British Journal of Psychiatry (1993), **163**, 542–546

The Current Literature

McHugh's "A Structure for Psychiatry at the Century's Turn – The View from Johns Hopkins"

R. H. S. MINDHAM, J. G. SCADDING and H. G. MORGAN

"I have three specific aims: firstly, to review some of the concepts supporting contemporary American (USA) Psychiatry; secondly, to explain the origins, strengths and frailties of these particular foundations; and thirdly, to provide examples of activity in the Department of Psychiatry at Johns Hopkins School of Medicine that intends to both revise and restructure these foundations in ways that enhance teaching, practice, and research."

The introduction quoted above is from an article by McHugh (1992). The present authors were invited to comment upon the study.

R. H. S. Mindham

When I began psychiatric training in the mid-1960s, the trainee, having obtained the approved background experience in medicine, neurology, and possibly paediatrics, was faced by a dilemma for which he was ill-prepared; should he become a physician-psychiatrist, viewing his role as being in the investigation, diagnosis, and treatment of disturbances of behaviour and experience; or should he abandon all that had gone before in his career and take a dynamic-psychological view of human distress and disorder, possibly forming an allegiance with one of the schools of dynamic psychology? There was some pressure to join one or other of these factions, but there was also an alternative – to become a psychiatrist with an eclectic view of the subject. To follow this course was fraught with risk however, as there was a view that to believe a little in anything or everything was to believe in nothing. Against this background, the trainee psychiatrist had to equip himself for practice in the real world, where it is necessary to be able to assess any patients, no matter what their problem; to do this in any setting; and to be able to make reasonable suggestions for their management.

In his lecture to the Section of Psychiatry of the Royal Society of Medicine, Paul McHugh examines the scope of psychiatry, and argues the case for a particular approach. Broadly speaking, he proposes that no single view of psychiatric disorders is adequate, but that psychiatric problems may be approached from four viewpoints: the disease perspective; the dimensional perspective; the behaviour perspective; and the life-story perspective. Some types of disorder fall more readily into one or other of these groups, but others may require consideration by more than one approach, the last perspective being especially useful because it readily embraces the others.

McHugh traces the emergence of these ideas from Kraepelin and Meyer, the austerity of the former's views prompting the individual approach of the latter. He sees a re-enactment of the tensions between these influences in the contrast between the approach to classification of DSM–III (American Psychiatric Association, 1980) and the 'biopsychosocial' approach of Engel. The Johns Hopkins view began to emerge in the early 1980s with the publication of the book *The Perspectives of Psychiatry* (McHugh & Slavney, 1983), developed further in Slavney & McHugh's *Psychiatric Polarities*, in 1987.

Do McHugh's perspectives form a suitable "structure for psychiatry at the century's turn"? Do they represent an advance in thinking? I believe they do. His proposals get away from a narrow, doctrinaire view of what constitutes psychiatric disorder, but there are snags, and McHugh himself acknowledges these. Furthermore, he does not claim originality in these ideas, rather seeing himself as bringing together ideas which have been around for some decades into a coherent, modern juxtaposition. How satisfactory are his perspectives?

The disease perspective has been given a prolonged trial in medicine, and it clearly has some use. In practice, however, the problem is in deciding how widely it is applicable in psychiatry. As McHugh says of DSM–III "By posing the existence of conditions DSM–III calls out for their validation and explanation". Thus, the diagnosis is a hypothesis which explains why the patient is unwell. This hypothesis is tested in the examination and investigation of the patient, but at the same time the process of stating a hypothesis is tested, eventually revealing whether the diagnosis is itself a valid category. Diagnosis can be investigated by the scientific method. Is this also

https://doi.org/10.1192/bjp.163.4.542 Published online by Cambridge University Press

true of the other perspectives; can they too be examined rigorously?

