Ten books

Chosen by Michael Gelder

The authors of this occasional series of articles are asked to select ten books that have had a significant impact on their professional life. My ten are, therefore, a reflection of the ways in which I have learnt more about psychiatry. The impression that each of the books made on me depended in part on the circumstances in which I read it. I read some when I was puzzled by a particular problem and the book helped me to resolve my uncertainty. I read others when I had met the authors and had been impressed by them and their work. It is unlikely, therefore, that other readers will experience the books exactly as I did. This is a personal choice, not a reading list for others to follow.

A classic text

Mark Twain wrote that a classic is a book that people praise and don't read. Kraepelin's (1899) textbook of psychiatry fits this definition all too well, for although widely acclaimed as a milestone in the development of modern psychiatry, it is seldom read today. In part, this neglect is because the important eighth edition (1913) is not available in a complete English translation, but it is also because many think that it is out of date. Of course, much of the content is dated, but the clinical descriptions and the observations of the natural history of psychiatric disorder are outstanding in their clarity and detail. Moreover, they are highly relevant to current practice because they describe cases seen before the clinical picture and course of psychiatric disorders were modified by modern treatments.

In common with most psychiatrists, I can read Kraepelin's textbook only in an English translation. A translation of the sixth edition (Kraepelin, 1899) was published in 1990 in the USA, but this is less significant than the eighth edition. Mary Barclay published translations of two sections of the later edition in 1919 and 1921 and these have been reprinted. The first of these translated extracts comprises the chapters on dementia praecox and paraphrenia; the second contains the chapters on manic depression and paranoia. I learnt much from both volumes, but I was especially impressed by the second.

I read Kraepelin's account of manic–depressive disorder when, as a trainee, I was caring for a patient with a mixed manic–depressive state. The textbooks that I consulted at the time told me little about such states and I was immediately impressed by Kraepelin's clear and comprehensive description not only of mixed states of mania and depression, but also of the rapid changes that can take place between mania and depression. I learned also that the clinical picture can be more variable than I had supposed, sometimes with different presentations in successive attacks. Kraepelin pointed out that mixed states, rapid changes from mania to depression, and variations in the clinical picture between episodes were a challenge to the then current theories of aetiology, and this is equally true of our present theories. I was struck too by Kraepelin's comments on the role of personality in shaping the clinical picture especially of the less severe states of mania and depression. He wrote, for example, that 'the less affected the person is by the actual pathological process, the more his personal individuality must come to bear on the form assumed by the symptoms' (reprint p. 287). This interplay of illness and the ill person is a theme of the next book in my list.

Science and psychodynamics

I read Jaspers' *General Psychopathology* soon after the English translation appeared in 1963. The contents were a surprise because Jaspers' phenomenological analysis was unlike anything that I had read before. At the time, I was beginning to lead seminars on psychopathology for trainees, and I was immediately interested in Jaspers' detailed analysis of symptoms and signs. As I read on, I realised that his approach was much wider than the analysis of signs and symptoms. I was impressed by the chapter on the biographical study of the ill person, in which Jaspers developed the idea that 'psychic illness is rooted in the person's life as a whole and cannot be isolated from this if it is to be comprehended' (p. 671). However, I found another chapter even more interesting.

In the chapter on meaningful connections Jaspers made the distinction between understanding and explaining the phenomena of psychiatric disorder. The distinction is now widely understood, but it was new to me at that time. By the term 'understanding' (*Verstehen*), Jaspers meant the intuitive process by which meaningful connections are identified between events and possible psychological consequences. By 'explanation' (*Erklären*), he meant the scientific approach to causation. Jaspers emphasised that understanding applies to a single case, and it is not made more valid if it is repeated in other cases. According to Jaspers, psychoanalysis is an elaborate form of understanding of meaningful connections. For Jaspers, psychoanalysis was not a form of scientific explanation nor could it become one, however many times its observations were repeated. In Jaspers' words, 'the falseness of the Freudian claim lies in the mistaking of meaningful connections for causal connections' (p. 539). Jaspers' analysis, continued in a chapter on explanatory theories, helped me to understand the limitations of psychoanalysis. More importantly, it helped me to understand the value of the psychoanalytic approach and showed me how it relates to others.

