Perspective

An occasional series in which contributors reflect on their careers and interests in psychiatry

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Biographical

The word perspective is variously defined in the *Oxford Dictionary*, but most appropriately in the present context as 'the proportion in which the parts of a subject are viewed by the mind'. Thus, perspectives are subjective phenomena determined by such influences as the viewer's age, status and experience. My viewpoint is that of a septuagenarian looking back over almost half a century in the practice of psychiatry.

Like so many people in those earlier days, I became a psychiatrist by chance rather than by choice—in my case, a refugee from the common life-threatening scourge of the time, pulmonary tuberculosis. Relegation to patient status was a humiliating, if eventually salutary, experience which gave me a new understanding of the way people feel when they fall victim to a serious and socially isolating illness. The sense of shame, the feelings of rejection, the threat of relapse, the fear that detection will alienate friends and limit the prospects of employment, have much in common with the reactions of young people who, today, develop psychiatric illness. Liberation from this shamed secrecy did not come about from any sudden access of enlightenment and tolerance in the community, but from the fortuitous discovery of efficient antidotes to the tubercle bacillus. What limited liberation has come to the mentally ill in the same decades has stemmed essentially from the same source—chemotherapy and other physical methods of treatment. Symptom control has relieved the extremities of suffering and given new confidence, both to patients and those who care for them.

During convalescence from my illness, I got a job as medical officer in a mental hospital because hours were short, work physically undemanding, and living conditions princely by the standards of the time. My career thus bridged the transition from the old custodial hospital regime to the modern psychiatric clinic with its policy of early admission, intensive treatment and quick discharge. It is in the light of this experience and these influences that I view some of the 'parts' of psychiatry in relation to our rapidly emerging and changing specialty.

Historical

"Those who cannot remember the past are condemned to repeat it". Santayana's often quoted aphorism has an especial relevance to some present trends in psychiatry. It required the genius of a Swift and the courage of a Pinel in the eighteenth century to draw attention to the plight of a despised section of the community, and the humanity and administrative ability of men such as Tuke and Conolly in England, and Halloran in Ireland, to establish a tradition of medical and nursing care for the mentally ill.

W. S. Halloran was physician to the lunatic asylum of Cork and in the year 1811 he published a memorable textbook entitled *Practical Observations on the Causes and Cure of Insanity*. To quote an extract from the spirited prose of his introduction, "The cloud of darkness and uncertainty which still, unfortunately, pervades this department of medical science, is deeply to be lamented. An extraordinary neglect, on the part of physicians, of due attention to the subject of insanity, bespeaks a supineness for which there cannot be any admissible excuse. There are some who would conceive it a departure from professional importance to step forward with a helping hand to the relief of the unfortunate maniac: there are others, who go so far as to allege it to be a malady *sui generis*, and suited only to the care of those who make it a particular study; the consequence of which is, that this particular study very frequently consists in the mysterious application of remedies which have their foundation in impudence, ignorance and folly. Insanity, it must be contended for, is as much within the province of medical acumen, as any other disorder incidental to animal life. It has its approaches, its symptoms, its varieties, and its terminations, in strict conformity with other acute diseases, in which the deviations from the healthful condition of the animal economy are most remarkable."

This timely reminder from the past will provoke a sympathetic echo in the minds of many who work in the field today, and perhaps cause some current theorists to reflect that only the advent of the medical model brought understanding and humane care to the mentally ill.

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One of the lessons from the past which we should not neglect is the general tendency to spontaneous recovery of many of the illnesses we treat: a tendency which has lent false credibility to many therapeutic 'advances' over the years. Halloran reports a series of 1,270 admissions to his hospital, of whom 691 were discharged 'cured', more than 50%. A remarkable statistic when one considers that 398 of these patients died from a variety of inter-current illnesses, many of which, no doubt, would have responded to modern medical treatments.

There are many other lessons we may learn from the therapeutic enthusiasm of this wise physician, not the least being the value of a well-organised hospital in promoting recovery. He stresses the need for hygiene, fresh air, exercise, occupation, segregation, and finally a rehabilitation programme for the recovered patient.

Like many others of my generation, I am concerned about the present-day schemes to replace hospitals by community based services, thus neglecting the benign aspects of the old time regime and the virtues of a hospital, both as a necessary 'retreat' and a rehabilitation centre.

