# PREVENTIVE PSYCHIATRY—IS THERE SUCH A THING?

By

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THE task of preventive psychiatry—if there is such a thing—can be expressed in a positive form as the promotion of mental health; but mental health can be defined in two ways: as the absence of recognizable mental illness or, in more grandiose terms, as the realization to the fullest possible extent of one's personal potentialities. The latter concept has been denounced by some authorities as representing much too wide an extension of psychiatry: that it continues to be prominent in discussions of mental health programmes and the like is due to the insistence of laymen perhaps even more than of psychiatrists. It appears that in the Western World people are increasingly turning to psychiatrists for the answer to problems which once would have been the concern of priests or politicians. That they do so is a psychiatric problem in itself; that they will continue to do so in increasing numbers seems very likely—so we had better have our answers ready, even if they are only disclaimers of problems which do not concern us.

The trouble is, of course, that it is so hard to draw the line between plain unhappiness and neurotic illness. To an increasing degree, it seems, it is coming to be believed—especially in the American urban middle classes—that to be unhappy is itself a mark of illness. Over thirty years ago Aldous Huxley wrote a pessimistic fantasy entitled "Brave New World". In the synthetic, de-individualized society which he envisaged, all citizens were conditioned to share identical tastes and prejudices, and to live in a perpetual state of unreflective euphoria. If ever they were threatened with anxiety or distress, they would swallow a gramme of "Soma", and euphoria would be restored.

Today, in America, this prophecy is becoming realized. The sales of "tranquillizers" amount to many millions of pounds a year. Readers of the evening papers may already be aware that Hollywood is coming to be known as "Miltown, U.S.A."; that James Mason's director fortifies himself with an ataraxic before interviewing him—only to discover that Mr. Mason does the same. A significant proportion of New Yorkers take sleeping tablets every night—because in this highly conformist society it excites anxiety to lie awake when everyone else is sleeping. (By a dramatic irony we find Huxley himself, a generation later, extolling mescaline as a—for him—new-found elixir, giving access to experiences of transcendental value.) In Britain, too, tranquillizers are bidding fair to displace phenobarbitone as the commonest drug in use.

These are attempts, after a fashion, at preventive psychiatry. The scale on which they are practised reminds us of the need to examine our own psychiatric resources.

I do not propose to devote much space to considering this wider meaning of mental health; except to point out that "divine discontent" (Kingsley, 1874) is an age-old attribute of mankind. It may even be regarded as an agency of evolutionary progress. In every society there have been satisfied conformists.

and dissatisfied rebels. Although the antithesis is by no means absolute, one can say that where dissatisfaction was centred on the material conditions of life, its expression has usually been political; where it was a protest against spiritual impoverishment its inspiration has been religious. We read in St. John: "I am come that they might have life, and that they might have it more abundantly"; and many other religions promise a similar enrichment of the personality.

Psycho-analysts (and perhaps especially analysands) do not like to be described as adhering to a faith: and yet in this respect they have inherited a religious tradition. How many people are there today who would be willing to spend five hours a week, at two or three guineas a time, in conference with a trusted clergyman, in the hope of bettering their wayward natures? Analysands are the *dévots* of our age.*

Historians tell us that unrest and non-conformism are always most evident in times of rapid social change. We are living through such a period now, but with a difference: never before has the social ferment been on a world-wide scale. Peoples' material discontents have been sharpened by the awareness that in the near future it will be technically possible for the first time on earth on the one hand to eradicate hunger and want, and on the other hand to exterminate the human race. There is some evidence that modern civilization, while conquering the major infective diseases, is giving rise to new pandemics of psychosomatic disorders in whose treatment and prophylaxis the psychiatrist is increasingly involved (Halliday, 1948). It is certainly the case that the educated public is showing a new awareness of the avoidable distress occasioned by minor emotional disorders, and by faulty human relationships. In consequence, psychiatrists find their advice sought in spheres with which they may be unfamiliar—such as education (of parents as well as children), vocational guidance, marriage guidance, personnel selection and management, problems of delinquency and crime, etc. One alternative is to abdicate from these responsibilities with a plea of incompetence; but it may be more realistic for psychiatrists to recognize these pressing demands, and to see that some members of the profession are suitably trained to meet them.

