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Reading About . . .

Postgraduate Psychiatry

If there is one comment that beats all others for snobbery, it is the one in Trevelyan's *English Social History* about education producing people who can read but who cannot tell what is worth reading. Unfortunately, as is often the case with snobbery, there is some truth in it, although it might be more accurately said of certain kinds of education, rather than all kinds.

Medical training is a culprit because it accepts – even encourages – knowledge ahead of everything else, including common sense. Even if this is less true of postgraduate training, as in psychiatry, it is often too late by then for students to change their learning style. The damage has been done by the multiple-choice questions and ward-round interrogations of earlier clinical study. Poor, damaged postgraduates, we go on protecting ourselves with the only things that ever saved us at medical school: lists of facts, lists of lists, and piles of textbooks covered with underlinings and highlights.

So trainees in psychiatry have an excuse for trying too hard and reading too much. An excuse, but no pay-off, because the College examination, particularly in its new format, clearly gives clinical sense priority over book knowledge whose importance is mainly in fleshing out clinical practice – in the same way, an understanding of aerodynamics helps in flying a kite, but is not quite the same thing.

The best examination question I know (although not in the College bank) asks what might be wrong with an elderly patient whose complaint is forgetfulness. Marks are allowed for dementia and depression, but to pass you must include another possibility: nothing. If the MRCPsych could be 'rationalised' to a single, acutely discriminating question, this could be it. Its only rival would be: what do your patients actually do in occupational therapy? I know of no textbook that tells you this, which illustrates the limited value of textbooks.

But that does not mean they are not valuable at all. The best of them can be concise, comprehensive, readable, accurate, up to date, well structured and a boost to both training and examinations. None is all of these things but then books are only human. The leading four British textbooks would score highly on a 'worth the effort questionnaire', if there was one, but for different reasons.

One of the strengths of the *Companion to Psychiatric Studies* (Kendell & Zealley, 1983) is that it includes the basic sciences (although one of the strengths of the others is that they do not). In theory, this feature means that it could be the only book a trainee needs, and certainly some chapters – Kendell on functional psychosis and Freeman on personality disorder – are as useful as anything on their subjects. Unfortunately, publishing a 40-chapter volume like the Edinburgh *Companion* is rather like painting the nearby Forth Railway Bridge – by the time it is finished, it is almost time to start again. All large textbooks suffer the same problem – published a few years ago means written longer ago, and that means no mention of molecular genetics or service delivery, the two most obviously expanding areas in psychiatry. It also means any account of substance abuse will lack the most recent substances; therapies may have been developed or discarded; and, as with AIDS, there may be new liaisons in liaison psychiatry.

So devotees of the major books need to find modern reviews of these areas, remembering that in an active research field, any review is modern only until the next one comes out. Not surprisingly, review journals are coming out across many medical specialties, the two most recent in mental health being *Current Opinion in Psychiatry* and *International Review of Psychiatry*. Both have addressed recent research findings in 'the new genetics', with succinct reviews about the major psychoses in the former (Matthysse, 1989; Gershon, 1989) and more detailed versions, covering a broader range of disorders, making up a whole issue of the latter (Owen & Murray, 1989). Both are modern enough to be cautious about what they claim for chromosome 5 and schizophrenia or chromosome 11 and manic–depressive psychosis, a warning of how quickly the new genetics grows old. Meanwhile, following the AIDS explosion has come an AIDS publication explosion – inevitably and quite rightly. But this has obscured what should be known, a muddle which can be rectified only by a straightforward listing of current information. The *British Journal of Psychiatry*'s recent review presents precisely that (King, 1990).

As for service planning and evaluation, the words themselves may be uninspiring committee speak but

they represent the future, in which doctors "can contribute more effectively to decision making and so influence the future direction of services". Who says so? The Government, in *Working for Patients* (HMSO, 1989). Whoever penned this arid document will never be Ernest Hemingway but they should be read nevertheless; after that, whatever service literature you should choose depends on what service you want to develop. Overall, there is little teaching or reading to be found which brings together the elements of this subject: pioneering service plans, training, measuring success and health economics. Yet knowing about these is essential to postgraduate training because if (to stay with mental health) psychiatrists do not design this academic discipline in their own image, someone else will.

But not all of those with a financial perspective are disciples of Adam Smith or even unreadable. There is, for example, Nicholas Barr's argument for the welfare state on *economic* grounds (Barr, 1987*a,b*). There is no point, he says, in using compassionate pleas against monetarist philosophy. Instead you show that efficiency in health care is *reduced* by market forces, largely because the efficient private market requires full information on all sides and this does not – probably never will – exist in health.

But back to the textbooks. One thing most of them have in common is the year one of their editions was published, 1983. Slightly embarrassingly, the same year saw a new Mental Health Act in England and Wales, which threatened the value of any newly published reference to compulsory treatment. For a while, the beneficiary of this mishap was *Essentials of Postgraduate Psychiatry* (Hill *et al*, 1986), whose current edition came out in 1986. Its style is that of a comprehensive review – hardly a statement is allowed to go unreferenced – in keeping with its aim to support psychiatry with science. By doing so it also exposes those areas where substantial research is yet to shape a vital subject. The most glaring of these is liaison psychiatry, the book's shortest chapter except for one on the related subject of self-harm. This is not the fault of its author or the editors, but it could be the fault of academic psychiatry's general thrust.

