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Psychiatry in Jeopardy

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Society's attitude to psychiatry has always been ambivalent. When, as a young doctor, I announced my intention to take up this discipline to my then chief, who was a distinguished clinical pathologist, his face turned a deeper shade of purple, and he muttered something about "mumbo-jumbo and guesswork" before stalking off into his den. Much more recently, I broke a lifelong tradition by actually entering into conversation with a stranger on a British railway train. Somehow or another, he extracted from me the information that I was a Professor of Psychological Medicine. "Well, well, he murmured, "and I always thought that was the stuff they put into those huge bottles of red and blue liquid you sometimes see in the windows of the older chemist shops". That gentle twitting is small beer by comparison with the grave reservations expressed by many individuals and groups.

Some of the more lurid attacks may be exemplified by the statements from the founder of the Church of Scientology: "Psychiatry hurts and kills people, violates all human rights, teaches hate, and indulges in almost every crime in the penal code. It is a simple story of a threatened and unworthy power seeking to destroy by any means new research and truth. These are not civilised men. It is up to the world if their reign of terror ends, and if true human rights begin" (Hubbard, 1969). Within the 'anti-psychiatry' movement, the very validity of the concept of mental disorder has been challenged, with the insistence that the schizophrenic experience represents an inspired and privileged insight into reality which ordinary mortals are denied. Furthermore, psychiatrists are cast in the role of society's thought police, acting to label and dispose of undesirable individuals. Thomas Szasz (1961), himself a Professor of psychiatry, has also tried to persuade the world that mental disorder does not exist.

As a professional psychiatrist, I have found some of the literature thought-provoking and stimulating. However, one of the reasons for choosing this subject springs from my experience of the passage through Parliament of the recent Mental Health legislation.

It was my job to follow this very closely, and indeed to try to influence it in various ways. I became very much aware of, and concerned by strong anti-psychiatry feeling, which was noticeable during the debates generally, and also in the proceedings of the Special Standing Committee of the House of Commons. This found expression on numerous occasions in terms of a lack of confidence in psychiatrists. There was, for example, an amendment moved in the Standing Committee to Section 137 of the 1959 Act. (House of Commons Official Report 1982) which is concerned with action to be taken where a Member of Parliament is detained under the Act, and therefore unable to represent his constituents in the House. The Speaker could consult the President of the Royal College of Physicians of London or the Presidents of the Scottish Colleges to procure the nomination of two psychiatrists to visit the sick Member and to report back to the Speaker. The 1959 Act, of course, came into existence before the inception of our College, and the amendment now proposed would have substituted the President of The Royal College of Psychiatrists for that of the Physicians. A lively debate ensued, in the course of which one Member is on record as saying that he would trust far more readily the judgement of a President of the Royal College of Physicians than The Royal College of Psychiatrists. In the event, the amendment was carried by 10 votes to 2, but fortunately the Speaker has not had occasion to call upon my services as yet.

All this had been interpreted as merely one facet of a movement against the professions in general in British public life. I believe, however, that it runs deeper than that and is fueled by social forces and needs which are worth identifying and commenting upon.

First and foremost is the nature of mental disorder itself, and the response this generates in society. Much has been written on the stigma of mental illness and on how society over the centuries has set about tidying away the more obvious examples of this malady. Attempts have been made to influence social attitudes through mental health education campaigns. A fascinating account of a particular endeavour of this kind in a Canadian town is described in the book *Closed Ranks* by Elaine and John Cumming (1957). This included an attempt to evaluate the impact of an educational campaign running for several weeks, including films, talks, panel discussions, and newspaper articles. Attitudes to mental illness were assessed, using

quantitative scales, by an independent team of social scientists at the beginning and at the end of the campaign. The findings indicate that, not only did the campaign produce no movement towards more positive attitudes, but actually resulted in the interviewing team being asked to leave town.

I spent part of my young life in South Wales, conducting research into community attitudes to mental illness. In the course of one survey, I visited a number of relatives at their home in the beautiful Vale of Glamorgan, who had had a patient resident in a local psychiatric hospital for a substantial period of time. One of the objects of the exercise was to assess the willingness of the family to receive the patient back into their fold when the time was ripe. I was half-way through the interview and the relatives had conceded the probability that they would be willing to find a home again for the patient on discharge, when suddenly the door was thrown open and in came another member of the family, hot-foot from the hospital, declaring that the patient had, in fact, been discharged that very day and was about to descend upon them. All hell was let loose, and I was immediately accused of having engineered the whole scenario. As I made my excuses and left with all due speed, there was no doubt whatsoever about the real attitudes of that family to the possibility of the patient returning home (Rawnsley *et al*, 1962).

