CHAPTER 1

The nature of the subject

Definition and preliminary considerations

Psychiatry is that part of medicine which is primarily concerned with disorders of thought, feeling, and behaviour. In one sense all illness or injury, and indeed all suffering of any kind, involves disorder of feeling; and this is one of the reasons why the basic principles of psychiatry are vital to a proper understanding of medicine and surgery as a whole. But the special province of psychiatry is the understanding of those disorders of subjective experience or objective behaviour which are themselves a cause of disability.

They may be primary, or secondary to some other illness or structural damage. The disturbance of experience or behaviour to which they give rise may be apparent to the sufferer, in which case he is said to have insight into the nature of his illness; or he may be entirely unaware that he is ill or disabled in this way, and may attribute his experience or predicament to changes in the world around him. All this every doctor must be able to acknowledge, to understand, to diagnose, and at least in some degree to treat. Psychiatry in fact includes in its concern that most human aspect of human beings, their awareness of themselves, and their capacity to communicate with each other.

Understood in this sense, the field is a wide one: it includes the normal emotional reaction to sickness or physical disaster of any kind, as well as the effects of emotion upon bodily function and structure; particularly the abnormal effects of excessive and undischarged emotion.

Disorders arising out of such repercussion of emotion upon bodily function or structure are often called psychosomatic illnesses; but although their particular study has proved one of the most rewarding and illuminating aspects of modern psychological medicine, their greatest importance lies in the light they have cast upon the aetiology of illness in general. It is in the psychosomatic approach to many of the problems

of general medicine, surgery, and obstetrics, as well as in the field of paediatrics, that psychiatry has made one of its greatest contributions to clinical knowledge and understanding.

Also included within the field of psychiatry are those disorders arising from a failure of function of the brain and nervous system, whether due to imperfect development, to diseases, or to injury. Finally there are those illnesses which present as abnormalities of behaviour, adjustment, or adaptation of human mental life in response to the environment; such abnormality being related to hereditary or constitutional factors, to the impact of excessive stress, or to causes as yet incompletely known.

This latter group of illnesses are sometimes collectively called *functional* mental disorders; they are of various kinds and have been variously classified. A distinction is frequently made in practice between one group of mental disorders which are called neuroses, and another which are called psychoses. Whether its fundamental validity is accepted or not, few will deny that in practice this distinction is useful and convenient. Under its terms, neuroses are those disorders of emotional and intellectual functioning which do not deprive a patient of contact with reality; while the psychoses are characterized by a profound and essential disturbance in the patient's appreciation of the nature of his environment and his response to it.

The practical implications of this distinction can be illustrated by an example of one of the simplest sources of distress from which a patient may suffer: the fear of illness. If a patient presents with palpitations, and a sense of constriction in his chest, and eventually and somewhat ashamedly confesses that he is afraid that his heart may cease to beat or that he is liable to drop dead after exertion, this may well prove to be a symptom of anxiety which can reasonably be regarded as neurotic, in the absence of any physical signs of pathology in the cardiovascular or respiratory systems. But if his elaboration of the complaint reveals that he believes that his heart has stopped already, in response to atomic fall-out directed specifically against him, and that he is now living on borrowed time, these bizarre and delusional ideas suggest that the underlying disorder is psychotic. While this is enough to exemplify the meaning of the distinction, its significance in terms of the nature and severity of any illness to which it is applied will be developed in later stages of this book.

Enough has been said to show that all these afflictions will tend in varying degree to produce an extremely disagreeable effect upon the patient who suffers from them; primarily an

impairment of his capacity both to interpret his own experiences, and to communicate them to others; and secondarily, and arising from this, an impairment in his capacity to achieve a normal relationship with other people. Indeed, it is a sad but constant experience that patients attempting to explain their feelings and troubles, when these are related to disturbances of their mental life, nearly always meet with hostility, contempt, or disbelief on the part of those to whom they entrust their confidence.

Any practising doctor is bound to encounter disorder of this kind in his patients, and must be prepared to listen without ridicule or contempt to the patient's own account of what seems to be happening to him, and the way in which he is experiencing it. Nothing is gained by dismissing such testimony as absurd or unreasonable; because either the patient knows this already and is very unhappy about it, or he does not know it, and is therefore bound to resent so insensitive and palpably obtuse an attitude, since it shows him that the doctor does not even understand what he is trying to say.

