Psychiatry in Decline: A Personal View

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Once it was generally supposed that people were afraid of psychiatrists. The fear of insanity, that ultimate loss of control, made people joke about psychiatrists as they joked about other fearsome things such as death and sex. Now it seems there are fewer jokes but much more open suspicion and hostility and there is much to suggest that over the years psychiatrists have become afraid of people. We have been so preoccupied with the clinical and heuristic aspects of our profession that we have not recognized the emergence of damaging paranoid forces, let alone made any adequate or appropriate response to them. This failure has created formidable problems for the mentally ill and their families and has been a significant factor in promoting one of the vicious backward swings in the pendular history of psychiatry.

I believe this pessimistic view is shared by many older psychiatrists who have observed the changes of the past 30 years and might lay claim to some historical perspective, however distorted. It is not my intention to speculate about the reasons for increasingly hostile social attitudes to psychiatry but to suggest that they are real and persistent and are likely to have an effect on psychiatric practice that is almost wholly negative. It seems that a vast majority of psychiatrists remain comfortably cocooned by their day to day clinical experience and so have little awareness of their poor social image. Their chances of enlightenment appear to be diminishing. In the fifties psychiatrists were much in demand as speakers to schools, voluntary groups, Church organizations, youth fellowships and the like. The experience could be embarrassing because of the uncritical enthusiasm and the essentially benign misconceptions of the audience. Now such invitations are rare and convey the impression of a scraping of the bottom of the barrel.

Thankfully my educative role has shrunk over the years and for the past decade has been confined to meeting Divinity students from St Mary's College of the nearby St Andrew's University. This is enjoyable as they are alert, intelligent, and mature in outlook, less abrasive than social work students, less callow than medical and psychology students. But they have read the *Guardian* and the *Observer* and other influential sources of social comment and the questions, polite but persistent, soon begin. Have not psychiatrists a very high suicide rate? Are they not themselves frequently subject to psychiatric illness? How carefully are they selected, how suspect their motivation? Soon we agree that psychiatrists are a rickety and unreliable lot quite unfit to treat the mentally ill. Who then should be entrusted with this task, for there is no denial of the problem. Psychologists? Uneasy laughter and little support. Social workers? An immediate derisive rejection. An awkward pause and then with surprising regularity comes the suggestion 'other doctors'. Well, yes–but should they be suitably trained and experienced and what should we call them. Non-psychiatrists? Alienists? My suggestion that the Church may wish to reclaim former territory is regarded, when it was not so intended, as a joke and with relief we move on to safer topics.

If we look closely at the bodies with a working relationship with psychiatry we find, in relation to the inescapable interface between psychiatry and the Law, that relations between psychiatrists and lawyers have seldom been relaxed or cordial. One has the impression that most lawyers are profoundly ignorant of the Mental Health Acts and prefer to remain so, and consequently the functioning of these Acts has been determined largely by psychiatrists. When either profession steps outside the boundaries of precedent and convention the results are sometimes disastrous, particularly in England where for whatever reason there has always been more open hostility than in Scotland. The English Courts have sometimes seemed almost too willing to leave psychiatrists to take the blame for ill-judged legal decisions, particularly those with political implications, and in this they have been helped by the more capricious elements of the media.

An obvious example is the case of Peter Sutcliffe. On the psychiatric evidence the Crown had accepted a plea of diminished responsibility but the Judge chose the unprecedented course of a trial—of the psychiatrists, in effect—by jury. When the jury, influenced perhaps by proceedings that clearly wanted him to be declared sane, and preferred uncorroborated evidence of a doubtful nature to that of experienced psychiatrists, duly obliged, *The Times*, the *Guardian* and the *Observer*—usually regarded as quite reputable newspapers—united in a gleeful chorus of condemnation of psychiatry. Who could not doubt that Peter Sutcliffe was then and is not suffering from paranoid schizophrenia? Yet I have seen no hint of a retraction in these worthy newspapers.

More comfortable relations in Scotland may have contributed to the failure of the medical profession, and psychiatrists in particular, to make the smallest protest about the introduction in 1963 of an Act that permitted solicitors to obtain the case notes of patients involved in civil actions, including divorce. At a meeting of the Scottish Division of the Royal Medico-Psychological Association in 1962, a single voice drew attention to the potential damage to the doctor/patient relationship and to the trauma that would be suffered by patients—fears that over the past 20 years have been fully realized—but received no support. Yet some years later a lawyer friend, who moves in lofty legal circles in Edinburgh, told me that the lawyers sponsoring the Bill had never expected it to succeed because of determined resistance by the medical profession: 'It was really just a try on', he said, 'and we found the doctors all asleep'.

