Introduction

It would be advantageous if one could offer the reader an uncomplicated description of psychiatry. This would encompass a description of its subject matter (mental illness), methods and goals (diagnosis, treatment, research and prevention). The ideal of such a presentation, however, appears unrealistic for two main reasons. First the descriptions and causes of aberrations of human behaviour, which constitute the subject matter of psychiatry, are themselves extremely complicated and therefore require cautious hypotheses and statements rather than pretentious assertions. Second, many of the working hypotheses, methods and goals of psychiatry are presently under attack, and these criticisms require an answer. The charges against psychiatry include the following: that mental illnesses are merely socially deviant behaviours rather than real illnesses; that medicine has traditionally been disinterested in mental illnesses until about two hundred years ago when it became apparent that profit was to be had in taking charge of asylums and their inmates; that in Western industrialized societies psychiatrists serve their capitalist masters by defining as mentally ill and confining in mental hospitals those who are social dissenters, troublemakers, and economically unproductive; that mental illnesses are created by psychiatrists by the very act of diagnosis; and that mental illness, if it exists at all, should not provide an excuse for criminal behaviour or a justification for involuntary hospitalization.

This book will attempt to describe the complex field of psychiatry and the many ethical, social and scientific problems that arise as human beings interact with one another. It will at the same time consider the charges of psychiatry's critics as these charges appear relevant to the particular topic being discussed.

We will begin by offering examples of mentally ill persons as they come to the attention of their families and communities, and eventually of psychiatrists. To the ordinary person, these examples speak persuasively as familiar forms of suffering for which medical care has appeared indispensable. We will proceed in Chapters 2 and 3 to demonstrate that, since the beginnings of written history, society has recognized mental illnesses and has expected medicine as a profession to accept responsibility for treating such problems. Further, it will be seen that the major characteristics, familiar to the general public, of symptomatic psychoses, schizophrenia and manic-depressive illnesses have been clearly recognized with some variations in every culture submitted to enquiry.

We will demonstrate in Chapters 4 and 5 that the concepts of illness and disease are *not* to be regarded as all or none constructs permitting axiomatic definitions devoid of all ambiguity. Indeed, a quest for pinning down with complete precision the meaning of such terms is a form, to use Popper's phrase, of empty verbalism. Our concepts of illness and disease are hypotheses, in some cases thousands of years old, about the nature of various forms of suffering, and are still in the process of being formulated and refined. We hope to substantiate the position that concepts of illness as used by psychiatrists do not differ from the use of such concepts by other medical practitioners. All concepts of disease begin as descriptions of behavioural states, with causes unknown. It is the diligent description of such illnesses which provides the indispensable precondition for the development of theories of disease, the testing of these theories against additional observations, and the consequent increase in knowledge.

This method of medical classification, which in the realm of psychiatry is attacked by critics as dehumanizing and destructive, has in fact been of immeasurable benefit to human well-being. The contributions of the psychodynamic and pharmacological approaches to the understanding and treatment of mental illnesses were born of direct observations in the clinic which were accumulated in various combinations until meaningful patterns could be discovered. We hope to make it clear that the concept of disease is wider in practice than the concrete examples of 'diseases' advanced by critics of psychiatry who insist upon the presence of structural pathology, and incorporates sociological and psychological factors. Thus not only conditions with demonstrable physical pathology in specific organs, such as pneumonia, brain tumours or broken arms, can be considered diseases, but so too can conditions demonstrating altered function, such as hypertension, diabetes, asthma, schizophrenia and anorexia nervosa.

Finally, with respect to both ancient and recent medical-legal issues, we examine in Chapter 6 situations that pose painful dilemmas to medicine, society, to the individuals affected by mental illnesses and their families. Epidemiological and clinical studies have repeatedly demonstrated that there is an increased mortality from psychiatric disorders not only as a result of suicide but also from increased morbidity of other illnesses. For example, the increased death rates in cases of cancer complicated by depression, of markedly anxious patients who have had a myocardial infarction compared with emotionally undisturbed heart patients, and of cardiac surgery patients who express hopelessness and wishes for death at the time of surgery all demonstrate the increased risk which untreated psychiatric disorders, especially depression, bring to the patient.