To return to the more strictly medical aspects of psychiatry: no one would question that during the present half-century there have been great changes in our practice and in the type of case we treat. When Sir David Henderson (my first teacher in psychiatry) began work in the Royal Edinburgh Hospital in the early years of the century, every third bed in the infirmary ward was occupied by a general paralytic; and there were many cases of gross alcoholic dementia. Both of these conditions have now dwindled to very small numbers indeed. Prevention has taken effect—but can psychiatry claim the credit? These are instances, rather, of the success of strictly medical and social interventions respectively.

## Medical Preventive Measures

Preventive medicine has made enormous advances in the last fifty years. Its mastery of syphilis has been the biggest direct contribution to psychiatry. Others which come to mind are the discoveries of effective preventive measures against pellagra and cretinism. More recently, obstetrics has also come into the picture. It has been shown that some cases of mental deficiency can be attributed to brain injury resulting from complications of pregnancy and

* I speak as an ex-*dévot*, but by no means an apostate.

childbirth: among these are eclampsia, asphyxia of the child and physical trauma.

Another, perhaps less obvious, relationship between obstetric care and the prophylaxis of psychiatric disorders was brought out in a recent study from Johns Hopkins University, reviewing the birth histories of 1,151 behaviour problem children and 902 matched classmates, from public schools in Baltimore (Rogers, Lilienfeld and Pasamanick, 1955). Abnormalities of the pre-natal and paranatal periods were found to be significantly associated with behaviour disorders in children. In the authors' view this lent support to the hypothesis that in some cases minimal brain damage may have occurred: they provisionally class them as belonging to the "continuum of reproductive casualty" (which includes at the other extreme foetal and neonatal mortality, cerebral palsy and epilepsy). The discovery that a specific infection (German measles) caught by a mother at a crucial stage in the development of the foetus may lead to brain damage as well as to deafness or blindness in the child has opened up the possibility of further preventive measures through improved obstetric care.

In one respect, the rapid advances in medicine have proved an embarrassment to psychiatry. Thanks to antibiotics and chemotherapy, everyone is living longer, including chronic psychotics and imbeciles. Many more people than before live long enough to run the risk of suffering from cerebral arteriosclerosis or senile psychoses—and this has resulted in mounting admission rates to mental hospitals.

## Social Preventive Measures

The reduction in severe alcoholism in this country can confidently be ascribed to taxation, which has made it so expensive to drink really heavily. Similarly, legal sanctions have cut down the amount of drug addiction. Other preventive measures of a social kind are the successive modifications of the laws governing the treatment of the mentally ill and the mentally defective: modifications which are still going on, but which have already done much to relieve the stigma of mental illness, and to facilitate early treatment. The National Health Service Act was itself an important preventive measure, because it removed the financial barrier to seeking early treatment, and accelerated the co-ordination of psychiatric treatment with that of the general hospital.

Anything which helps to overcome public dread of mental illness, and reluctance to seek expert advice, is a step in this direction: judicious propaganda, like the recent television series "The Hurt Mind" and current radio programmes on problems of mental health and mental deficiency, has some effect—but the most potent propaganda of all is the demonstration of successful therapy. Within the last ten years we have seen a dramatic change in public attitudes to tuberculosis—because, thanks to isoniazide, streptomycin and P.A.S., sufferers are seen to recover and to be able to lead normal lives. Similar results are accruing from the results of modern methods of treatment in psychiatry. If public attitudes are slower to change with regard to mental illness, this may be because our treatments are still seen to be only partly successful.