For many years it was difficult to obtain the English translation of Jaspers' book, but it was reprinted recently (1997). This is one of the books in my list that I would recommend to every psychiatrist.

The life story approach

When I trained at the Maudsley Hospital, London, we compiled detailed accounts of the lives of our patients, and with this information tried to understand the development of their personalities and the ways in which they responded to stressful events. This way of assessing patients was championed by the Swiss–American psychiatrist Adolf Meyer and is sometimes called the Meyerian approach. However, this term implies the acceptance of other aspects of Meyer's 'psychobiological' approach, and these are not generally accepted today. McHugh & Slavney (1983) have suggested the alternative term 'life story approach' for this particular element of Meyer's teaching.

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Although the life story approach is learnt best by discussing cases with experienced clinicians, reading can help. The obvious place to seek information about the approach is in the published volume of Meyer's collected writings (Meyer, 1948). However, the book has been out of print for many years, and in any case Meyer, although an inspiring teacher, did not explain his ideas clearly when writing.

Biographers are expert in evaluating life stories and I have learned from them. I find it difficult to choose a single biography for my list, but I have selected Quentin Bell's (1972) account of the life of Virginia Woolf. There are several reasons for my choice. Virginia Woolf had a complex and interesting personality, she experienced repeated mood swings throughout her life, she suffered several episodes of mania and depression, and she died by suicide. Also her life is particularly well documented because she kept a diary (Bell, 1979), her husband wrote a volume of memoirs, and she and her friends and family wrote frequent letters, many of which have been preserved. Finally, a psychiatrist, Peter Dally (1999) has published his own assessment of Virginia Woolf's life story. Bell wrote a vivid and insightful account of her childhood, her personality and her relationships. The book amply confirms Meyer's teaching that a life story can be evaluated without recourse to complicated psychological theories. Dally's book shows what special psychiatric knowledge can add.

The experience of psychiatric illness

The best way to learn how it feels to experience a psychiatric illness is to listen to patients, but written personal accounts can also extend our understanding. Few published autobiographies have much to say on the subject, but two have impressed me. The first was written by the physiologist Moran Campbell (1988) who described the devastating effects of manic–depressive disorder on his life. He wrote vividly and with at times painfully honest insight about his state of mind when manic and the destructive effects of his illness on his own life, on his colleagues and on his loyal and supportive wife.

I had known Kay Jamison for many years before I read the next book that I include in my list. I admired her and her research and was impressed by her published work, especially by the scholarly monograph on manic–depressive illness written with Frederick Goodwin (Goodwin & Jamison, 1990). The book for my list is *An Unquiet Mind* (Jamison, 1995), in which she recounts her own experience of manic–depressive illness. The book was striking to me not only because I knew the author, but also because I read it when I was trying unsuccessfully to persuade a patient with manic depression to accept the prophylactic treatment which I felt sure he needed. Kay Jamison wrote a particularly insightful account of her own reluctance to accept such treatment and thereby risk losing the periods of mild elation in which she was creative and felt that she could live life to the full. The book contains much more than these insights and, to me, it is unmatched as a powerful and absorbing account of the experience of what the author calls the 'cyclical upheavals' of manic–depressive disorder.

Cultural differences

I first became aware of the importance of cultural factors in psychiatry when, early in my training, I treated a Japanese patient with depression. Although he spoke fluent English, I could not understand his view of the world, however much I tried. Then Michael Shepherd, my consultant at the time, suggested that I read Ruth Benedict's (1947) book *The Chrysanthemum and the Sword*, which is an account of the Japanese character and of traditions in Japanese society. The book helped me to understand better my patient's ideas of indebtedness and obligation towards members of his family, and to feel more empathy with the painful emotions that he attached to these ideas.

Later, I read Alison Shaw's (1988) book *A Pakistani Community in Britain*. The book had a particular relevance to me because it described a study based in Oxford, the city in which I was working. However, Shaw's work has a more general importance because she studied not only the Oxford families, but also the communities in Pakistan from which these families had originated. She showed how certain ways of living that puzzled the English neighbours and the doctors of the families in Oxford, were understandable attempts to keep alive the traditions of the families from which they had come. She described also the overwhelming importance of the family for people in this community, an importance that far outweighed the interests of any individual member. The book showed me how important it is to understand patients' backgrounds and beliefs – and how difficult it can be to achieve this understanding.