In addition, the antipsychiatry writers often ignore the very tangible devastation which mental illness imposes upon patients and their family. Job loss, family disruption, economic hardship, loss of educational opportunities, and social drift downwards are all frequent consequences, rather than causes, of serious mental

illness. A significant part of this suffering and loss can be prevented with readily available pharmacological and psychological treatments.

Furthermore, although the majority of people with serious mental illnesses are not dangerous, there is a substantial minority whose conduct places the community at grave risk. In some cases the correlations are well known, as in the risk of spouse murder by persons with morbid jealousy or the sexual offenders who employ violence in the execution of their crimes. The dangerous psychopath also represents one of the most controversial medical-legal issues, namely the question of whether character disorders should be accorded illness-status. It is problematic how far such disorders are predetermined by genetic and developmental influences in the formative years, and to what extent such unwelcome influences should mitigate responsibility.

There is a dilemma here for all societies that have attained and strive to live by civilized standards. It is implicit in human relationships within such societies that individuals are responsible for their actions. Yet they know them to be shaped and to function within certain limits by heredity and by the vicissitudes of the early formative years. The laws which hold people responsible are not peculiar to any one kind of political system or social organization. They are an indispensable precondition for the establishment of trusting human relationships and for the creation of communities whose citizens can be vouchsafed an adequate measure of security and protection. For this reason those who flagrantly break such rules are made to suffer disapproval or punishment. The more extreme forms of rule-breaking are regarded as crimes and certain types of crime, for example, the predatory murder of strangers is execrated and condemned in all cultures. But exceptions to such implicit rules have been made since the beginning of recorded history. Most societies have recognized diminished responsibility of individuals with certain forms of mental disorder while striving at the same time to protect its citizens. Such exceptions have been judged essential in the interests of compassion and justice.

Psychiatry and the behavioural sciences have played a part in describing a socio-medical profile of psychopathic personality disorders, but have been less successful in changing them. The question of whether psychological medicine should remain involved in the diagnosis, treatment and assessment of risk of these disorders is a problem of immense complexity. We discuss both sides of the issue in Chapter 6. We see a need to strike a fair and equitable balance between the requirements of society for protection and justice and the rights of the individual.

It has been the traditional role of the medical sciences to soften harsh moralistic ideas and punitive attitudes that have prevailed historically. With regard to homosexuality and other behaviours that have often been defined by law as misdemeanours, science has brought a more objective and compassionate approach by arguing that deviance is not due to original sin but stems from the influence of

early factors. The advance of science has helped societies in their thinking about aberrant behaviours to move from moralistic-theistic concepts to definable naturalistic mechanisms that may ultimately be either alterable or acceptable as legitimate alternatives. In the case of the behaviour disorders, we run into serious philosophical and social problems. We discuss these problems in Chapter 6 also, and offer tentative approaches rather than final, simplistic, absolute solutions.

We judge it essential to spell out to the reader certain *caveats* regarding the generalizations which we employ and to ensure that the many qualifications and nuances which might otherwise be lost are at least acknowledged. Thinking and writing in our culture traditionally follow a linear progression and therefore automatically and immediately do an injustice to the richness of most complex subject matters. In a consideration of human behaviours within a biological and social context, many events and analyses are occurring simultaneously, and contradictory and complementary attitudes exist side by side. Words, however, can only be placed one alongside the other. Consequently, while one statement is presented – such as 'the biological model has replaced the psychological model as the dominant aetiological hypothesis regarding mental illness' – all the other statements which might half-contradict this one or which might suggest the numerous nuances which must be attached to the core statement in order to make it a thoughtful premise which accurately reflects *all* the complexities attached to it, must patiently wait as the ticker-tape of thought slowly unrolls. The problem is that every statement requires a footnote or a textual paragraph to clarify and correct it; yet repeated qualifications and caveats would be tedious and confusing. We therefore trust the reader will appreciate that there is an opposite side and multiple facets to every statement, that a dominant hypothesis does not wholly invalidate alternative hypotheses, and that small parcels of theory and data are constantly being attached to and extruded from the dominant theory.