There are several instances in which medical and social agencies work together in order to prevent, or to minimize, psychiatric breakdown. In the armed forces, for example, prevention begins with the screening of recruits and of combat troops: at least, this was the intention, but so much uncertainty still attends psychiatric prognosis that the normal screening procedures had a

wide margin of error. In one remarkable study (Plesset, 1946) a divisional psychiatrist had an opportunity of observing how 138 soldiers, who had recently been brought to his attention with neurotic and psychopathic symptoms, fared in five months of combat experience. During this period, only three required to be evacuated on psychiatric grounds, whereas eight were awarded medals for meritorious service; at the end of the war, 120 were still on duty. Similar reports from psychiatrists in the German as well as the Allied armies have given many instances in which the performance under stress of neurotic individuals exceeded expectations (e.g. Kalinowsky, 1950; Hunt, Wittson and Hunt, 1952).

In recent wars, psychiatric casualty rates have been shown to fluctuate with unit morale, and also with the tide of battle; they generally rise in proportion to the rise in the rate of wounded and killed, but a notable exception is during a full retreat. For example, at one stage in the Korean war the United States forces were in retreat and the enemy were said to be practising atrocities on the captured prisoners: for a time there were very few psychiatric casualties indeed (Glass, 1953).

This recalls a view which Dr. C. P. Blacker has put forward: that there is no preventive of neurosis so strong as the experience of *shared* physical distress. It was repeatedly shown in Germany (Kalinowsky, 1950) that psychiatric cases were least common where populations were exposed to severe bombardments. This might be interpreted as a case of the greater evil driving out the lesser; but it also indicates the importance of group solidarity as a prophylactic against breakdown. Good morale in a unit, as competent officers came to learn, can be fostered: it demands contiguity, time to get to know one another, free channels of communication throughout the group, a sense of shared purpose, or at least of a common fate. Out of these emerge a readiness to help each other, and a confidence that help will be given to oneself in time of need.

These attributes of good morale are found in many closely integrated primitive communities: they are nowhere so conspicuously lacking as in the areas of social disorganization which can be found in large industrial cities. A succession of monographs, from the pioneer study in Chicago (Faris and Dunham, 1934) to quite recent investigations in London (Sainsbury, 1955) and Bristol (Hare, 1956) have shown that suicide, delinquency and some mental illnesses (particularly schizophrenia) occur at a higher rate in socially disorganized areas: but it is easier to diagnose this situation than to offer a remedy. Social services are the contemporary substitute for the "neighbourliness" of integrated communities. They are efficient in providing against destitution, but cannot annul the loss of personal contact. There is no sense of give and take in stamping one's insurance card, and drawing "benefits accrued"; often where the need is greatest the receipt of "national assistance" is felt as a disgrace.*

We have to face the fact that social circumstances may sometimes be so adverse that a normal personality adjustment becomes almost impossible: for example, in the 'thirties Professor Lewis studied a group of chronically unemployed men whose mental health was in question (Lewis, 1935). In several cases he concluded that their mental state was either caused or much aggravated by their unemployment—but it was little use to prescribe work at that time of economic depression.

*During a follow-up study of ex-mental hospital patients, in which the writer is currently engaged, it was found that one man made it his first task to pay back £300 which had been paid to his wife by the National Assistance Board. He felt that until he did so he could not remove the slur of being a pauper.

Fortunately, social exigencies are not always so hard to meet. During the war the same author and a social worker colleague analysed the social causes of admission to a mental hospital for the aged (Lewis and Goldsmidt, 1943). They concluded that the admission of many of these old people could have been avoided by timely social work. Since then Dr. Cosin at Oxford and Dr. Macmillan at Nottingham have shown in practice that this is so.

As we know, at this time several experiments are under way to test the advantages of community care for mental patients, on the Querido plan. I include these under the heading of social measures because what they prevent is not illness (though this may prove to be the best method of treatment in some cases) but the social fact of admission to hospital.