Mental illness of the profounder variety entails a fundamental change in the ego of the sufferer, and it is the incomprehension and anxiety generated in the relatives or friends which I believe to be the basis of society's perennially negative view of psychiatry. The notion that the self, the very essence of being of a loved one, can be warped or transmuted into a caricature—and therefore by implication that this may conceivably happen to oneself—is a deeply disturbing business. There is only marginal comfort to be derived from the awareness that, at least in some cases, the process may be reversed or halted by chemical or electrical means.

The endogenous nature of severe mental illness, and the fact that normal feelings, lucid thinking, and *joie de vivre* may sometimes be restored by the exhibition of pills or shocks is mysterious, puzzling, and quite unsettling. The would-be captain of his soul and master of his fate is unnerved by these capricious developments, which call in question the very nature of the human mind and spirit, and which may appear superficially to reduce all fine feelings and the poetry of the mind to terms of chemistry and physics. These considerations are, I believe, at the root of society's ambivalence to the mentally afflicted and are the basis of much of the antipathy to psychiatrists and the treatment they offer.

ECT, for example, is represented as being a crude assault upon the organ of the mind, which, if it produces any benefit to the patient at all, does so only by stupefying the memory and blunting the feelings. The case for ECT has, of course, not been helped by instances of misuse in the past, and by examples of poor practice, as revealed by our own College survey (Pippard *et al*, 1981). The power of these strictures, however, has led to great difficulties in prescribing ECT in many parts of the world. Here, then, is a form of treatment which many psychiatrists regard as quite invaluable in particular cases, which has in some places been deleted from the therapeutic repertoire by social action, based on misconceived ideology.

Other forms of treatment could well be placed in jeopardy as an indirect result of legislation designed to protect the mentally ill. During a late stage of the passage of the Mental Health Bill through Parliament, the Minister, Mr. Kenneth Clarke, accepted, apparently without demur, an Opposition suggestion that for psychosurgery, the second opinion procedures should be extended to patients "not liable to be detained". The College made very vigorous efforts to have this stipulation removed during the final debate in the House of Lords, but to no avail. Our worry was not just about leucotomy; we were concerned lest other treatments might be added to psychosurgery under the powers which the Secretary of State has to augment this list at any time.

We readily accepted that, in the case of detained patients who were being considered for psychosurgery, their own consent, backed up by a second opinion from the Mental Health Act Commission, was a reasonable safeguard. To have this extended, however, to informal patients, out-patients, and, in fact, any patient in the country suffering from mental disorder, seemed to us to represent a fundamental departure from the right of a private individual, together with his medical adviser, to agree together on a particular form of treatment or care. However, this requirement is now with us in England and Wales, though not in Scotland (Mental Health Act, 1983).

Already, within only months of the passage of this Act of Parliament, moves are afoot to consider extending the list of treatments under this particular category, which already includes the injection of hormones to reduce male sexual drive. The Chairman of the Mental Health Act Commission has asked the College to discuss the suggestion that certain other treatments should be added, viz—behaviour modification, other brain surgery, and operations for transsexualism.

I have mentioned what I regard as the fundamental root of society's ambivalence to the mentally ill and, by halo effect, to those who minister to their needs. Our critics have, however, been well supplied with ammunition by events within the psychiatric fold. I am

thinking firstly of the so-called disaster enquiries, which had their curtain-raiser in Cardiff in 1969, with the Report of the Inquiry into the affairs of Ely Hospital. Ely has risen to the challenge during the intervening years, but the effects of the report, at the time and for many years afterwards, had a black side, resulting in a sense of despair and in impairment of morale among existing staff, patients, and their relatives. Happily, that has now been put to rights, and Ely is set fair to become one of the foremost centres of care, therapy, and research in the field of mental handicap in this country. However, ammunition from that report and from the many that followed in other hospitals and units has been used to good effect—"Don't trust the psychiatrists" is the cry.

There is a much more sinister betrayal, though, which strikes at the very heart of psychiatry, and which is reminiscent of the philosophy operating in the land of Erehwon created by Smuel Butler. People in that country were treated for their crimes and punished for their illnesses.