1 Mental illness, psychiatry and its critics

At first thought, there does not seem to be any compelling reason why someone who behaves strangely, complains of hallucinatory voices, of enemies who pry into his intimate thoughts through the television screen, speaks incoherently and tries without cause to take his own life should be considered as having an illness. The word 'illness' conjures up diabetes, pneumonia, myocardial infarct and epilepsy, which appear to have little resemblance to conditions such as agoraphobia, schizophrenia and manic-depressive psychosis. The range of behaviour patterns and experiences to which the term mental illness is applied appears to merge with mere human eccentricities and even with normality itself.

On the other hand, the nature of the conditions regarded by psychiatrists as forms of 'mental illness' seem so clear and self-evident that one may puzzle why there should be any controversy at all. All societies throughout the ages have recognized the existence of insanity or mental illness among some of their members, and have distinguished these from conditions such as feeble-mindedness, criminality, and incongruent gender roles or sexual behaviour. It is true that near the boundaries between mental illness and criminality, feeble-mindedness, and even normality the distinction can be hard to make. Such difficulties, however, have not prevented all societies from recognizing and providing special care for sufferers from those conditions identical with the forms of mental suffering which within our own culture are denoted as mental disorders. Furthermore, the indigenous descriptions of mental illness within very disparate cultures are extraordinarily similar and demonstrate the repetition of a few basic elements: incoherent speech, bizarre and idiosyncratic beliefs, purposeless or unpredictable or violent behaviour, and apparent absence of concern for one's own safety and comfort. These features appear to be universal, across time and geography.

Basic questions regarding human behaviour

These, then, are the two crucial issues. First, how does it come about that certain types of behaviour and experience are regarded as illnesses? Is there justification for this position by an examination of the facts of nature rather than by an appeal to the labelling havits of different cultures? Second, in the face of a universal and immediate experience of certain types of mental illness, how does it happen that

a small number of influential writers claim that there is no such thing; that those persons who appear to suffer from any of these conditions are merely adapting their behaviours to conform with the labels of deviancy that are applied to them; that special concessions and rules ought not to be granted to those who appear to be 'insane'; and, since such conditions bear no relation to illness, those affected should not be cared for or treated by the medical profession?

The phenomena of mental illness evoke questions of great complexity for which dogmatic and simplistic answers do not exist. These questions involve the relationship of minds to bodies, the nature of human motivation, the real or illusory nature of free will as against predetermined action, and the puzzle of human illness seemingly both mental and physical. It is in the field of medicine in general, and psychiatry in particular, that our deepest philosophical questions and disagreements about human obligations, values and responsibilities become concrete. Society is forced to move from thinking about abstract principles to the making of hard choices – decisions about involuntary hospitalization, the administration of medication and other treatments with a risk of harmful side-effects, decisions about criminal responsibility. And each one of these choices may profoundly affect the lives of those persons who are subjected to them. The institutions of government – courts of law, legislatures – must determine how far it is justifiable to interfere with personal autonomy in the interests of society. It is, no doubt, the nature of the ordinary world that complicated problems are ultimately reduced to and resolved by yes/no decisions: to medicate or not medicate, hospitalize or not hospitalize. But pragmatically reducing a knotty problem to a simple solution does not mean that the issues are ever clear or that boundaries are unambiguous. The decisions required of us may be agonizingly difficult; it does not serve either society or the physician well to pretend otherwise.

Some examples of mental illness

To bring the subject sharply into focus, it may be helpful to consider a few brief accounts of the development of states of mind which caused those affected to be thought of as 'mentally ill'. It was rarely psychiatrists who first formed this opinion. Spouses, parents, friends, relatives and, in some cases, members of the public had reached the same conclusion. The attachment of a psychiatric diagnosis or label, or time spent in a mental hospital, were not the causes of the disturbed behaviour or the concomitant mental distress. These had been manifest previously. The influence of newspapers, television and other media in shaping people's attitudes may also be discounted. For, as we plan to establish, the states of mind to be described are very similar to those in descriptions handed down through the centuries, from the beginnings of recorded history.