Despite these problems, lawyers and psychiatrists have

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to work together and the Courts both in England and in Scotland have generally been sympathetic to patients with major mental illness and have facilitated necessary treatment. When tensions have arisen they have often been attributable to the intrusion of medical or political intervention at some level.

Then we should consider the status of psychiatry within medicine. The attitude of the Dean of an American Medical School who considered that a student's choice of a psychiatric elective was sufficient evidence of emotional instability to debar him from medical training is by no means universal. But the hope that a greatly expanded teaching programme would bring about an improvement in attitudes has not been realized. Only 20 years ago two-thirds of British Medical Schools had no chair of psychiatry and many were giving less than 12 hours of teaching. Although things have changed for the better, there remains a depressing tendency for medical students and young doctors to share the fantasies and misconceptions of psychiatry prevalent in the populace. Psychiatrists are perceived as less educated, less 'scientific' than other doctors, and in truth the striving for academic respectability has not brought any great enlightenment.

Many doctors still seem reluctant to acknowledge the importance of psychodynamic factors in disease, and in the past year three leading medical journals in Britain have had leaders casting doubt on the effectiveness of psychotherapy. If their purpose was to examine cost benefit in terms of case load and outcome of various types of psychotherapy, it was a legitimate exercise. But if, as one suspects, it was to raise doubts about the fundamental place of psychotherapy in the doctor/patient relationship one can only marvel at this persisting superstitious belief in mechanistic medicine, particularly at a time when computers are showing a clear superiority to doctors in many areas of traditional medicine. It is surprising to find doctors asking if psychotherapy works when they should be asking how and where it works.

The Church, like the Law, has generally been ambivalent towards psychiatry. A common heritage of wrestling with psychosis together with an awareness of the immanence of neurosis has led to a fair degree of sympathy. The Established Churches in England and Scotland seem to have learned to live with psychiatry, the English Free Churches to respond more enthusiastically, while the Roman Catholic Church has always taken a quiet pride in its ability to encompass psychoanalysis.

Turning to the elusive concept of public opinion and to the influence of the media, I believe the presentation of psychiatry on television has often been of a very poor standard and much that has been presented has been subject to selective editing that has given a heavily biased and unrepresentative picture of current practice. A reasonably balanced view has been discarded in favour of a series of sensational snippets linked to present material in the dramatic fashion that has become the hallmark of the so-called semi-documentary—the edited truth or Newspeak that Orwell disliked so much.

Colleagues involved in the making of one such programme described spending more than four hours in filming interviews only to find that the screened product contained only three brief extracts totalling less that two minutes and those placed outwith the context of the original presentation. My own limited experience in this field has not been reassuring—a telephone conversion was broadcast by the BBC despite an emphatic assurance, not sought by me, that it represented an exploratory contact and would not be used.

At this point the reader may wonder why my essay is not called 'The Decline of Psychiatrists' as I have been largely concerned with attitudes towards practitioners rather than to practice. If this were the whole story it would matter little. Psychiatrists are apt to see themselves as the only realists in a deeply neurotic world and questions of prestige, professional status and self-esteem rightly go unheeded. Many dismiss their current unpopularity as a passing whimsy, a product of society's neurotic denial and paranoid hostility brought to the boil by the mischievous media and not a serious threat to anyone. This, I am certain, is a grave mistake, as it must be obvious to the least perceptive among us that the whole practice of psychiatry—the basic nature of the help we can offer our patients and their families—has been undermined by the hostile attitudes that have become entrenched in the recent amendments to the Mental Health Acts both in England and Scotland.

Less than a year before the passing of the Amendment, no one in Scotland anticipated any major changes in an Act which was thought by many to be the best legislation so far in the field of psychiatry. Clinical psychiatrists, College representatives, members of the Mental Welfare Commission, and the staff of the Scottish Home and Health Department were all convinced that any amendments would be of a very minor nature. Only at the stage of 'consultation'—a hurried and ill-presented process that predictably brought about no significant changes in the content of the initial draft—did it become apparent that major changes very much in line with those in England were being pushed through.

What can one think about a Parliament that can accept that the equally advanced Data Protection Bill was too controversial to be so easily passed yet chooses to ignore the anxieties of concerned professionals and the advice of bodies with direct experience of major mental illness, such as the National Schizophrenia Fellowship, in foisting on the public legislation that is in every important respect inferior to the Act it displaces? Psychiatrists should have taken far more serious heed of the warning given in July 1982 by Peter Sedgwick in 'The Fate of Psychiatry in the New Populism'.[1] In discussing Parliament's role in the Mental Health Act Amendment he pointed out: 'It has been notable to see that the psychiatric profession now lacks any source of stable advocacy from any quarter in either House'.