Normally it does not require a great deal of effort or imagination to put oneself in the patient's place, when his complaint is largely physical. Patients with structural illness or injury, in this respect at least, are in a relatively fortunate category; for even though their description of their sufferings may be clinically inaccurate, it is usually recognized and accepted by doctors without difficulty. Sensing this, some patients suffering from symptoms of fear, unhappiness, or emotional tension, will seek to convey them in physical terms, to gain at least the immediate sympathy and help of the person to whom they are turning. Against the neurotic patient, with his apparently indefatigable capacity for continued complaint, seemingly unrelated to any objective pathology, many a harassed physician has felt driven to attack as the best method of defence. The patient's reaction to this is often to cling yet more stubbornly to the idea of a physical basis for his symptoms, and to describe them in physical terms. Not only does this seem more respectable to him; he assumes that it will also seem more respectable to his doctor. Moreover, many patients' powers of description, introspection, and self-analysis are sufficiently limited to make physical complaint the only way in which they can experience or express their need of help.

The greater the element of emotional disturbance, whether the underlying disorder be structural or functional, the greater will be the discrepancy between the patient's understanding of what is

happening, and his capacity to explain this to others, or to maintain a normal relationship with them in other ways. When the main source of a patient's distress is a disturbance of mood, intellect, or behaviour, of the kind which characterizes so many mental illnesses, this factor of the patient's own incapacity to understand what is happening, and the difficulty which other people may at first experience in accepting such a patient at all, may be crucial; and the task of understanding and treating patients suffering in this way will be correspondingly difficult. This is because our basic confidence in our capacity to understand our own feelings and those of other people, is an aspect of our lives which we normally take very much for granted; and we are therefore intrinsically handicapped in recognizing that a disruption of these capacities in mental illness is as much of an objective disability, and as little of a deliberate breach of the rules of good manners, taste, or behaviour, as is the display of physical symptoms or signs on the part of patients whose plight is immediately recognized as due to a failure of bodily structure or function. *There is in fact a wide gulf between the instinctive approach of the normal person to mental disaster on the one hand, and to physical on the other.* When in the past medicine has recognized the essential need to bridge this gulf, patients have been helped, and progress has been made. But when the gulf has yawned wide, the aims of medicine have been lost, and its principles have been betrayed.

Emotional repercussions

Emotional disturbance in human beings tends to be in itself disturbing and even distasteful to others. Their instinctive reaction is at first surprise, then rejection and, finally, outright hostility. Two lessons emerge from the study of man's reaction to those of his fellows who are mentally ill.

The first is that the general reaction of human beings to the difference or dangers, the illnesses or afflictions of other individuals, may sometimes be far less than the best of which they are capable, and lamentably remote from the ideals which they might profess and the principles to which they might subscribe. The second is that nevertheless man is not bound inevitably to betray himself, and that ideals and principles can be preserved in his attitude, if he will pay more particular attention to the plight of the individual who confronts him.

Some alternative to this pattern of behaviour, whether it be mainly innate and instinctive or largely conditioned by society

in its powerful pressure against deviant behaviour, by which we first deride, then reject, finally perhaps even attack the individual whose behaviour we do not or cannot accept, is of course indispensable if we are to raise ourselves above the level of animals in the way in which ultimately we treat each other. The doctor's example in handling his patients here must be impeccable. Sometimes this will not be easy. From what we have already learned of the impact of emotional disturbance upon communication between human beings, it begins to be clear that the key to a proper approach to such disturbance *whether or not* it occurs against a background of mental illness, is to attempt to understand the way in which this disturbance or illness is affecting the patient's relationships with others, and his power to interpret and communicate his own experiences. The frequently disruptive impact of such illness upon these two aspects of human existence, normally taken completely for granted, helps to explain why, throughout the history of mental illness, the attitude of the average person towards this type of catastrophe has been more often one of resentment or blame or fear, than of compassion, or a willingness to accept and understand.