On the other hand society may be able to influence the amount of its psychiatric casualties through education. This is clearly shown in the case of mental defect. A number of recent studies (e.g. O'Connor and Tizard, 1956; Clarke and Clarke, 1953) have shown that in many cases the defect is not an insuperable barrier to learning; in some, intellectual maturation is delayed rather than absent. If appropriate measures of graduated social and elementary scholastic teaching are applied, many of these patients can be restored to a socially useful existence. This process is being accelerated at the present time by social pressures applied by Lord Goddard on the one hand and an inflamed public opinion on the other.

A more general question is whether education, in school and in the home, can influence the incidence of mental illnesses. This question is so closely linked with psychological theories about the aetiology of these illnesses that I propose to consider it in the next section of my paper.

## Psychiatric Preventive Measures

So far, I have briefly discussed ways in which preventive medicine and social measures have contributed to the prophylaxis of psychiatric disorders: but are there any preventive measures which are clearly *psychiatric*? I suggest that there are—but not many.

Prevention can operate at three levels:

1. Where the essential aetiological factors of a disease are known, timely intervention may prevent their occurrence.
2. Effective treatment, applied early, may limit the development of illness.
3. Treatment of established illness can be designed to alleviate the disabilities which it entails.

Let me begin with the third level. One way of putting it is this: even if we cannot *cure* serious mental illnesses, are we doing all we can to prevent our patients from getting worse? There is a growing realization that the regime which used to prevail in all our mental hospitals—and which still prevails in some—had the effect of increasing patients' helplessness and regression. To a considerable extent, so-called "secondary dementia" is a hospital artefact: this is being proved today in many hospitals in which active social treatment is both arresting and reversing the process in long-stay patients.

Another important field of ameliorative prevention, which is as yet inadequately developed in this country, consists of the supportive follow-up of discharged patients. To be really effective, this calls for the co-ordination of psychiatric and P.S.W. efforts. There is an interesting report (Stevenson and Geoghan, 1951) of a five-year experiment in psychiatric prophylaxis, in

which the authors placed reliance upon regular out-patient E.C.T. as a prevention against recurrent manic-depressive illness. They found that patients were strangely reluctant to undergo shock treatment once a month for five years, even when they felt perfectly well; and they found some cases in which the prophylaxis did not work. For these they recommended prophylactic leucotomy! In a number of cases it became plain that the illness was related to adverse home circumstances, and the help of social workers was invoked: to this extent, at least, the experiment resembled the sort of co-ordinated follow-up which I have mentioned above, and which is already an established part of psychiatric practice in some parts of Holland.

Secondly, early treatment: our profession takes pride in the many new empirical treatments which have been introduced in the last twenty years, and public confidence in the value of these treatments has been indicated by the great increase in the numbers of patients who come voluntarily for treatment at an early stage of their illness. In some instances (such as the use of E.C.T. for involutional depression) the beneficial results are unmistakable; there is little doubt, again, that in the last war energetic measures of treatment in the forward areas proved effective in preventing much chronic psychiatric disability (Gillespie, 1942; Appel and Beebe, 1946). In other cases (such as the sweeping claims which are made for each new tranquillizer as it appears) our evaluation has to be more cautious, because results attributed to these drugs, as in the past to leucotomy, may be due in part to more general influences, such as the "Hawthorne effect" of receiving special attention and increased social stimulation.

In this matter of the systematic assessment of the results of therapy, psychiatry is only now emerging from its neolithic stage. It is no longer respectable to publish reports based on subjective "clinical impressions"; but as soon as we try to be more rigorous in evaluating the outcome of treatment, we are confronted with the baffling complexity of factors which may influence the course of an illness.

If this is true in the comparatively simple case of assessing physical treatments of established illness, it applies with still greater force when we consider claims that it is possible to intervene in a specific way, so as to prevent or minimize the development of mental illness in persons exposed to risk.