Case 1

A married woman of 50 had previously suffered a depressive illness of five months' duration when she was aged 37. The day before the present admission to the psychiatric unit of a university hospital her 21-year-old son had been stabbed to death a few yards from her home. Her immediate response when she learned the news was to run lamenting and screaming into the street, tearing her hair, pounding her head and body and lacerating her face and neck. This behaviour settled within a few hours of admission and there followed a half-day during which she was quiet, immobile and unresponsive. She then became suddenly over-active, continuously moving around the ward, shifting the furniture, taking the possessions of others and scattering them around the ward. She burst into rapid, voluble and excited speech with an abundance of rhymes, puns, jokes and obscene words wholly out of character for her. She was excited, distracted, sang songs in endless succession and made jocular remarks about the staff and patients and displayed disinhibited erotic behaviour. She appeared wholly oblivious of her son's death. She was awake at 5.00 a.m. and began the day writing ten- to twenty-page letters to the Queen, members of the Royal family, the prime minister and local dignitaries.

After two weeks in the hospital the state of acute elation was interrupted by brief episodes of agitated depression in which she exhibited the previous pattern of grieving, lamenting and tearing her flesh. She moaned and bewailed her son's fate and blamed herself for neglecting to care for him. She was actively suicidal and had to be restrained to prevent her from plunging a knife into her chest or hurling herself through a window. Such brief surges of acute depression were abruptly interrupted by a recrudescence of her manic state which predominated during this phase of her illness. She was treated psychologically by means of the relationship established with doctors and nurses and with a combination of antipsychotic medication and lithium carbonate. She gradually became more subdued over a period of three weeks. Her condition then settled into a state of mute retarded depression in which it was difficult to get her to eat or drink. With the aid of antidepressive treatment she gradually improved over the next four weeks. Three months after admission she had returned to her normal self and though continuing to mourn her son, was able to return home and function effectively in the roles of wife and mother and to perform her domestic duties.

She was much concerned about her relapse after a twelve-year interval of healthy life and was distressed by memories of the pattern of behaviour during the early manic phases of her illness. She had not experienced manic

symptoms during her previous illness. She was worried also about a possible recrudescence of what she regarded as a serious illness and was anxious to be treated and supervised so as to minimize the chances of relapse.

During the first five weeks of illness following her bereavement a state of paradoxical elation predominated in this woman's mental state, interrupted by brief surges of intense depression. She was diagnosed and treated for a manic-depressive illness and it is doubtful whether any other view of her condition could have saved her from taking her life.

Case 2

A girl of 18 became mildly depressed after learning that her performance in a recent examination had been disappointing. Ten weeks later she left with her parents and grandparents for a holiday in France. She remained despondent and a little taciturn but was able to cheer up in the presence of congenial company. A week after arriving in Paris she developed the idea that after the first encounter with one of her French relatives there had been a change in her body and she wondered whether she was becoming a man. For several days in succession she experienced the hallucination of having sexual intercourse with her uncle who lived in another French town 300 miles away. She was observed to carry out rhythmic bodily movements followed by outbursts of shouting, screaming and weeping. She complained that her behaviour was being relayed by television to all her friends and relatives in England.

She thought that the actions of people around her implied that she should kill herself and she heard the voice of God ordering her to die. When other people looked at her she experienced further sensations of bodily changes towards a more masculine physique. Every action by others and every tick of the clock appeared to have some sinister and mysterious significance she could not fathom. The world appeared unfamiliar, alien and permeated by some evil force. All remarks made to her seemed to carry a double meaning. She wore a look of perplexity and bewilderment. Twelve days after leaving England she was stuporous and mute and was admitted to a mental hospital. In a sudden bout of agitation she tried to throw herself out of a window. She explained subsequently that in attempting suicide she was seeking to escape from the ever-present conviction that she could kill others by glancing at them.

She made a good response to pharmacological treatment and supportive psychotherapy. However, there was some adverse change from her previous cheerful, bouncy and outgoing personality to being withdrawn emotionally,

cold and unresponsive, apathetic, lacking in initiative and curiosity. She was fearful of watching television because all communications seemed to refer to her.