And what a bizarre and preposterous Act we are now lumbered with. To call it an amendment is to misuse

words, as it stands the 1959 Act on its head. If the Parliamentary Debate of the Mental Health (Amendment) Act in England lasted longer than its Scottish equivalent the contributions appear to have been uniformly unenlightened. The prize must surely go to the MP who at the last ditch managed to get the mandatory second opinion in 'treatments of special concern' (yet to be defined by the Government and to be reviewed periodically) extended to informal patients. This means that in future patients eager and willing to have a treatment prescribed by a doctor in whom they have every trust may be denied it—by a Commission of predominantly lay persons. To thus stigmatize psychiatrists may simply be fashionable, but so to stigmatize psychiatric patients is the work of foolish, unfeeling and unthinking people.

When it was first alleged by the enemies of psychiatry that 'public opinion' was against 'treatments of special concern' these treatments were thought to be psychosurgery and hormone implants—very rarely used and rightly regarded within psychiatry as causes of special concern. But already for detained patients we have a second category requiring informed consent or a second opinion and this category includes electroplexy and 'medication for mental disorder given for more than three months'. Such measures can only make the treatment of schizophrenia and severe depression difficult, subject to hazardous delay, and in some cases, impossible. Another Government review of the categories of 'treatments of special concern' may result in a major shift towards the banning of psychiatry altogether.

No one has shed any light on the questions raised a year ago by the Stratheden Medical Committee—who carries legal responsibility when first and second opinions differ? What liability will be incurred by doctors of whatever grade giving 'urgent' and life-saving treatments? (A good example of the double bind now imposed on psychiatrists who have a common law duty to deal with emergencies and in consequence are put in legal jeopardy by an extremely confused statute law.) Nor has there been any firm indication of the allocation of financial resources to meet the cost of additional social work staff and the cost of second opinions, now reputed to be earning some psychiatrists more than £600 a day.

The central purpose of a Mental Health Act is to ensure that the seriously mentally ill who cannot give knowing consent to treatment nevertheless receive appropriate treatment, and for more than 200 years this has been a medical responsibility. Throughout this time there have been critics from Lord Coleridge to Thomas Szasz who have vehemently opposed the very existence of such legislation but this is surely the first time the law has become so ambiguous and potentially so unjust both to the patients whom it seeks to protect and to the doctors whom it charges with their treatment. In effect, it gives 'power without responsibility' to people who are not primarily concerned with treatment and the medical profession, including psychiatrists themselves, do not quite seem to have understood this. To the lawyer who argues that a detained patient cannot give valid consent to psychiatric treatment, to the social worker who can see no grounds for admission under the Act, to the psychiatrist whose second opinion rejects my prescribed treatment I would give the same answer: 'Very well, you may be right and I wrong, but you must accept the responsibility of your decision. I cannot, and will not, share it.'

Of course effective controls and safeguards are necessary. Psychiatrists have indeed frightening powers and responsibilities and like any other group in society, we are sometimes capable of abusing power and eschewing responsibility. I have for many years been one of a none too popular minority that has advocated closer monitoring of individual psychiatrists in their use of compulsory powers, and a more precise evaluation of standards of care both from within and outwith psychiatric services.

I now come to the core of my case and the real reason for taking up my pen—the failure of psychiatrists themselves of recognize these trends and acknowledge their destructive effect and to take any action to combat them. Why have we become so passive, so detached, even to the point of seeming to collude with the ill-assorted forces ranged against us, to the detriment of our patients?

Much can be attributed to the Freudian teaching that influenced the older generation of psychiatrists. Negative transference, the arousal of hostility towards the therapist, was an essential phase of therapeutically induced neurosis and the earlier it could be evoked and the longer it lasted the better. Counter-transference, hostility aroused in the therapist towards the patient—by definition unconscious and therefore discernible only to other analysts—was a dreaded vortex that might betray a failure in personal analysis or might even render us unsuited to our chosen profession. This led easily to the familiar caricature of the bland remote psychiatrist of the *tabula rasa* countenance mopping up insults as a tribute to therapeutic expertise. Many of us when younger found it convenient to preserve this lofty detachment outside the consulting room whenever our profession was under attack. Goodness knows it worked well enough—the mask of nonchalance and opaque wisdom sufficed to reduce opponents to inarticulate rage more quickly than any reasoned argument.

Younger psychiatrists may have escaped this influence but now the broader and sometimes divergent aspects of training create other anxieties that seem to encourage an escape into research or into early specialism. There has been an increasing tendency to regard administrative psychiatry and legal psychiatry almost as a specialized area of knowledge and experience and in a somewhat cowardly fashion we have made forensic psychiatrists our spokesmen for organized psychiatry in matters relating to the law. I have great respect and admiration for forensic psychiatrists, who get little enough help from generalists in their gargantuan struggles, but their experience—confined largely to the serious offender patient—is so unrepresentative as to constitute a major handicap and this may have contributed to the débâcle of the recent Mental Health Acts.

