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PROGRESSIVE TRENDS IN PSYCHIATRIC THOUGHT

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Psychiatry is on the march and it is fitting, in 'World Mental Health Year 1960', that a serious attempt should be made to determine the direction of its progress. It may well be that the next great advance will come, not in the form of further discoveries in the treatment of specific diseases, but, as Thomson[1] said, from a study of the precise relation of medical practice to society.

The trends in psychiatric thought in the world today are not easy to assess because of the many schools and the diversity of outlook. It should be remembered that psychiatry is a social as well as a biological science and that it will always be influenced by the cultural setting in which it has developed. Moreover, the volume of literature published since the second world war has added to the confusion and made it difficult to obtain a clear picture of the contemporary scene.

THE UNITED STATES

It has always been difficult to determine the trends of thought which are truly representative of American psychiatry. For this reason the recent publication of the *American Handbook of Psychiatry*[2] is both welcome and timely, and the editors are to be congratulated on the thoroughness and objectivity with which they have carried out their onerous task.

For many years the field of psychiatry in America had been divided into two main schools of thought, the organic and the psychobiological. The first school reduced psychic phenomena to organic causes, and the second, represented by Adolf Meyer, emphasized the importance of environment as well as biological factors in the causation of mental disturbances.

Late in the third decade of the present century the initial trend towards a better integration of psychiatry into the social structure of American culture became evident. The administration and the training of the personnel of mental hospitals rapidly improved and, as a result of a vigorous programme of after-care and rehabilitation, the institutions themselves were readily accepted by the community. Research also entered a new phase with the development of psychosomatic medicine, the introduction of the newer methods of physical treatment, including psychopharmacology and electro-encephalography. Clinical research was also stimulated in the fields of mental deficiency, child psychiatry, industrial psychiatry, military psychiatry, space psychiatry, criminology, alcoholism and geriatrics.

After the second world war the basic principles of mental hygiene were firmly established, including extensive programmes for the prevention of mental illness and the rehabilitation of veterans. Finally, the Federal Government officially recognized the importance of training a sufficient number of psychiatrists to meet the growing needs of the community.

WESTERN EUROPE

Science cannot be limited by geographical or political boundaries. But psychiatry, as a branch of medicine, is an art as well as a science. It is not surprising, therefore, to find that the philosophic approach of psychiatrists to personality problems differed on the Continent from that of their colleagues practising in Britain and America.

On the Continent psychiatrists have been nurtured in the intellectual traditions of Leibnitz and Descartes, whereas in Britain and America they have been dominated by the empiricism of Locke. Continental theories tend to focus on the 'whole' man whilst Anglo-American concepts, by contrast, are more often concerned with traits, attitudes, syndromes and performance. Speaking generally it may be said that the Anglo-American approach is more concerned with social relationships and expresses itself in an optimistic and vigorous positivism.

The emphasis in European psychiatry, however, is still focused on diagnostic categories. In Germany this trend follows the Kraepelinian tradition and the pathology of the last century. In France a similar approach is found based on the brilliant clinical school of descriptive medicine of the same period. In the Scandinavian countries the emphasis is on genetics and constitutional classifications, with greater attention to detailed statistics.

In Europe, as distinct from Britain, psychiatrists still speak of mental diseases, whereas in Britain and America they usually speak of 'reactive states', a concept which implies a more dynamic approach and a greater consideration for the individual.

In Britain and America today the principles of the psychodynamic school are fairly generally accepted. On the Continent, on the other hand, a variety of approaches is found—phenomenological and existential psychiatry, logotherapy and the conditioned reflex therapy of the Russian school.

THE SOVIET UNION

With the recent increase in cultural and scientific exchange between Russia and the Western World, there has occurred a corresponding interest in Soviet psychiatry. Wortis[3] said early in his book that Soviet psychiatry could best be understood if it were related to three basic sources of influence: its socialistic setting in a broad framework of public health services; its conformity with the general principles of dialectical materialism; and the teaching of Pavlov.