I refer, of course, to the abhorrent practice in the USSR whereby mentally normal individuals are incarcerated in mental hospitals and forcibly treated with powerful drugs for speaking out against State policy, or even for drawing attention to clear deviations from Soviet law. This is grist indeed to the mill of the anti-psychiatrists. The Royal College, of course, has been in the vanguard of the international campaign against this prostitution and abuse of our profession. It is easy for us to protest from the comfort of our offices and in other protected circumstances. I pay tribute, though, to those brave people who have had the courage to speak out within the Soviet borders, and who have paid for this with deprivation of liberty, impairment of health, and even death. The College is proud to have among its members two such protesters—Semyon Gluzman and Anatoly Koryagin. Gluzman was the co-author with Vladimir Bukovsky of that incredible document "A Manual on Psychiatry for Dissidents" (1975), which includes detailed advice on how to conduct yourself, if you have the misfortune to be swept up by the net as a potential psychiatric prisoner in Russia. It also includes a remarkable categorisation of psychiatrists under such headings as The Novice, The Academic, The Writer of a Dissertation, The Voltairian ("a clever and experienced person and psychiatrist, he has become long since disillusioned with psychiatry as a science. He is highly intelligent, loves art and literature, and can talk a great length about them. He is socially inactive, since he does not believe in the success of any social transformations. An outward public position is a possibility, perhaps lecturing"), the Philistine, and finally the Professional Hangman. You are advised to be reasonably polite to the psychiatrist, answer all his questions, as far as possible, though some questions may seem 'stupid'—"What is the date today?", "what day of the week is it?", "what year?", "what is a hundred minus thirty?", "what is the meaning of the proverb 'you are sitting in the wrong sleigh'?", and so on. You will have a chance to determine the psychiatrist's intellectual level and his way of conducting a conversation; your aim should be to talk with him "in the same language, on the same conceptual level". This abuse still continues, though I had hoped that following the withdrawal of the All-Union Society from the World Psychiatric Association last year, and the consequent reduction of the glare of publicity, the Soviet Authorities might have thought it prudent to quietly change their tack.

Another source of our vulnerability derives from the very richness of our discipline, which allows of so many and diverse approaches to the secrets of mental illness, though things may be a little better now than they were some years ago. A noted conference on Postgraduate Education in Psychiatry under the auspices of the Royal Medico-Psychological Association and Association for the Study of Medical Education was held at the Institute of Psychiatry in 1969. The proceedings were, to my mind, marred by an unseemly wrangle between those who advocated the psycho-dynamic approach and those who were in favour of, for want of a better term, the organic approach. Escape from this false either/or dichotomy has been a long time coming, but I believe there is a willingness to embrace a truly eclectic approach, which rejoices in the complexity of the human mind and is aware of the equally valid contributions from genetics, biochemistry, pharmacology, and psychology (both in its dynamic and behavioural mode), and from the social sciences.

We have had a fairly bad press recently, resulting from our involvement with Courts of Law in serious crimes where the issue of diminished responsibility is raised; Peter Sutcliffe is one example here. It is hard to know how to escape responding to the requests of our legal brethren, but we allow ourselves to be placed in a false position. It should be relatively easy for us to advise the Court on whether or not a prisoner is suffering from a mental disorder and to comment on the desirability of treatment. The question we are asked, however, following on from diagnosis, is the degree of impairment of responsibility. Perhaps this is not such a fraught issue now as it was during the time of capital punishment, but it is still a question which springs from lawyers' modes of thought, rather than from those of psychiatrists. How much simpler it would all be if sentence could be passed without consideration of these imponderables. The role of the psychiatrist *after* sentence would then be to give expert advice on the most appropriate management and treatment of

those prisoners who manifested mental disorder. This happy solution would need to wait upon a modification of the law, which at present prescribes a mandatory sentence for murder of life imprisonment. This is a rather extreme example of what is a common occurrence, and one which demands our ceaseless vigilance. It is the business of being placed in a false position, arising partly from the misconceptions of others, as to what we are all about, or the grandiosity of some of us as to the boundaries of our discipline, and to the relevance of our wisdom and knowledge to the wider social scene. It is highly embarrassing to hear colleagues holding forth publicly as psychiatrists on matters of life and death, war and peace, religion and economics, as if possessing some special expertise in those areas.