Of course hospitals should be smaller and adapted with greater sensitivity to patients' needs, but both kinds of facility are essential for patient care, family support and the welfare of our specialty. The concept of institutional neurosis has become a bogeyman in the minds of many who seem to forget that it occurs at home, in hostels or halfway houses. We must accept that in hospitals, institutional neurosis is an iatrogenic disorder and it is our responsibility as doctors to ensure that conditions for which we are responsible do not foster it.

There is ample testimony to the tragic personal and social consequences of the policy of restricting admissions and discharging patients from hospital without adequate provision for their care. The time may come when it will require the innovative courage and scourging satire of another Swift to highlight the effects of administrative and political expediency and insensitivity to the individual needs of sick people. Meanwhile, our planners should study the comprehensive report by Rosalind Furlong (*Bulletin*, July 1985, **9**, 130–134), with its sensible conclusions and recommendations.

Changing times

My first enthusiasm for my new work in its strange setting was occasioned by observing a melancholic man who had been in hospital for more than a year, deeply depressed and agitated, tortured by guilty ruminations over past 'misdeeds'. He was transformed overnight to a jovial, outgoing, competent human being, his new zest for life apparent in his concern to get back to his neglected family and business.

This type of spontaneous transformation without any special therapeutic intervention, leavened the load of apathy, withdrawal and despair, so prominent a feature of the symptomatology in the hospital wards of those days. Mood change and its effect on behaviour in all its variations has remained the great fascination of my clinical experience.

One of the drawbacks facing a trainee psychiatrist today is the lack of opportunity to observe the natural history of the illnesses which come our way, uninfluenced by the symptom-relieving treatments now available. For example, there may never be the opportunity to follow the full cycle of a manic depressive illness from depressive retardation to stupor to spontaneous remission, with perhaps an ensuing manic episode. The young doctor may never have had the chilling experience of trying to establish rapport with a deteriorating schizophrenic, powerless to influence the bizarre thought-content and vivid hallucinations which had become the patient's reality. Lack of first-hand experience of such a distressing progressive and destructive alienation may well be a factor influencing the judgement of those who find it hard to accept the reality of mental illness as a disease entity. To some extent too, this lack of first-hand experience is fostered by many present day psychiatric training programmes with their short-term rotations, which lead to a cross-sectional rather than a longitudinal view of the common clinical pictures and consequent lack of opportunity to establish more than transient therapeutic relationships. Neither is the system good for patient care; how often do we hear the forlorn comment, "but I see a different doctor every time." When I consider my own great good fortune in having worked for five years with that giant among psychiatrists, the late Professor Willy Mayer-Gross, I feel that a return to some form of apprenticeship might be a better training plan for doctors and provide better care for their patients. Another, though I am afraid unpopular, suggestion would be the creation of a specialist psychiatrist grade. Such doctors would be relieved of the administrative and leadership duties of the consultant, but have both a hospital and community base from which they could commit themselves to the treatment and support of their patients through the course of their illness and, when necessary, rehabilitation.

Apart from difficulty in visualising the old-time hospital and its residents, the young psychiatrist may find it difficult to imagine the incredible sense of enthusiasm and optimism experienced by hospital personnel with the advent of the physical methods of treatment. The only previous comparable drama was the occasional gratifying response of a general paretic to the debilitating rigors of benign tertian malaria therapy. Electroplexy, insulin therapy and chemotherapy, apart from the dramatic symptom relief they often achieved, provided a great incentive to therapeutic endeavour. Hospital morale was elevated, we felt we were real doctors and nurses again, who could determine events rather than wait passively for them to happen. In the mid 1950s I remember reading a paper on the new chemotherapy and saying "I have never taken either chlorpromazine or reserpine, but these drugs have done me an immense amount of good through their effects on my patients. I am a more confident doctor, and in particular, I can make friends with my schizophrenic patients." Of course we were too optimistic and our brightest hopes were not fulfilled. It was especially disappointing that aetiological enlightenment did not follow fast on symptom relief. Despite these drawbacks, the physical treatments in psychiatry must rank among the

great achievements of modern medicine. It would be inconceivable to turn the clock back and try to run a hospital service without their aid. Locked doors, excessive sedation and prison-like supervision would of necessity return, in the interests of patients' safety. Much of the unjustified criticisms and alleged dangers of the physical treatments stem from lack of care and sophistication in their application. Faulty diagnosis, inappropriate dosage, insensitive technique, inadequate follow-up (especially the latter) are more frequent causes of disappointment and failure than the limitations of the methods themselves. While awaiting the enlightenment of future research, humane empiricism becomes a necessary philosophy in many areas of medicine as well as many aspects of life.