Historical consequences

The scope of this book does not include a detailed consideration of the history of psychiatry. Sources from which this may be sought are given in a brief bibliography at the end of this chapter.

Taken all in all, it amounts to a savage and sickening story. The concept of man as a whole being of infinite worth and potential dignity, originated in 400 BC by Hippocrates as a proper approach to the study of medicine, did not long survive him. Hippocrates had taught simply and consistently that the physician's task was to study the diseased individual, rather than disease as an abstract entity: the whole, and not the part. When his disciples forgot and betrayed these teachings they reopened the way to a cleavage which once again developed between mental illness and all other kinds of affliction; and once mental illness could be regarded as a thing apart, the fear and hostility latent in the attitude of men towards those whose behaviour they could not understand, largely determined the treatment accorded them.

Up to the beginning of the last century, patients suffering from mental illness were in general still so brutally treated that few of them had any chance of recovery. Their illness was maintained and indeed increased by isolation, darkness, cold, filth, starvation,

purging, beating and chains. It may now seem beyond belief that doctors and the public could contemplate other human beings naked, shivering, crusted with their own excrement, chained and starving in the dark on stone floors, without pity and without remorse. But they could, and they did, and it was only by the exertions and examples of exceptional men and women that our own standards have been raised above this appalling state.

A vivid example of the complacency with which Elizabethan society accepted this state of affairs is given by a gay aside from Rosalind flirting with Orlando, in *As You Like It*:

> Love is merely a madness. And I tell you *deserves as well* a whip and a dark cell as madmen do.

The italics are ours; but there is nothing to suggest that Shakespeare was here concerned with irony or social criticism. This was simply a lighthearted maiden's coyness, whose underlying assumptions were shared unquestioningly by the audience.

When, some 200 years later, in 1793, Philippe Pinel, Physician Superintendent of the Bicêtre Hospital in Paris, removed the chains from patients under his care, he released by this act not simply the bodies of the patients, but ultimately the minds of his colleagues, from preoccupation with cruelty and fear as permissible ways of treating the mentally ill. Even today this shadow still lingers over the public attitude to treatment. Nothing but understanding, compassion and respect for the individual man or woman who is the patient, will ever finally dispel it.

Social implications

Psychiatric disorder in its widest sense is a both common and important aspect of medicine as a whole. The occurrence of psychiatric problems, however, is not easy to determine because of the difficulty in defining psychiatric disturbances. Sometimes the approach is to assess anxiety or depression secondary to physical conditions. Sometimes only primary psychiatric symptoms are assessed. Furthermore, different societies often view psychiatric symptoms in different ways. For example, in the USA schizophrenia tends to be diagnosed more than it is in Britain where affective disorders are more frequently diagnosed than in the United States.

About 60–70 per cent of the population consult their general practitioner in the course of a year. It has been suggested that up to a third of all illnesses dealt with by family doctors are of

psychiatric origin and it is clear the general practitioners deal with most psychiatric problems, referring only about 5–10 per cent to psychiatrists. Those with psychiatric disorders tend to visit their doctors more frequently than patients with other illnesses, many of the psychiatric cases have a poor prognosis and they also experience relatively more physical conditions as well. Even then, a good deal of psychiatric disability is not even recognized as such by general practitioners.

At present about 1 in 6 women and 1 in 9 men are admitted to hospital for psychiatric reasons sometime during their life. The relative chronicity and the social disabilities of psychiatric illnesses are shown by the fact that, taking mental illness and mental handicap together, there are about 200 000 discharges from hospital or deaths therein each year in Britain, and about 40 per cent of the total hospital beds are occupied by patients with these disorders. For comparison, acute surgery takes up only 20 per cent of the total hospital beds and the discharge and death rates are approximately 2 500 000 annually, a much faster turnover indicating a very short average stay.