Despite this, *Essentials* could claim to be the most complete of the textbooks, for the moment, although the many admirers of its rival, the *Oxford Textbook of Psychiatry* (Gelder *et al*, 1989), would probably disagree. For one thing, the latter is uniquely honest. The *Handbook of Psychiatry* (Shepherd, 1983–84) is far too big for anyone's hand, *Essentials* is full of detail and the *Companion to Psychiatric Studies* is not really companionable. At least the *Oxford Textbook* comes from Oxford.

It is unusual in one other way, which seems central to its popularity. It was written, rather than edited, by the triumvirate whose names it bears, which partly explains why it is so coherent. It presents you with many facts and tells you where to find more. One place it recommends is the *Handbook of Psychiatry* (Shepherd, 1983–84), a five-volume epic, erudite and unusually multinational in its contributors but destined by its length to be used for reference or read piecemeal.

Within the last two years, a new edition of the *Oxford Textbook of Psychiatry* (Gelder *et al*, 1989) has fully incorporated current mental health legislation in a way that its prototype could only struggle towards. It is now the clearest general account of the subject, although not as comprehensive as Bluglass' *Guide to the 1983 Mental Health Act* (Bluglass, 1983), the latter being vital to any examination candidate who uses one of the other major texts. Bluglass's achievement is in making the Mental Health Act seem simple, which it is not, and – in its matter-of-fact account of how to section a Member of Parliament – even humorous.

Among much that is solid, the Oxford authors, without saying so, take a stand against tradition in one chapter, indeed in chapter 1 on descriptive psychopathology. They present an account of what Fish calls "disorders of thought possession" (Hamilton, 1985), i.e. insertion, broadcasting and withdrawal, clearly stating that these are delusions. Jaspers (1963) took a different view. To him these were experiences, not beliefs, and they were disturbances of the self. He described awareness of the self as coming in four varieties, the most important being activity and distinctness. Mental activity, he said, possessed an I-quality – when I think, I am aware that I am the one doing the thinking. When in schizophrenia this personalisation is disrupted, thoughts no longer have the same subjective quality and are experienced as implanted or withdrawn. Similarly, feelings and movements may be experienced as 'made' and therefore carried out passively, hence passivity phenomena. When distinctness of the self is lost, thoughts are no longer confined to some personal inner space but are experienced as widely available, or broadcast in a pre-Marconi sense of the word.

Jaspers recognised that patients explained these curious experiences by delusional elaboration, but he did not regard them as delusions in themselves. As always, Fish tightened up Jaspers' terminology but agreed with his definitions. So too does the Present State Examination (Wing *et al*, 1974) but not Cutting's *The Psychology of Schizophrenia* (Cutting, 1985). Who knows whether or not this distinction will be diagnostically important once more is known

about the biological causes of schizophrenia? Until more is known, perhaps we should stick with Jaspers.

The big names of psychiatry's numerous personality cults are more often purveyors of psychodynamic rather than descriptive psychopathology. Freud, Fromm, Frankl and all the others were firmly in that tradition even before it was a tradition but their ideas can still confuse postgraduate study. In a way that no large textbook does, *Introduction to Psychotherapy* (Brown & Pedder, 1979) provides an invaluable sorting out of any confusion, concentrating on the therapy end of psychotherapy.

In doing so, it has to omit most of the case histories, dreams and descriptions which make Freud such a lively read – if anything should be compulsory reading in postgraduate psychiatry, it is those case histories. While papers like *Mourning and Melancholia* (Freud, 1917) are clinically astute, in the end they drip with jargonistic theory. But the case histories are riveting. They are not, as is sometimes implied, merely the stuff of Freud's observations, equivalent to Archimedes' bath water, allowing him to develop his greatest work; they are themselves his greatest work. Perhaps the single examination question I am looking for could be: why was one of Freud's cases known as the Rat Man? (Freud, 1909).

There is no doubt that medical publishing and examination-inspired obsessional worrying after facts thrive on each other, so I have tried to stress that a small collection of books, carefully chosen, is all that is needed for postgraduate study. And few individual papers need to be added to the trainee's list, as most are given due limelight in book chapters. But a great many are intriguing to sample in the raw, if only to show that their famous findings are too often simplified. Thus the *Social Origins of Depression* (Brown & Harris, 1978) is revealed as a huge meticulous enterprise whose celebrated results on women, their jobs and their children are really the kernel to a more voluminous nut. Likewise, that much-quoted seven-point cocktail by which the clinical syndrome of alcohol dependence can be strictly defined was meant only to be provisional (Edwards & Gross, 1976).

Beyond new textbooks and journals there remains one worthwhile written source of clinical insight: fiction. On the whole I have little time for articles whose authors pretend they read Proust so it is enough to confirm that there are many novels which could legitimately be required reading for psychiatrists. Yet one is worth mentioning by name. Kingsley Amis's *Stanley and the Women*, once you have waded through its rampant misogyny, is a brilliant portrayal of a man's perplexity and despair on finding schizophrenia in his son. At the same time it exposes the way health staff behave towards relatives, not by accusing us of blaming them – although it does that too – but by revealing the subtler ways of keeping relatives at bay. When Stanley first arrives on his son's ward, anxious and distressed, the nurse asks him "Can I help you?" but in a tone of voice that means, "What do you think you're doing here?"

The same question could be put to the final reading suggestion. No sympathy can be expected by anyone who recommends their own publications. However, since my textbook has the same title and subject as this article, and has recently been published, it seems only fair to its contributors and a patient publisher to mention its existence (Appleby & Forshaw, 1990).

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