From my perspective, it is a sad and worrying development that these safe and valuable means of relieving human suffering should be so misunderstood by so many people and their misrepresentation and dramatisation be allowed to provoke so much unnecessary fear. While this morbid trend in society is due to many influences, as a specialty we need to take particular care to educate our patients, their relatives and our local communities about the nature and purpose of the treatments we use. Many years experience of such an organised educational programme as part of the hospital's daily routine has proved to me that people are avid for information and deeply appreciative of the reassurance of facts and that truly 'present fears are less than horrible imaginings'.

The psychiatrist as clinician

Apart from the revolution in hospital care, one of the most satisfying developments in psychiatry has been the transformation of the out-patient department by the advent of chemotherapy, particularly the judicious use of antidepressant drugs. Response to these latter medications has made us more aware of a *core* of biologically determined mood change at the heart of many of the clinical pictures previously regarded as primarily emotional reactions to external stress. This concept of 'melancholia minor' or 'masked' depression presenting in the guise of neuroticism, accepts the hypothesis that the word depression is usefully represented as a sliding scale. At one end of this scale, depression is the understandable, though excessive, emotional reaction of a vulnerable personality to an identifiable external stress, past or present. At the other end of the scale, the word depression means the unexpected and apparently inappropriate response of a predisposed personality to the slowing down of metabolism, characteristic of melancholia. Thus, it is assumed that depression is always a reaction to stress. At one end of the scale, the provocation is mainly external and psychological, at the other end, mainly endogenous and biological. In the case of masked depression, both types of stress play a part. The effects of biologically induced metabolic slowing have a variable influence on function, depending on the psychological characteristics of the individual. For example, latent anxiety, guilt, frustration, obsessionality and other anomalies of personality may be liberated and manifest themselves for the first time, while inevitably character traits and foibles are exaggerated sometimes to the point of caricature. These emotional reactions or their physical concomitants may come to dominate the clinical picture. Once aroused, these morbid reactions become in themselves a source of concern to the patient, and a vicious circle of worry is established which will remain as long as the underlying retardation lasts. If the depressive cycle is a long one, a pattern of chronic invalidism may be initiated which will persist even after the original stress has subsided. Thus, the spectrum of presenting symptoms is a wide one and the fascination in diagnosis and skill in treatment of these mixed depressive reactions lies in the evaluation of the relative dominance of the various factors in the aetiology of a particular illness. This evaluation is all the more important, in my view, because experience suggests that antidepressant drugs are an effective antidote to depression only in proportion to the presence of clinical pointers to a biological element in the evolution of the symptomatology.

This concept of mood change as a stress factor from within, as well as a reaction to external events, has had an important influence on the development of clinical psychiatry. It has increased the numbers, though lightened the load of our out-patient clinics. It has opened a wide field of satisfying therapeutic activity to family doctors and perceptive specialists in other branches of medicine. It is a particularly gratifying diagnosis to make when the presenting symptoms are such vague complaints as fatigue, inappropriate anxiety, or somatisation in the form of autonomic dysfunction. Gone are many of those long and often wearying interviews when painstakingly we tried to find 'buried treasure' in the form of provocative events in the past to account for present misery. Indeed, while we readily rejected the absurdly inadequate 'reasons' proffered by the old fashioned melancholics to explain their 'just desserts', we tended to become ensnared by the more subtle rationalisations of the more articulate masked depressives. It was a sign of the times when a physician (Bayliss, 1964) writing in a Recent Advances number of *The Practitioner* could report—"perhaps the most outstanding advance, involving *all branches of medicine*, in recent years, has been the realisation of the protean manifestations of depression. Those patients with obvious depression, whether or not they have suicidal inclinations, who find their way to a psychiatrist, constitute but a small visible apex of the iceberg. A much larger number of patients, the underwater component of the clinical iceberg, present to their family doctor with somatic symptoms ranging in spectrum from tension headaches, backache, general malaise and abdominal symptoms to the drenching sweats of the menopause, cardiac symptoms, shortness of breath, chest pain and urological disturbances". This heightened awareness of the prevalence of hidden mood change and the judicious use of appropriate chemotherapy has brought relief from distressing disability and avoidance of unnecessary life-changing decisions to a whole cohort of patients who may have been dismissed previously as "just neurotic I'm afraid." Needless to say, life events must be carefully scrutinised, they play their part as