I referred to false positions in which we find ourselves and which may do us harm. I recently gave oral evidence to the House of Commons Social Services Committee, which is focusing on community care. Much of the discussion was about the possible consequences, both good and bad, of the rapid implementation of Government policy in the mental health field, which involves closing mental hospitals and mental handicap hospitals, and developing District general hospital units and various facilities in the community. We are not against the strategy in principle, but two aspects are worrying. Firstly, uncertainty as to the optimum placement of the most severely disabled chronic psychotic patients, who may not fit easily into the proposed new facilities. Secondly, and most importantly, the uncertainty as to whether the resources will be forthcoming, especially from the Local Authority end, to make these plans workable. Rapid shifts on the Health Service side, without corresponding moves by the Local Authority, could leave patients stranded and exposed. We have already seen this happen in some parts of the country during the great exodus from psychiatric hospitals in the late 50s and 60s. We must fight with vigour against being placed in this particular false position, which will only result in harm to patients and further antipathy to those who care for them, but who do not necessarily control policy or command the deployment of appropriate resources.

Henry Maudsley (1871), in his Presidential Address to the Medico-Psychological Association, had a word to say about community care: "Not many persons recover in asylums who might not recover well out of them; and the removal of a patient from the asylum sometimes directly conduces to his recovery. True, there are patients which cannot be treated out of asylums, because they may need care and control to prevent them doing harm to themselves or others, or because the expense of treatment in a private house is too great. But where there are the necessary means of securing good attendance and medical supervision there are comparatively few cases where it is necessary to send the patient to an asylum . . . I mention cases of insanity from masturbation; they seldom get well in asylums but sink by degrees into a hopeless state of chronic insanity. The one thing wanted for such patients is some intelligent and judicious person of higher education and position than an attendant, who will take a genuine interest in them, gain their confidence, and influence them beneficially". It is good to have such a specific indication for extra-mural care!

What, then, should be our response to the criticisms levelled against us; to doubts expressed concerning our role in the diagnosis and treatment of mental disorders; to the destructively aggressive attitudes; to the derisive humour? We must accept that society will remain ambivalent to us, and to our patients, for reasons adumbrated earlier. This we must absorb and live with, as part of our calling, but we have to return to the fundamental question of what psychiatry is all about, and where *we* fit into this scene.

Prevalence studies in the general population have amply demonstrated the high frequency of mental disorders in all settings. In this country the bulk of this morbidity, where it comes into the treatment networks at all, is handled by the General Practitioner. Maybe the GP and his patients escape the ambivalent attitudes in this field because the public perceives his work as essentially concerned with disorders of the body, rather than with those of the mind, and, in any case, many of the mental disorders he deals with present in somatic terms with headaches, palpitations, dyspepsia, etc. When all is said and done, however, the GP is practising front-line psychiatry, and his attitudes to the subject may have important influences upon the patients and their families. These attitudes certainly affect the number and types of patient referred by him to the psychiatrist (Rawnsley & Loudon, 1962). The epidemiological findings—that about 5% of the population of the U.K. consult the GP primarily for some form of mental disorder every year—should be kept firmly in mind as a fundamental point of departure. Of these patients, about a tenth—in absolute numbers upwards of a quarter of a million individuals per annum—are passed on to a psychiatrist. *Pace* Dr. Szasz, this volume of morbidity can scarcely be dismissed as a myth.

There are, of course, those who argue that while conceding the existence of this army of affected individuals, their disturbances do not, for the majority, properly fall within the ambit of medicine. These should be construed as disorders due to faulty learning, or as behavioural aberrations arising from an anomalous weave of the social fabric, so that doctors have no great part to play in their evaluation or management.

In fact, doctors have fouled the pitch by imposing their medical model on the scene, inducing a sort of myopic reductionism which vitiates true understanding. These views spring from a radical misconception of the nature of medicine in general and of psychiatry in particular; we have sometimes done ourselves a grave disservice by taking a very narrow, sectarian view of the essence of our subject, and showing a regrettable tendency to assume defensive/aggressive positions at the polar extremes within it.

The psychiatrist should freely acknowledge the skills of other practitioners in the multi-disciplinary field of practice. He should also be sensitively aware of the contributions to the subject springing from a wide range of sciences. However, as a doctor with an undergraduate education in the socio-biological basis of human behaviour, and with his subsequent professional training, the psychiatrist commands a unique vantage point to survey the aberrations subsumed under the heading of mental disorders, to evaluate them, and to manage them. This is the case whether the condition seems to have a basis in flagrant lesions of the brain, or for the so-called functional psychoses. Likewise, this holds for the personality disorders and neurotic illnesses which, though not necessarily associated with brain pathology, are nevertheless patterns of behaviour and experience springing from the whole organism, and reflecting the complex interaction between constitutional predisposition and precipitating causes, whether physical, psychological, or social.