Aspects of health can certainly be examined in dimensional terms: blood pressure is an example where the normal range in man is known and individuals who depart from this range may be regarded as having an abnormal result. Personality traits might be tested similarly, but there are conceptual difficulties where such descriptions as 'hysterical personality' are concerned, as these contain several items of information of mixed origins. This would appear to be a less secure category than hypertension, but the existence of difficulties in recognising the features of a trait or constellation of traits do not mean that the concept is invalid. Over-simplification of a dimensional model of personality can lead to ideas which are difficult to apply clinically, as seems to be illustrated by the characterisation of personality by assessment of traits or dimensions of introversion, extroversion, neuroticism, and stability.

I am, however, least convinced by the category of problems arising from changes in motivated behaviour. While eating and sexual activity may be seen as goal-directed, motivated behaviour, it is more difficult to see more complex behaviour such as attempted suicide, refusal to eat in anorexia nervosa, or delinquency and drug abuse in the same terms. Do these serious manifestations of disorder not arise from a variety of sources and influences, varying markedly between subjects showing the same behaviour? The migration of animals (an example given by McHugh & Slavney, 1983) appears to have the same purpose for each animal of the species.

The life-story perspective certainly contains the warp and weft of psychiatric practice, but is it any more than a way by which clinicians can approach and make contact with a patient? Does it contain a concept which is explanatory and itself capable of being tested? I see the life-story approach as being a way of trying to understand the individual patient, rather than of one conceptualising a clinical problem. Within the method, however, are procedures which themselves may be subject to scrutiny. In a sense, its weaknesses are those of some of its constituent parts, and in particular our difficulties in characterising the personality in a reliable and valid way.

In spite of these comments, I believe that McHugh has done psychiatry an important service in stating, as he sees them, ways in which we can consider and try to understand psychiatric disorders. He has given us an interim report on progress in this area which demands our attention. He is right to claim that psychiatry has a substantial area of understanding, competence, and expertise, but also wise to qualify these claims and to recommend caution in asserting them. His "structure for psychiatry" would have reassured the trainee in the 1960s, and does provide "foundations . . . that enhance teaching, practice and research". This paper deserves to be widely read and should be a major influence on our thinking in the present decade and beyond.

J. G. Scadding

As a non-psychiatric doctor who has long been concerned with the logic of medical discourse, I have referred several times to the special problems of psychiatric nosology (Scadding, 1980, 1982, 1990, 1992). It is from this point of view that I make some comments on McHugh's lecture.

One of the difficulties encountered in discussion of these topics is that of making sure that all parties are using key words in the same sense. McHugh suggests a "structure for explanations" in which the concepts of disease, dimension, behaviour, and life story are regarded as different perspectives, from which psychiatric disorders are seen and within which they may be explained. I will therefore try to set forth my understanding of what is implied by each of these "perspectives".

Disease perspective

Failure to agree on the proper usage of the word 'disease' is a frequent cause of misunderstanding (Scadding, 1988). It is unfortunate that in colloquial discourse (and also in unguarded medical usage), the names of diseases seem to refer to causes of illness; but analysis of informed medical discourse shows that this is always a logical error. The following statement (Scadding, 1988) aims to make explicit the factual implications of the name of a disease.

> "The name of a disease refers to the sum of the abnormal phenomena displayed by a group of living organisms in association with a common characteristic or set of characteristics, by which they differ from the norm for their species in such a way as to place them at a biological disadvantage."

Disease terminology is a convenient aid to stating concisely the end-point of a diagnostic process, which starts from assessment of the patient's current status by the procedures of the medical consultation and relevant investigations, and proceeds to unravel as far as possible the causal chain leading to it. The name of a disease may: firstly, refer to no more than a consistent syndrome, recognition of which is useful because study of previous cases has provided knowledge about prognosis and possibly useful therapeutic measures, although causation remains unknown;

https://doi.org/10.1192/bjp.163.4.542 Published online by Cambridge University Press

secondly, it may refer to the effects of a specified disorder of structure or function, although the cause of this defect may be uncertain; or thirdly, it may refer to the effects of a specified causal agent or process. Thus, in the disease terminology, diagnoses have varying causal implications. If the disease is syndromally defined, we are admitting uncertainty about its cause; if it is defined by a disorder of structure or function or by cause, it is an effect of its defining characteristic and must not be confused with its own cause. In no instance is it correct to regard a disease as a cause.