cause and effect inevitably and chemotherapy, if indicated, is complementary, not an alternative, to psychotherapy in one of its modes. However, despite the rewards for patient and doctor of accurate assessment of mood change, it is my experience that still too many people, too many doctors and, dare I say it, too many psychiatrists, are insufficiently aware of the subtlety and power of the old fashioned mental mechanisms, rationalisation, projection, and, more deviously, dissociation—so much more obvious in the florid illnesses of the past. Too often the cart is put before the horse, life events before biological mood change. So subtle, varied and ubiquitous are the manifestations of endogenous mood change and so responsive to appropriate chemotherapy, that this diagnostic skill has become an essential attribute of the clinician, whether psychiatrist or practitioner in any other branch of medicine. I look forward to the day when these subjective judgements can be monitored by quantitative laboratory measurements.

Long continued service as a consultant in one location has provided the opportunity to review the life story of patients who return with recurrence of symptoms after years or decades of wellbeing. This experience has emphasised the inadequacy of diagnostic labels in psychiatry, and hence the unreliability of statistics in a discipline where nothing short of a descriptive formulation can convey an estimate of the clinical picture, and provide a basis for assessment of prognosis. Family history, early environment, intellectual and physical endowments, strength of neurotic traits, and above all the elusive characteristics associated with personality maturation, or the absence of it, combine to determine symptomatology and future expectations. In these long-term reviews, life events can be seen to have modified the original symptomatology, but the essential characteristics of the personality remain as determinants of outcome. This observation, of course, accords with conventional wisdom. The child remains 'father to the man'. These opportunities for reassessment have provided further evidence of the cyclical nature of the progress of so many varying clinical presentations, and account for the fact that with age and experience, my estimate of prognosis has, in general, become more optimistic where a biological mood change is a critical factor in aetiology.

Psychotherapy

The varied interpretations of the word psychotherapy have tended to distort the public image of the psychiatrist and it is still synonymous in the minds of many people with some form of psychoanalysis. There are so many and varied psychological approaches to the relief of emotional problems nowadays that despite the propriatorial air sometimes adopted to the word psychotherapy, it is probably best thought of in terms of an attitude of mind common to all the caring professions, rather than a special technique. In its wider sense it might be defined as the influence of one personality on another, specifically directed to the relief of emotional problems and the encouragement of a healthier adjustment to stress. Apart from the heightened sensitivity to people's needs implied by this definition, the relationship involves the assumption of a degree of responsibility by the therapist for the sufferer's welfare, due to the inevitable psychological regression accompanying the distress of illness. A more conscious awareness of the importance of the relationship between doctor and patient is one of the contributions that the concept of psychotherapy has made to general medicine, all the more important in this age of increasing technology, proliferation of specialties and drift to a more impersonal medical service. To counteract this tendency, we do not necessarily need more psychiatrists, but more psychiatrically orientated doctors, nurses and ancillary personnel in every branch of medicine.

The growth of a more sophisticated awareness of psychotherapeutic influences has been a feature of modern times, not only among the helping agencies, but in society generally. This development has been reflected in the growth of a number of self-help organisations dealing with specific problems such as alcoholism, compulsive gambling, eating disorders, and disabling phobias of various kinds. The participants in these groups are drawn together by the urgency of some common need, and their formation has been a helpful development in society, worthy of our encouragement and support: all the more so, since they have developed in response to the failure of more orthodox medical approaches to their problem. As with all other aspects of life where objective certainty is absent, theories abound, and the multiplicity of individual and group psychotherapies have much in common with the character and diversity of religious sects. Beliefs tend to be held with the assurance and fervour of a religious faith. Relief from disability is often accompanied by some of the psychological characteristics of the phenomenon of conversion.

As psychiatrists, we belong to a branch of scientific medicine and whatever form of psychotherapy we come to adopt as a result of our training, experience and the foibles of our own personalities, it should be based on factual communication with our patients. Morbid fears and fantasies should be countered by explanation and illustration adapted to our mutual level of understanding. Medical psychotherapy should be a heightened form of two-way communication, an educational experience for both patient and doctor, satisfying because symptoms are relieved and an enriching experience because a measure of self-knowledge has been gained.