This presupposes a clear-cut, accepted explanation of the way in which such illnesses are caused: but no such explanation exists. In his outstanding monograph on dementia praecox, Eugen Bleuler was quite candid about this. He wrote: "As yet we do not know of any real prophylaxis for this disease", and added, with a sort of desperation: "The avoidance of masturbation, of disappointments in love, of strain or frights are recommendations which can be made with a clear conscience because these are things which should be avoided under all circumstances" (Bleuler, 1950).

Even if we knew how to intervene to prevent schizophrenia, it might not be easy to know when to do so. In an early paper, Kasanin showed that when he investigated the school records of schizophrenic patients he found that the great majority had been regarded by their teachers as either model pupils, or as presenting no problems (Kasanin and Veo, 1932).

My own experience in child psychiatry was the obverse of this. In 1949 I worked for six months in a child clinic in New York, principally with a group of eight children aged about five. In accordance with the prevailing fashion, nearly all of these children (*and* their mothers) were diagnosed as schizophrenic. When I revisited New York 6½ years later I called at the clinic and asked for

news of them. In every case I inquired about, the child was now in a normal school class and getting on quite well.

We probably should all agree that inherited constitutional factors can predispose a person to some forms of illness: but except in rare cases, the amount of such predisposition remains conjectural, and the advice which we can reasonably give if we are consulted about marriage and procreation is correspondingly qualified.

On the other hand, there is wide divergence of opinion within psychiatry about the degree to which environmental factors contribute to mental illness, and about the manner and the stage of development at which they do so. Psycho-analysis represents in the clearest and most authoritative form the view that early psychological experiences play a vital part in aetiology, that their harmful results can be modified by psychotherapy, and that psycho-analytic theory can indicate ways in which the upbringing of children—in the home and in school—can be carried out so as to minimize the risk of later neurotic or psychotic breakdown.

Fenichel puts it in this way: neuroses are based on neurotic conflicts; neurotic conflicts are created in childhood between instinctual impulses and the fear of dangers associated in fantasy with yielding to these impulses. Everyone, in the process of growing up, finds his instinctual impulses confronted at times by limitations inherent in the reality situation. Faulty education consists in confronting the child with threats which are out of proportion to the real danger, so that he takes fright and his impulses are not merely restrained but repressed—to the detriment of his emotional health in later years (Fenichel, 1945).

Psycho-analytic theory has inspired a great deal of the practice of child guidance clinics; and it has also had a considerable indirect influence upon education and upon the way modern parents treat their children. Fenichel gave a few practical hints for child-rearing derived from his theory of neurosis: avoid premature excitation of sexual feelings, and avoid exaggerated condemnation if these occur; delay toilet training until the child is physiologically prepared to respond, and do not force it; anticipate emotional trauma, such as the birth of a sibling, the absence of its mother, or an operation so that the child will not meet it unprepared; in matters of discipline "it is better to understand the child's needs than to use rigid disciplinary patterns".

To a considerable extent all of these maxims have already been accepted by enlightened parents and teachers. It is also becoming widely realized that when one member of a family is emotionally disturbed, another may be in need of treatment.

Yet it has to be admitted that there is *no* evidence that the work of child guidance with patients or with their parents has made any significant difference to the attack rates of neuroses or psychoses in any community. These therapists are inspired by convictions which are based on faith rather than certainty. Personally, I think no less of them for that, provided that they remain willing to re-examine their premises in the light of objective evidence whenever this becomes possible. To refrain from action if there is a possibility that we may do the patient harm is a reasonable precaution, but to continue to refrain until we are absolutely convinced of its rational justification is to succumb to *folie de doute*.