Lebensohn[4], after his recent visit to Moscow and Leningrad, confirmed these observations and said that the Soviet approach to psychiatry was ultra-conservative. To cite only one example: the two treatments which lie at extreme opposite poles in American psychiatry, namely prefrontal lobotomy

and psychoanalysis, were either officially banned or unofficially condemned, leaving only the large middle ground, with its emphasis on physiology.

Soviet psychiatry, unlike European psychiatry, is not 'hospital orientated'. There is much more emphasis on out-patient treatment and prophylaxis than on hospital-building programmes, and the average Soviet psychiatrist is more 'research minded' than his American counterpart.

BRITAIN

The unity of British and American psychiatry began in 1927 with the publication of Henderson and Gillespie's textbook,[5] which was not a full exposition of the psychobiological doctrine of Adolf Meyer, but reflected a dynamic approach to psychiatric case-taking and treatment.

The acceptance of this essentially dynamic viewpoint, as Roger[6] said, created a soil more favourable to psychoanalysis than to phenomenology. It is against this background that the significance of the publication of a textbook, *Clinical Psychiatry* by Mayer-Gross *et al.*[7] in 1954, should be judged. Although the book puzzled American reviewers, who saw it as a retrogressive trend in psychiatry, there are many psychiatrists in Britain and elsewhere who regard it as a salutary return to careful clinical appraisal on a symptomatological level.

The general psychiatric trend in Britain today is perhaps indicated by the approach of the mental hospital psychiatrists. In the selection of their cases for physical treatment their approach is phenomenological, whereas in their out-patient treatment of the psychoneuroses they are interested in psychoanalysis.

Under the National Health Service in Britain it has been recommended that part-time appointments of all grades be made to the mental hospitals. It is felt that this will attract doctors with keen clinical and research interests to the mental hospital service and establish close associations with the general hospitals. Thus strengthened, it is anticipated that the mental hospital service will undertake diverse extramural activities which will include comprehensive out-patient services, child psychiatry, and industrial forensic and criminal psychiatry.

The social rehabilitation unit established by Maxwell Jones[8] at Belmont in Sussex is of particular interest. The patients consist of the misfits in industry and are admitted from the employment exchanges, but others are referred by psychiatrists and by the courts. Their stay in hospital is up to a period of 12 months. It is stated that in this atmosphere of group endeavour the psychopath develops concern about his antisocial behaviour and, as his feelings of guilt increase, begins to identify himself with the aims of the unit.

Roger[9] has remarked on the increased attention which is being given to recreation and occupational activities in hospitals and pointed out that at Banstead Mental Hospital a Medical Research Council team has been supervising an experiment to create a factory within the hospital providing paid employment for patients. According to the first reports, the results are encouraging. Carse and his co-workers[10] described a district mental hospital service which provided out-patient and domiciliary treatment for the South Coast town of Worthing. The effect of this pilot experimental service has so reduced the number of admissions to the neighbouring mental hospital that the writers believe that the present problem of overcrowding would be completely resolved if similar services were provided in the rest of the mental-hospital 'catchment area'. Perhaps this is why Quarido's experiments[11] in the domiciliary care of psychiatric patients in Amsterdam are being followed with such interest.

McKeown[12] recently made a study of the whole hospital population, except mental defectives, in the Birmingham area. He suggested that, in future, differentiation between the actual symptoms of illness should be ignored, and that patients who needed hospital care should be grouped in one hospital centre with four divisions. The first should have all the facilities of a hospital, with surgical, medical and skilled nursing care; the second should be for those patients who chiefly require simple nursing without medical supervision; the third should be for those who need limited facilities but some degree of supervision or simple nursing because of their mental state; and the fourth should be for those who must remain in hospital, chiefly for social reasons—these would mainly be geriatric, psychiatric and arthritic patients.

This plan would obviate the present difficulties of obtaining adequate medical and nursing staff for long-term chronic patients, whether physical, psychiatric or geriatric, since the staff would rotate between long-stay and acute patients. It would centralize both surgical and laboratory facilities. If the number of patients in one division of the hospital diminished, the buildings would be available for other purposes. This scheme would also simplify the organization of professional education and encourage research in psychiatry and many other neglected fields of medicine.