The psychiatrist and society

The heritage of fear of mental illness and the misunderstanding of emotional aspects of illness generally remain with us still to some extent, and even among our colleagues in the medical profession, it is responsible for some ambivalence towards our specialty. Overt hostility is rare nowadays, but covert defensiveness often betrays itself in such attitudes as amused tolerance or jovial dismissiveness. This ambivalence among some of the establishment figures of our teaching hospitals may be one of the reasons why, despite the challenging nature of the subject and the scope it offers for fascinating clinical experience, psychiatry does not attract its fair share of the outstanding personalities in

most student years. Too often they follow the well-trodden path to the more highly regarded specialties. No doubt every specialty feels it deserves the best, and fortunately there are many notable exceptions to these observations.

The image of the psychiatrist in the minds of the general public is still a blurred one. While sometimes he is revered, often he is feared and perceived as a somewhat vague, anomalous phenomenon of modern times: vague because his status is an emerging one, and anomalous because his sphere of influence in a tenuous way seems to try to bridge the gaps between science, philosophy, psychology, sociology, theology and, some would say, mythology! This picture is not a happy one, nor is it a fair representation of the achievements of the hard-working body of men and women engaged in the day-to-day battle against mental illness.

Nonetheless the past four decades have been an exciting time in the evolution of psychiatry as a medical specialty. The area of mental suffering where specific and often speedy symptom relief can be provided has enhanced the image of the psychiatrist as a healer and an orthodox exponent of the scientific approach to medical problems. He has become more human in the eyes of the community, and his work is surrounded by less drama and false mystique.

There remains the vast area of human discontent and suffering which comes within the psychiatrist's field of interest and concern in so far as these reactions are manifestations of environmental stress or the inadequacy of people to cope with that stress. There are the many medico-social, medico-legal and community problems for which, like other disciplines, we have no specific remedies to offer. There is the whole range of personality inadequacies, disorders intellectual and emotional, which make a proportion of our population prone to calamity in our competitive society. There is a wide and increasing variety of problems, such as urban violence, vandalism and theft, symptoms more of social than personal malaise, forming a background of insecurity inimical to happiness and mental health. There is the vast challenge of unemployment, over-crowding, educational disadvantage, the growing problem of alcohol and drug abuse and what appears to be administrative and political insensitivity to these trends. The list is a long one and there are many 'lacks and loads' which combine to determine the plight of some of the patients we see in our hospitals and out-patient departments. The failure to distinguish between these social maladies and the identifiable illnesses for which we can provide relief, sometimes places the psychiatrist in a false light by raising expectations of help which cannot be fulfilled. As good citizens we must be concerned about these urgent disasters of our civilisation, offer our diagnostic skills to illuminate the causes and suggest remedies for others to carry out, but our training as doctors and psychiatrists does not fit us to become political activists or social reformers or endow us with any special therapeutic wizardry for these illnesses of society. It would be megalomanic to suggest that the insights of our specialty offer an open sesame to utopia. In this area of our work, co-operation with other disciplines must be an important function, particularly in providing the results of our clinical experience to workers in all the other fields of endeavour which combine to determine the quality of human life.

The scientific method has given rich returns to our specialty and, if forsaken, would put ourselves and our patients at risk of returning to the suspicious fears and neglectful cruelties of the past. Like the cobbler and his last, we should stick to the medical model. Too much diversification, too much tilting at windmills, will dissipate our energies and will perpetuate the somewhat quixotic and eccentric quality still seen in the portrait of the psychiatrist by some of our fellow citizens. These comments on 'parts' of psychiatry, these hobby-horses I have ridden, reflect the influences and experiences of a life time and, no doubt, betray the rigidity and dogmatism of the ageing mind. But, to misquote Henry Ford—history is *not always* 'bunk'.

MSc in Psychiatry (University of Keele)

Applications are invited from Registrars or Senior Registrars in the Midlands for a Master of Science (MSc) Degree of the University of Keele. This research postgraduate training leads to a degree by thesis and is not linked with an MRCPsych Course requirement. The degree may therefore be appropriate for Senior Registrars (or Consultants), as well as for trainees undertaking their general professional training. The period of study is one year full time, or two years part time. Further information: Professor John L. Cox, Department of Postgraduate Medicine, University of Keele, or Mrs N. Steele, Department of Postgraduate Medicine, Thornburrow Drive, Hartshill, Stoke-on-Trent, ST4 7QB (telephone 0782 49144, ext 4746).

Christmas Lecture

Professor Anthony Clare will deliver the first Christmas Lecture for Young People (12–18 years) at 3.00 pm on Friday, 19 December at The Royal Society, London. Further details are available from the Education Department, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (and not from The Royal Society).

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