McHugh's statement of his disease concept, though not discordant with this analysis, is more restrictive, suggesting that a syndrome is appropriately considered a disease only if an underlying disorder of structure or function can be shown. However, acceptance of this view would require the rewriting of the history of medicine, since a common first step in medical knowledge – historically probably the most common – is the recognition of a syndrome. Even without the support of studies showing various deviations from biological norms in some patients with schizophrenia, such as those showing atrophic changes in the brain, it is entirely correct to regard schizophrenia as a disease, at present defined syndromally, with the justification that we can recognise it by its symptoms and signs, and that we have useful knowledge of its course and of measures which may affect this favourably. Is it not a standard pathway in the advancement of medical knowledge to define an operationally useful syndrome, and then to seek within it correlations with disorders of structure and function, and with possible causal factors, both genetic and environmental? If the finding of structural changes is required as a defining characteristic of schizophrenia, what about patients with the clinical picture of schizophrenia in whom no such changes can be shown? Are they to be excluded from this category, or are we to assume that changes of this sort are present in them, but not demonstrable? This latter procedure would imply that all cases of schizophrenia are associated with this structural change, whereas we surely should allow for the possibility that schizophrenia is not a pathogenetically homogeneous category. Acceptance of a syndromal definition legitimises comprehensive investigation, and allows for the possibility (probability?) that we may eventually be able to distinguish within schizophrenia a number of pathogenetically distinct categories, just as we can within the anaemias, or indeed among the epilepsies.

Dimensional perspective

I was surprised to find that this section deals only with psychological features, in effect with the assessment of personality. But gradation and quantification, in which respects McHugh suggests that this 'perspective' provides a contrast to disease, are surely important in all diseases, whether defined syndromally, by disorder of structure or function, or aetiologically. Physical dimensions, such as height and weight, with which the assessment of personality is claimed to be analogous, are certainly graded factors. This analogy though, introduces what I call the "fallacy of misplaced precision". Height and weight are physical properties which can be measured by simple reproducible procedures, open to general inspection, whereas the 'dimensions' of personality are abstract concepts, about which there may be legitimate disagreements. I believe that assessment of personality should enter into every medical consultation, even for patients with diagnosable organic diseases; the justification for naming it as a separate 'dimension' can only be to emphasise its special importance in the psychiatric consultation, and to draw attention to the desirability in this context of minimising its dependence on subjective judgements.

Behaviour and life-story perspectives

These are especially important in the affective and behavioural disorders which enter so largely into psychiatric practice. However, they also enter into all medical consultations, to a variably important extent. In my own practice in the field of respiratory diseases, I devoted much effort to discouraging the undesirable behaviour of cigarette smoking, and the role of 'life-story' factors, both in the aetiology of some functional disorders of respiration and in affecting patients' reactions to organic disease, was obvious. Did McHugh perhaps bring in the life-story dimension to appease the Freudians?

These four 'perspectives', however, are unduly divisive: each should enter into every medical consultation in varying degrees, and I would prefer to emphasise their inter-relation. The general statement about the proper usage of the names of diseases, quoted above, emphasises that psychiatry is to be considered within the general ambit of medicine. Most of its diagnostic categories are at present syndromally defined. The delineation of syndromes is a proper starting-point for studies of correlation with causal factors and with specifiable disorders of structure or function; these will extend the area within which practice can be based

https://doi.org/10.1192/bjp.163.4.542 Published online by Cambridge University Press

upon objective knowledge, rather than subjective judgements.

Finally, I was disappointed to find no reference to the difficult problem of the definition of the limits of personal responsibility, both general and of doctors, including psychiatrists. I have suggested elsewhere (Scadding, 1980) that the phrase "in such a way as to place them at a biological disadvantage", in the general statement may help in this respect.