This girl's illness had indeed followed partial failure in an examination and some minor difficulties in her relationship with her boyfriend. But these were mere hand-claps which brought down an avalanche. She was judged to be suffering from a schizophrenic illness from which she made a partial recovery following treatment and rehabilitation. She is able to work as a clerk on a part-time basis.

We have begun with examples of psychiatric illness which provide a clear and, in our view, indubitable starting point for its definition. It need hardly be emphasized that, as is the case with all concepts developed from observation of the real world, the boundaries and limits cannot be drawn in clear and sharp lines.

There is, for example, place for debate regarding the dividing line between normal behaviour and neurotic states. But even in this territory, certain disorders are found in which a kinship with medical disease may be postulated. At the very least a disease hypothesis seems as justified as any other formulation and has in many cases already proved of practical value. Two examples of neurotic disorders must suffice.

Case 3

A 33-year-old married woman discovered some beetles while clearing out an old cupboard in her house. She immediately had to wash her hands and to repeat the washing three times. Each time she cleaned or dusted the house she began to wash her hands three times, and thereafter in increasing multiples of three. She was soon washing her hands hundreds of times a day and thereafter felt compelled to bathe herself between six and nine times daily. All the time she recognized that these compulsions were morbid but felt helpless against them. In the next stage of the disorder she developed the belief that every object that might have come into contact with hair had become contaminated. She began to dispose of her own and her husband's personal possessions and thereafter to sell articles of furniture ridiculously cheaply. At the time of her admission, an entire suite of furniture from her house had been sold and the patient came in covered by an unused bedsheet, the only uncontaminated object in the home that could be used to cover her naked body. She made a good response to treatment with pharmacological and behavioural methods and psychotherapy and returned home with minimal symptoms after ten weeks in the hospital.

Case 4

An 18-year-old girl who had recently begun a degree course at university thought herself to be obese, ugly and ungainly in comparison with other women students in her class. She began to avoid all carbohydrate food and her weight declined from 47.7 kilograms (105 lb) to 38.2 kilograms (84 lb) during her first year. Towards the end of the year she began to indulge in binges after dinner, eating a loaf of bread, or half a tin of biscuits or a cake or a box of chocolates. Abnormal distension and discomfort and intense feelings of guilt followed such bouts of over-eating which were often terminated by self-induced vomiting. Her weight began to show marked fluctuations of 3.5–5.0 kilograms (8–10 lb) from one month to the next. Intense depression, guilt and suicidal urges were regular concomitants of periods in which she gained weight. She came under psychiatric observations following a serious suicidal attempt in which she swallowed one hundred aspirin tablets she had bought at a pharmacist. She had to be resuscitated in an intensive care unit.

What constitutes disease?

Critics of psychiatry would regard these examples of mental suffering as descriptions of non-illness or social protest. They would further regard the psychiatric approach to them as forms of mystification in which veiled account is taken of social and moral problems and the whole result manipulated for the maintenance and protection of the established order. It is difficult to categorize the critics of psychiatry, because the different critics disagree with each other in some areas and overlap in others. Fundamentally, criticisms against psychiatry seem to fall into two major groupings. The first consists of those who assert that there are no such things as mental illnesses. Within this group, one subgroup, represented by Thomas Szasz, explains the seeming presence of persons with mental illness by asserting that most of them are frauds, mere simulators of craziness.[1] Another subgroup, represented by Lemert, Goffman, Scheff and Rosenhan, claims that persons begin to act as though mentally ill only after and as a result of having been labelled as such by psychiatrists acting as agents of the dominant social order.[2] Members of the second major grouping of critics of psychiatry, unlike the first, acknowledge to greater or lesser degrees that there are such things as mental illnesses, or rather, that persons do indeed become mentally ill. They claim, however, that mental illnesses are not diseases in the medical sense, but are reactions to unbearable stresses in life. This approach is represented by R. D. Laing, who lays the blame for mental illnesses upon the tyrannical bourgeois family which drives sensitive, creative souls into