SOUTH AFRICA

Psychiatry in South Africa is in a state of active transition. In 1956 a Faculty of Neurology and Psychiatry was established within the College of Physicians, Surgeons and Gynaecologists of South Africa and the first travelling Fellowship in Psychiatric Medicine has been awarded for 1960. A scholarship valued at £500 has also been offered to assist a suitable postgraduate student to prepare for the higher qualification of Fellow of the College of Physicians with psychiatry as an additional special subject. In 1959 the first full-time Professor of Psychiatry was appointed to the University of the Witwatersrand in Johannesburg, and it is anticipated that similar chairs will soon be established at the other medical schools.

The South African Medical and Dental Council, which is a statutory body in this country, has recommended that psychiatry should be better integrated into the undergraduate medical curriculum and that a mental health service should be established in the Union of South Africa.

It is now generally agreed that the mental hospitals should retain their key position in the proposed mental health service, and that they should, wherever possible, be raised to the status of teaching hospitals with university affiliation. The mental health service[13, 14] should be organized on a regional basis around the mental hospitals and the medical schools. The importance of specialized mental hospitals will in no way interfere with the growing facilities provided by the general hospitals for the treatment of mental illness, which has done so much to make, not only the public, but also medical and nursing students and even the doctors aware of psychiatry as an essential branch of medicine.

It is anticipated that the present overcrowding in our mental hospitals, as elsewhere in the world, will be reduced by the establishment of early treatment centres, run on similar lines

to the Antwerp[15] and Worthing[16] experiments. These centres are likely to be gradually established throughout the Union in the 'catchment areas' of the mental hospitals, and will provide a small number of beds, a day hospital out-patient service, and full facilities for domiciliary treatment.

Consideration is also being given to the establishment of institutes of psychiatry in Johannesburg, Cape Town and Durban. These institutes will be part of the mental hospital service and, with the assistance of the universities and the College, they will provide the necessary teaching facilities for the psychiatric training of doctors, nurses and auxiliary workers, including public health nurses and probation officers.

The psychopathic hospital which I have discussed elsewhere[17] has also been approved in principle and will be established as soon as the necessary funds are available. This will do much to resolve the social problem created by the criminal psychopath and provide an opportunity for research into the problem of offenders who do not respond to the ordinary methods of correction.

It is anticipated, too, that regional medical officers of mental health will be appointed under the Commissioner for Mental Hygiene to work outside the mental hospitals and to coordinate the services of other government departments and the numerous voluntary organizations at present independently concerned with various aspects of mental health.

Medical education in South Africa is undergoing radical changes and there is a steady recognition that humane medicine must be taught. Better integration of psychiatry into the undergraduate medical curriculum will do something to restore the physician-patient relationship which is the key to every health activity and the basis of the art of healing. For, as Rees[18] has said, just as most general medical and surgical procedures are carried out by family doctors, the specialists dealing mainly with the rarer and more serious conditions, so with the development of psychiatric insights; the major responsibility for applying them, both for prevention and treatment, will in the future rest with the family doctor and the public health nurse.

It would be a catastrophe, however, if the establishment of a mental health service were to create the feeling in the minds of general practitioners that mental illness is the responsibility of others. The practitioner is the man who first sees the sick person and knows his environment; therefore the psychiatrically-minded general practitioner will remain the mainstay in the fight for mental health.

CONCLUSION

Looking back into the past we see, as Blacker[19] said, that institutional psychiatry developed as a segregated speciality cut off from general medicine. The diagnosis and treatment of neurosis developed as an offshoot of neurology. Child guidance began as an independent movement, insufficiently linked to general medicine and paediatrics and little related to institutional psychiatry. Testing procedures and vocational guidance have been partly derived from non-medical psychology. It is now vital that these various approaches to the problem of increasing mental ill-health should be integrated into general medicine and combined into a multi-disciplined mental health service.

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