I am aware that, as in other concise statements of complex ideas, the terms of this phrase need expansion. Although 'biology' in its widest sense includes everything from molecular biology to ecology, I intend it here to refer to the study of life by scientific methods, that is by the formulation of testable hypotheses which are accepted as provisional approximations to truth, so long as they have survived refutation by observation or experiment. 'Disadvantage' is to be interpreted in relation to survival and reproduction in the given environment, since the survival of each species is its only perceptible objective; and in the definition of a disease, it refers to the group specified by the defining characteristic, rather than to the individual. If the criterion of biological disadvantage applies, there can be no doubt of the propriety of medical intervention. If it does not, specifically medical responsibility ends with the exclusion of biological causes, although the doctor has the common moral responsibility for guiding the individual to agencies that may help him/her. In those instances in which there is doubt about the relative importance of biological factors or environmental stresses in the causation of subjective distress or behavioural changes, or both, it seems to me wiser not to attempt formal categorisation, but rather to admit this doubt by a descriptive statement, which may, of course, include reference to possible causal factors.

H. G. Morgan

This paper examines the ways in which clinicians classify and understand psychiatric disorder. After first looking back at the foundations of contemporary American (US) psychiatry and appraising the current scene, Professor McHugh then sets out the possible ways to enhance teaching, practice, and research. Central to his theme is DSM-III (American Psychiatric Association, 1980) – how it came to be, its strengths and vulnerabilities, and ways of moving on from it.

The foundations of DSM-III are identified here as arising from Emile Kraepelin and Adolf Meyer: most people are well acquainted with the former, but Meyer seems to have sunk into relative obscurity, at least this side of the Atlantic. His attempts to synthesise everything, with an emphasis on common-sense analysis, may perhaps fail to resonate with the present-day search for precision. Yet George Engel's call for a biopsychosocial synthesis, an approach supported by many psychiatrists today, arose out of Meyer's psychobiological theory, which was severely critical of the rigid categorisation inherent in the disease-entity concept. Meyer emphasised the uniqueness of individual personality, and required that the life-history narrative should be explored in great detail. As a result, he rightly focused on the need to understand each individual's unique reaction to events in the light of his/her personality profile, and he was the first to set out clinical analysis in the form of an individual formulation. Such an approach did, however, make it difficult to establish general rules of psychopathology. Kraepelin and Meyer were poles apart and essentially irreconcilable, yet DSM-III has bravely attempted to effect a reconciliation. Professor McHugh comments that as it is based on empiricism, with the potential to include any entity which can be operationally defined, DSM-III must be heuristically sterile, offering no rules and no directions: its biopsychosocial approach is so broad and non-specific that it can do no more than remind psychiatrists to be prepared to look at everything, providing "ingredients but no recipes" in attempts to validate and explain. DSM-III is seen as both neo-Kraepelinian and neo-Myerian, merely replaying long-established themes. Professor McHugh then describes attempts to reappraise psychiatric explanations, and provides a conceptual structure which he believes can take clinical psychiatry forward, out of the limits set by such older ideas.

At the Johns Hopkins Hospital, four distinct clinical perspectives are identified in contemporary psychiatric thought on the nature of mental disorder, and these are presumably included routinely in the assessment and management of patients who attend there. Each perspective is distinct from the others with regard to its underlying logic and in the way it sets operational guidelines.

The *disease perspective* is categorical and appears not to differ from axis I of DSM-III. When clusters of clinical features can be linked with distinct and clearly demonstrable neuropathological abnormality, the disease entity is confirmed: research concerning atrophy of the left superior temporal gyrus and its relationship with auditory hallucinations in schizophrenic patients is quoted as an example.

The *dimensional perspective* is concerned with individual variation, and presumably has much in common with axis II of DSM-III: individuals who deviate to an extreme along dimensions on which we

https://doi.org/10.1192/bjp.163.4.542 Published online by Cambridge University Press

are all placed may suffer as a result. Professor McHugh cites research in Baltimore concerning DSM-III compulsive personality disorder which illustrates this point well. The remaining two perspectives do not compare closely with any axis of DSM-III, however.

The *behaviour perspective* concerns phenomena which are goal-directed: the examples of drug addiction and certain sexual abnormalities are quoted, initiated by exposure to certain stimuli or situations, and then self-perpetuated by both psychopharmacological and conditioning mechanisms. Successful management requires measures to 'stop' the behaviour which may themselves be quite inappropriate in the treatment of diseases.