Perhaps the area which is most immediately under threat is our role in the field of mental handicap. Complex forces are at work here. The replacement of 'mental subnormality' by the highly unsatisfactory category of "mental impairment" in the 1983 Mental Health Act was the outcome of powerful lobbying by MENCAP in the House of Lords. Their argument boiled down to a reluctance to allow the word 'mental handicap' to appear in an Act of Parliament alongside mental illness, since this would somehow stigmatise the former condition. Their point of view was ill-founded, however, and the consequences of their action could well boomerang to the disadvantage of the people they aim to shield. More seriously perhaps, certain Health Authorities are revising their services for the mentally handicapped, and in so doing are dispensing with the need to have psychiatrists specialising in this field at all. The College has resisted these moves with vigour, but what is happening today in mental handicap could spread tomorrow to services for the mentally ill.

Some of my colleagues bemoan the fact that psychiatry cannot boast the 'high tech' achievements which have transformed many aspects of medicine in the last half century and which, they believe, help to secure these branches firmly in public esteem and in the hearts and minds of the planners. Certain it is that in the long term, our future depends upon our ability to deliver the goods clinically and therapeutically, at a level which passes muster by modern canons. This can only derive from greater knowledge of pathogenesis and from the development of more sophisticated forms of intervention. We rely upon research and critical evaluation of treatments to provide these answers. Abiding knowledge can only come from well conceived and fully documented research, using this term in its broadest sense. Our Charter and Bye-laws enshrine the objects and purposes for which the College is constituted, and one of these is "to promote study and research work in psychiatry and all sciences and disciplines connected with the understanding and treatment of mental disorder . . ." The College Research Committee has been labouring mightily in this connection, and Council has decided that to pursue this aim still further, we should have our own Research Unit. This would be ideally placed to call upon the goodwill and resources of members throughout the College in the conduct of research which might involve multi-centre operations.

In matters of scientific progress and the sharing of ideas, we tap into psychiatry and the related sciences world-wide. In the vital issue of standards of clinical practice, we must clean our own stables within Great Britain and Ireland, and it is here that our College has its high duty and responsibility.

The principal value of the Membership examination is the lever which it affords the College to insert and manipulate in pursuit of improved standards of training in individual hospitals and units. This it does through the Approval Exercise; of all College endeavours to date, this has done, and will continue to do, most in the long run to promote another of the prime objects set out in our Royal Charter, which is "to advance the science and *practice* of psychiatry". Good practice is our best ambassador, both to the public and to our colleagues in other branches of medicine, especially in primary care.

The framework for general professional training and for higher training in psychiatry has evolved rapidly throughout the country during the last decade. Discussions with Council on the future of the Consultant in psychiatry, which were carried widely throughout the College, have revealed a strong wish for further efforts in the field of continuing education of Consultants (Rawnsley, 1984). There is no particular desire to follow the American pattern of gaining credit points for attendance at educational events, but Council has taken the message, and has stipulated that the College should put out an initiative in this matter.

I referred earlier to the regrettable tendency to take sectarian positions within psychiatry, and thereby to

generate tensions which are not helpful. In the early years of the College's existence, tensions were apparent along another dimension, i.e. between the various specialties within psychiatry. There was a time when I was seriously concerned that we might witness the secession of one or more of our Sections from the body of the Kirk. Happily, in recent years this possibility has receded, and it is a source of great satisfaction that in this respect, psychiatry in this country is showing a coherence and a unity which is of great importance.

Conclusion

I believe the psychiatrist, like the mentally disordered, will always attract ambivalent social attitudes. The balance of that ambivalence will be swung by the public's perception of the quality and effectiveness of psychiatric practice. This will, of course, depend on a large number of factors, including the volume of national resources made available. However, our young College has the power now, and increasingly in the future, to make a massive contribution to the viability, acceptability, and strength of our discipline. I have tried to indicate some of the ways in which this may be done—essentially through the promotion of good training, high standards of practice, research, and the unity of psychiatry. As our locker fills up with this ammunition, we can gaze more confidently towards our critics, make it possible for our young men and women who have chosen this most perplexing, yet fascinating branch of medicine as their life work, to feel proud of it, and most important of all, to ensure a better prospect of relief for the vast number of mentally afflicted persons.

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