Yet these appear inadequate reasons for our quietism and it may be that it is the very nature of psychiatry that undermines our purpose. Collectively psychiatrists have a tendency to yawn when questions of high seriousness arise and in consequence we make poor medical politicians. We are quickly bored by pomp and pretension and remain steadfastly self-deprecating, as should be those who for a living trade on the whispered secrets, the fantasies and foibles, the sheer madness of mankind. Our knowledge of ourselves and others makes us ineffectual and lacking in authority—the uncontrollable hysterical giggle is always uncomfortably near the surface.

Perhaps then it is unfair to criticize too sharply the institutions that mould our profession. The Royal College of Psychiatrists has to encompass a far wider spectrum of opinion than any comparable body. Thus in responding to political pressure both from within psychiatry and in society at large it has appeared uneasy and vacillating, preferring to avoid controversy of any sort. Its presidents, drawn mainly from an academic background, are amiable men who give the impression of wanting to survive their three-year period of office without unpleasantness.

The College has many committees, including a Public Policy Committee, our bulwark in the recent legislative battles. A member reviewing a decade of the PPC's work[2] concludes rather gloomily: 'I consider that too wide a range of subjects reduces effectiveness and in its present role the PPC may have a limited future. I forecast that it will either be fragmented and absorbed into other College bodies or that it will thrive with more sharply defined, if more restricted, terms of reference.' No doubt the College in maintaining its broad church has a daunting task. But one does wish that now and again it would, like Eliot's Hippopotamus, take wing, however uncertainly, rather than remaining below the rockfast True Church, 'wrapt in the old miasmal mist'.

The Society of Clinical Psychiatrists has always shown a lively concern about major issues and its publications bring a sharp focus that is widely shared by psychiatrists everywhere. But it is difficult for a small group to exercise the sort of influence that is needed to meet the continuous political pressure to which psychiatry has become subject.

Should psychiatrists remain in untroubled slumber, are there any reassuring signs of anxiety in other quarters? The President of the General Medical Council has warned of the baneful effect that the constant replacement of Common Law by Statute Law will have on medical practice, not in psychiatry alone. In contrast to the *Journal* and *Bulletin* of the Royal College of Psychiatrists—which exhibits all the urgency of the summer of 1939 issues of the *Tatler*—the pages of the *British Medical Journal* have in recent years shown a thoughtful concern for the important ethical problems arising from changes in the law and social attitudes. Voluntary bodies such as the National Schizophrenia Fellowship understand well the dangers of a combination of shrinking resources and repressive legislation.

Surely few would deny that our first inescapable duty is to provide the best possible care for our patients, that we have a secondary but equally important responsibility for the families of our patients and that we have a concomitant duty to educate and enlighten society about mental illness and its treatment. We have failed miserably in this third function and the measure of our failure is our inability to provide the standard of care that our patients and their families deserve. If things are not to get worse psychiatrists will need far more nerve and resolution than they have displayed in the seventies and eighties. Unless they can somewhere be found, I for one shall be tempted to join my Divinity students in the search for someone who can do the job better.

References

[1]Sedgwick, P. (1983) The fate of psychiatry in the new populism. *Bulletin of the Royal College of Psychiatrists*, **7**, 22–25.

[2]Levine, S. (1983) The Public Policy Committee—A decade on. *Bulletin of the Royal College of Psychiatrists*, **7**, 33–35.

M.Sc. Course in Clinical Psychotherapy in the Faculty of Medicine, University of London

A new intake of students for this course, held at St George's Hospital Medical School, London, will start in September 1985. The course aims to encourage the academic study of psychotherapy as a discipline in its own right and approaches the subject from an eclectic base; it will be particularly relevant to senior registrars or consultants in psychiatry who either wish to become specialist psychotherapists or who want to apply psychotherapeutic principles as part of their general psychiatric practice.

The course consists of five components. Firstly, there is a series of theoretical seminars in which important psychotherapeutic concepts are critically examined. A further series of seminars comprises an academic study of applied psychotherapy looking at treatment techniques, clinical research and case histories. Students are required to prepare and carry out a research project for which regular supervision is available. Practical experience is gained by students receiving supervision for their own cases from at least two tutors with different theoretical backgrounds. Cases supervised include the following: individual psychodynamic, behavioural and family and marital treatments. Finally, students participate in a sensitivity group which runs for three years.

The course lasts for three years on a one-day per week basis, and is at present limited to medical practitioners only. Further information and application forms: Mrs Hensman, Psychotherapy Section, Academic Department of Psychiatry, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE. Fees at standard University of London rate.