A celebrated example of the danger of uncritical acceptance of an aetiological theory is given by the history of what has come to be known as the "Bowlby hypothesis" concerning the far-reaching harmful consequences of

maternal deprivation during a child's first three years. Dr. Bowlby's book *Maternal Care and Mental Health*, which was published by the World Health Organization in 1951, contained descriptions of cases and cited evidence from other workers which provided very strong support for his contention. The publication of a "Pelican" version of his report made his views widely known: with important social results. One result has been that many children's hospitals and obstetric units have modified their rules in a way which must make the hospital experience certainly more enjoyable and probably more beneficial for their patients; but another result has been to spread alarm and despondency among mothers, and among those responsible for orphanages and similar institutions. Had the "Bowlby hypothesis" been firmly established, this might have done no harm, but in fact, as he himself very honestly admits, in the last five years a number of studies have clearly shown that maternal deprivation is not always accompanied by such dire consequences as many people had been led to believe (Bowlby *et al.*, 1956). Even Margaret Mead, at first an enthusiastic protagonist, now sees its uncritical acceptance as "a new and subtle form of anti-feminism in which men—under the guise of exalting the importance of maternity—are tying women more tightly to their children than has been thought necessary since the invention of bottle feeding and baby carriages" (Mead, 1954). Dr. Bowlby is now engaged in refining the concept, and in analysing additional factors which may mitigate the effect of maternal deprivation.

Before concluding this brief review of preventive psychiatry, I should like to point out that psycho-analysis gives especial prominence to one element in the treatment of mental disorder which has long been part of good psychiatric practice—which is, indeed, as old as the Hippocratic oath: namely the relationship of mutual respect between doctor and patient, the readiness to help and (when volition is not lost) the readiness to accept help. There is no statistical proof that sincerity and humanity in one's dealings with people in need will influence their future mental health; but this is an act of faith which I, and many others, have no difficulty in making.

## References


Appel, J. W., and Beebe, G. W., *J.A.M.A.*, 1946, **131**, 18, 1469–75.

Bleuler, E., *Dementia Praecox*, 1950. New York: Int. Univ. Press. (Translation of his 1911 monograph.)

Bowlby, J., *Maternal Care and Mental Health*, 1950. Geneva: W.H.O.

*Idem, et al.*, *Brit. J. Med. Psychol.*, 1956, **29**, 211–47.

Clarke, A. D. B., and Clarke, A. H., *Lancet*, 1953, *ii*, 1025–30.

Faris, R. E. L., and Dunham, W. H., *Mental Disorders in Urban Areas*, 1939. Chicago.

Fenichel, O., *The Psychoanalytic Theory of Neurosis*, 1945. New York: Norton.

Gillespie, R. D., *Psychological Effects of War on Citizen and Soldier*, 1924. New York: Norton.

Glass, A. J., "Psychiatry in the Korean Campaign", *U.S. Armed Forces Med. J.*, 1953, **4**, No. 10, 1387–1401 and No. 11, 1563–83.

Halliday, J. L., *Psychosocial Medicine*, 1948. London: Heinemann.

Hare, E. H., *J. Ment. Sci.*, 1956, **102**, 349–57.

Hunt, William C., Wittson, Cecil L., and Hunt, Edna B., *Amer. J. Psychiat.*, 1952, **109**, 168–71.

Kalinowsky, L. B., *ibid.*, 1950, **107**, 340–45.

Kasanin, J., and Veo, L., *Amer. J. Orthopsychiat.*, 1932, **2**, 212–217.

Kingsley, C., *Health and Education*, 1874. London, p. 20.

Lewis, A. J., *Lancet*, 1935, *ii*, 293.

*Idem* and Goldsmidt, H., *Sociol. Rev.*, 1943, **35**, 86–98.

Mead, M., *Amer. J. Orthopsychiat.*, 1954, **24**, 471–83.

O'CONNOR, N., and TIZARD, J., *The Social Problem of Mental Deficiency*, 1956. London: Pergamon Press.

PLESSET, MARVIN R., *Amer. J. Psychiat.*, 1946, **103**, 87–90.

ROGERS, M. E., LILIENFELD, A. M., and PASAMANICK, B., "Prenatal and Paranatal Factors in the Development of Childhood Behaviour Disorders", *Acta Psych. et Neuroscand.*, 1955, Suppl. 102.

SAINSBURY, P., *Suicide in London*, 1955. (Maudsley Monograph, No. 1.)