each other. That's working for most areas, the one area where it seems to be broken down is for personality and personality disorders, where it is likely to turn up with two very different versions of the truth, I suppose. But for Mood, I think they will be pretty similar.

4. Is psychiatry on the verge of losing its contact with other branches of medicine?

I think the slide I showed from the paper by Professor Martin Prince, entitled *No health without mental health*, I think that illustrates the fundamental point that mental health is a core part of health, disease and medicine. In the past, we had a strange view of medicine, we almost looked to organs on their own and I think that we need to look at the whole person. So, for example, even if you are a transplant surgeon, you may think that this is all about surgical technique and that's obviously true, but also there is the wider aspect of the person and there is

also the aspect of thinking about the reasons why the transplant is needed in terms of other areas of health care. So, no particular part of medicine is an island to paraphrase John Donne, but it needs to be aware that it's part of the whole, and a very, very important part of that whole is psychiatry and mental health. As I've said, I think we are good at certain things, we have been good at working together as teams and very good in developing psychotherapy, in having other treatments, in having a holistic view of the patient, but I think that, in terms of advancing, we need to be much more at heart of medicine and we need to make the rest of medicine be much more accepting of that. Perhaps the most important area is a general practice or a family medicine. That is the biggest part of it and all of the other specialties should really flow out of that.

5. What would be the relationships between biological, psychological and social elements in psychiatric practice?

I think they are all important and they all differ with each individual patient. There is no separating social environment from health and we look at the early determinants of disease, early life experience and even the environment that the child is in before birth. We know that this will determine future health in a long term, not just mental health, but also physical health. Similarly, the psychological aspect, the idea that the psychological aspect is divorced from the physical aspect is to my mind just very difficult to sustain, because we are all human beings, we all experience everything; everything is psychosomatic,

even if you are hit by lightning. There will be a psychological reaction to that. That will be very important. Very often these psychological aspects determine the outcomes of disease, perhaps even more powerfully than the physical ones. So, I think, these three different aspects have got to be considered in every patient.

6. Can one establish resemblances and/or differences between the bio-psycho-social concept and psychiatry centred on person?

Absolutely! I think all of medicine essentially starts with the individual. We want to help the individuals with their illness or their illness experience better. But to do that, we have to then look at populations and groups and so on. So, there is a difference between the art and the science and medicine. The art is focused on the individual person, thinking about the various different factors that may be important. In science we have to look at things like epidemiology, genetics and so on and so forth. But the two are not incompatible anyway.

7. Are scales for assessing the clinical condition an instrument for establishing the diagnosis? Can you give us some considerations about Young Mania Rating Scale?

There are a number of different things here. So, the rating scales like the YRMS measure mania or depression, but that is not diagnostic. Diagnosis rests on a diagnostic interview. There are structured diagnostic interviews, such as the SCID for DSM. That's a way of structuring and standardising the diagnostic process. We do use these, but they do not a really substitute for having an experienced

psychiatrist. The rating scales are very important for research and for allowing us to quantify the effects of, for example, treatments for mania or treatments for depression. They have been very influential. There is also the use of screening tools, but these are again not diagnostic. For example, we have the hypomania checklist (HCL) which is a screening tool for bipolar, but not diagnostic. So if we just take the individual patient through it, if they came to my clinic they might get some screening tools like HCL, that might alert us to the fact that it might be bipolarity there, we will then do a diagnostic interview, which would essentially be similar to one of the structured ones and, then, if we want to chart people's progress we would either do things like the young mania rating scale or the self report versions of these, and the self report versions are, actually, very important. People have mobile phones and they can chart their mood daily and this gives us very good information about clinical progress.

8. Can we predict the behavior of psychiatric patients?

I read a quote the other day that prediction is always very difficult, especially when you are talking about the future. Is very difficult to predict the future behavior of anything. We have seen this in economy and the market. The weather you can predict for five days, beyond that it doesn't seem to be very predictable. There is always a great worry that psychiatric patients are going to be violent. Now, this needs to be put in context. The risk of being assaulted by a schizophrenic is less than being assaulted

by a football fan. The football fans are much more likely to beat each other up. If we then look at who's at risk from schizophrenia, people that are most at risk are themselves (suicide or attempt). Thereafter the closest carers are at greatest risk. However, perspective is often lost, these are mostly very safe patients. In terms of predicting the future for patients, the other thing to be said in general sense is that being in treatment in a general sense seems to be a very good thing. Professor Angst in Zürich has done some follow up studies and he has looked at people with severe depression and bipolar disorder and where those who remain in treatment in a broad sense, taking any form of medication or not and the rate of suicide was reduced in the group that continued to take the treatment and also the physical health outcomes, things like death from heart disease were reduced by treatment as well. So, I think we can generally say that we need to educate the public not to stigmatize psychiatric patients, even more by suggesting that these people are very dangerous whilst being aware of the risks. We also need to generally be aware of the fact that the treatment can be a very good thing long term.

9. Do you think that, starting from the two systems of classification DSM and ICD, we can be confronted with a dichotomy in the clinical approach in psychiatry?

I don't think so. I think, that in practice, the only people who use DSM in day to day bases are the Americans, the Canadians maybe. The Americans use it because they have to code to get paid by insurance

companies. The main way in which DSM is going to trump ICD is for the research and for the related trials. But hopefully the two systems overall will be pretty similar. I think for Mood disorders, they are going to be pretty similar.

10. Can we speak of a crisis in psychiatry in the context of the other medical sciences?

I don't think so, I'm very optimistic about psychiatry because I think psychiatry is by far the most interesting medical specialty. If we think about the challenges that psychiatry faces, our greatest organ is the brain and it is the highest centers of the

brain that concern psychiatry. We have left perhaps the less interesting bits to the neurologists, but we are also faced with Society and so on in a wide broad sense. So, I think, for any doctor who is particularly interested in these areas it's a very challenging specialty and I think we will see huge advances in the future. I think we have already got very good treatment options and the challenges to deliver those to patients where is effectively possible. I think the possibility for new treatments and for new understanding in the future is very great and that makes me very optimistic for the profession.