Finally, the *life story perspective* concerns the way mental distress may arise from life events of the past. Professor McHugh comments on how a 'missionary fervour' may develop with regard to this approach, in which endless schools of psychotherapy produce equally interminable theoretical reconstructions, leading to conflict and polarisation. Nevertheless, when this perspective is the most relevant to any clinical problem, he concedes that an individual may benefit greatly from such an approach. In describing these four themes, it is pointed out that each subsumes issues which might be regarded as biological, dynamic, or sociological, varying in salience from one perspective to another, rather than these being perspectives in themselves.

In evaluating ways forward towards new styles of thinking, it is always difficult to disengage from long-established patterns of ideas, and we have to ask ourselves whether the four perspectives described by Professor McHugh really are novel, or perhaps no more than new wine in old bottles. The first two perspectives make no real break with the past, and are indeed closely represented in DSM-III itself. The behaviour perspective infers an explanation and mechanism for symptoms and signs which have been observed through clinical assessment. The life-story perspective involves the specific clinical application of history taking, which is already a routine part of clinical method in psychiatry. Professor McHugh of course emphasises that each perspective which he describes is quite distinct from the others, but it would be interesting to learn more about how they are all incorporated into routine clinical work at the Johns Hopkins. They undoubtedly represent important and distinct aspects of psychiatric disorder, but they are already integral to contemporary conventional routine clinical assessment. How then are they conceptually new?

Professor McHugh's paper is, however, a welcome and stimulating attempt to take things forward. Throughout it, the many dilemmas facing psychiatrists are writ large. If our understanding of psychiatric disorder aims to do justice to the complexity of causes which underlie it, then clinical psychiatry must find itself at the confluence of many distinct scientific disciplines. Our responsibility as psychiatrists is to achieve a synthesis of the whole, without becoming over-aligned in any one direction, with inevitable loss of balance in clinical judgement. We have no alternative but to assimilate evidence and concepts from many different fields of endeavour into our routine clinical work. Perhaps the clinician's amateur status in some or even all of these helps to temper enthusiasm, when this becomes too partisan in any one direction. Ours is the middle ground of Adolf Meyer, our skills those of overall balance and synthesis. This needs to be acknowledged as fundamental to the discipline of clinical psychiatry.

References

American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM-III). Washington, DC: APA.

McHugh, P. R. (1992) A structure for psychiatry at the century's turn – the view from Johns Hopkins. *Journal of the Royal Society of Medicine*, **85**, 483–487.

—— & Slavney, P. R. (1983) *The Perspectives of Psychiatry*. Baltimore: The Johns Hopkins University Press.

Scadding, J. G. (1980) The concepts of disease: a reply. *Psychological Medicine*, **10**, 425–427.

—— (1982) Review of *What is a Case? The Problem of Definition in Psychiatric Community Surveys*. (eds J. K. Wing, P. Bebbington & L. N. Robbins). London: Grant McIntyre, 1981. *Psychological Medicine*, **12**, 207–208.

—— (1988) Health and disease: what can medicine do for philosophy? *Journal of Medical Ethics*, **14**, 118–124.

—— (1990) The semantic problems of psychiatry. *Psychological Medicine*, **20**, 243–248.

—— (1992) Commentary on *Diagnoses are not Diseases* by Thomas Szasz. *British Journal of Psychiatry*, **161**, 686–691.

Slavney, P. R. & McHugh, P. R. (1987) *Psychiatric Polarities*. Baltimore: The Johns Hopkins University Press.

R. H. S. Mindham, MD, FRCP(Ed), FRCPsych, *Nuffield Professor of Psychiatry, The University of Leeds, 15 Hyde Terrace, Leeds LS2 9LT*; J. G. Scadding, MD, FRCP, *Emeritus Professor of Medicine, 18 Seagrave Road, Beaconsfield, Buckinghamshire, HP9 1SU*; H. G. Morgan, MD, FRCP, FRCPsych, DPM, *Professor of Mental Health, Department of Mental Health, University of Bristol, 39–41 St Michael's Hill, Bristol BS2 8DZ*

https://doi.org/10.1192/bjp.163.4.542 Published online by Cambridge University Press