The special importance of psychiatry in relation to general medicine is that virtually any medical or surgical condition may have important psychiatric associations, whereas the reverse is not equally true. Even something as clearly structural as a fractured limb may produce troublesome psychiatric symptoms because, for example, it disrupts regular employment perhaps at a time when redundancies are likely. However, taking the more clearly diagnosable psychiatric disorders which are self-reported as long-standing illnesses, in the age group 15–44 years the rate per 1000 individuals for injuries is 11, next come respiratory conditions, and psychiatric illnesses are about 9. With the age group 45–64 years cardiovascular and arthritic problems have a rate of about 40 per 1000 population while mental disorders are at 19. The occurrence of psychiatric illnesses does not change greatly after 65 years but arthritic conditions reach 123 while cardiac conditions increase to 100. These figures place psychiatry in some sort of proportion; but they distort because, in general terms, more psychiatric patients are likely to need treatment in hospital than are those with longer-term physical disabilities. (Government statistics: general household survey, morbidity statistics from general practice.)

Despite the size and significance of the problem, there is no clear evidence that psychiatric illnesses are increasing. With affluence comes an increasing sensitivity to anxiety and depression

which may be regarded as illnesses but which may well be normal reactions. Comfortable, affluent individuals are used to a high level of security and so they tend at an early stage of distress, to seek the relief of medication. In the absence of external threats many become over-sensitive to their own psychological experiences. It is probably for this sort of reason that our national suicide rate dropped during the 1939–45 World War.

Nor are the social implications of psychiatric disorder confined to the personal distress which it may cause the sufferer or his family, or to the pressure on professional time and hospital beds. Between a quarter and a third of all absence from work due to sickness is due to illnesses having an essentially emotional basis. Absenteeism through this cause is many times greater than that due to labour disputes.

In practice, what links psychiatry inescapably with general medicine, surgery, and obstetrics is the ultimate impossibility of treating states of mind apart from states of body, or states of body apart from states of mind. Had psychiatry made no greater contribution to the balance and equilibrium of the general medical curriculum than to endorse and emphasize this single fact, its contribution would still have been invaluable; for it has too often been the assumption in the past that, while bodily states had to be exhaustively observed and meticulously studied, mental states could either be taken for granted or dismissed as irrelevant, in the training and clinical approach of the doctor.

Where the clinical material of psychiatry tends to differ from that of the rest of medicine and surgery, however, is in the frequency with which the actual basis of communication between doctor and patient is involved in, and impaired by, the illness from which the patient is suffering. *The essential raw material of clinical psychiatry is therefore carefully observed behaviour*: the term behaviour being used here in its widest sense, to include speech and writing as well as action; what the patient says, as well as what he does. The precise nature of a patient's complaint may be of decisive diagnostic significance, in the absence of objective physical signs; while *clear-cut syndromes, capable of correct and verifiable diagnosis, may yet be found to rest upon no objectively demonstrable structural pathology of any kind.*

All this makes clinical psychiatry a difficult but never a dull subject. Dealing with so much that is inevitably intangible, it cannot afford to be vague or nebulous, woolly or imprecise. The

degree of its proper understanding is a measure of a doctor, and distinguishes the true physician from the hack.

To thread his way through this tangled morass of apprehension, prejudice and misunderstanding, with accuracy, wisdom and compassion, to the prestige of his profession and the ultimate benefit of his patients, the doctor needs a clinical competence and a sound but imaginative technique in examination. These must be the foundation of his clinical approach.

Further reading

History

R. Hunter and I. MacAlpine (1963), *Three hundred years of psychiatry 1535–1860* (Oxford University Press: London).

K. Jones (1972), *A history of the mental health services* (Routledge & Kegan Paul: London).

D. Stafford-Clark (1952) (final revision and 11th reprinting, 1973), *Psychiatry today* (Penguin: London): 50 pages on the history of psychiatry, from cave dwellers to the twentieth century, open the book.

Epidemiology

A. Clare and G. Davies (2nd edn, 1987), 'Psychiatry in general practice', in *Essentials of postgraduate psychiatry*, eds P. Hill, R. Murray and A. Thorley (Academic Press: London).

M. Shepherd, B. Cooper, A. C. Brown and G. W. Kalton (1966), *Psychiatric illness in general practice* (Oxford University Press: London).

P. Williams, A. Tarnopolsky, D. Hand and M. Shepherd (1986), 'Minor psychiatric morbidity and general practice consultations: the West London Survey', *Psychological Medicine*, Monograph Supplement 9.