Stigma

Stigma and exclusion are much discussed at present, but they have always been important. Indeed, when I read Erving Goffman's (1968) book *Stigma* in the 1960s, my patients were describing a stigma that seemed even greater than it does today. The book helped me to put into perspective the stigma experienced by psychiatric patients, because Goffman also described the stigma attached to physical illness and deformity, disapproved lifestyles, and membership of certain religious and ethnic minorities. To Goffman, stigma was deeply entrenched in the structure of society and part of a basic tendency to stereotype people whose behaviour does not conform to the norm. He wrote vividly and with many telling examples of the ways in which stigmatised people try to cope with their situation. He described how such people and their families try to hide or otherwise control information about the condition, and he showed how these attempts can add to their difficulties. Goffman's view that stigma is deeply rooted in the structure of society is a sobering reminder of the difficult task of any campaign to reduce the stigma of psychiatric disorder. However, there is hope in the greater acceptance today of some of the conditions that he described as severely stigmatising nearly half a century ago.

Persuasion and Healing

In 1964 I had the good fortune to spend some time with the research group led by Jerome Frank at Johns Hopkins University in Baltimore, Maryland. This was a time when, especially in the USA, psychotherapy was the preferred treatment for many psychiatric disorders, and details of technique were thought crucial for the achievement of good results. Frank and his group had taken a very different view and were investigating non-specific factors in psychotherapy. During my stay, Jerome Frank gave me a copy of the first edition of his book *Persuasion and Healing*, in which he presented evidence that the shared features of the various methods of psychological treatment are more important than those by which they differ. At the time, this was a

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controversial message, although it is widely accepted today. I was embarking on a study of behavioural treatment, and the directions of this and of subsequent studies were guided by the lessons of the book. Also, the insights that I gained during my visit to the group influenced my approach to the use of psychotherapy for my patients.

For my list, I have chosen the third edition, written jointly by Jerome Frank and his daughter Julia Frank (1991), rather than the first edition which I read in 1964. I have done this because the later edition develops more fully an idea that I found particularly helpful. This is the idea that patients who seek treatment are often in a state of hopelessness caused by repeated failures to conquer their problems. One of the first tasks of the therapist is to overcome this hopelessness, thereby enabling patients to take the active role that is needed in any programme of psychiatric treatment.

Cognitive–behavioural therapy

Throughout my career, I have been interested in cognitive and behavioural therapies. My interest was stimulated originally not by any book but by the experience of working alongside clinical psychologists such as Gwynne Jones and Victor Meyer at the Maudsley Hospital. They were using the early techniques of behavioural therapy and I was impressed by the results. I read Joseph Wolpe's (1958) pioneering book *Psychotherapy by Reciprocal Inhibition* and I learnt to use the techniques that he described. His book was important at the time but not as significant to me as another that I read a few years later. This other book helped me to understand how cognitive factors could be introduced into behavioural treatment, thereby removing a serious limitation of the behavioural approach, namely its failure to take account of the thought processes that lie behind behaviour.

I read *Depression: Clinical, Experimental and Theoretical Aspects* (Beck, 1967) shortly after a visit to its author, Aaron T. Beck, in 1971. As the title suggests, the book is a broad survey of the clinical aspects of depressive disorder, of the theories of its aetiology and of the various approaches to treatment, but two chapters especially caught my attention. In the first, Beck described in a particularly clear way the cognitive aspects of the depressive disorders. In the second, he outlined the basic features of the new cognitive therapy that he was developing. At this distance in time, it is difficult to separate the impact of the book from that of my meetings with its author, for Tim Beck is an inspiring advocate of the cognitive approach. Nevertheless, the book certainly contributed to a deep impression that led me to apply cognitive approaches in studies of anxiety disorders. Beck subsequently joined with colleagues to write a fuller account of his cognitive therapy for depression and to describe cognitive therapy for anxiety disorders and other clinical problems. But it was the first book, *Depression* that opened my eyes to the cognitive approach and I have chosen it for my list.

Social factors

My next book is *The Social Origins of Depression*, by George Brown & Tyrril Harris (1978). When the book first appeared, I had read many of Brown and Harris's scientific papers and had heard them speak about the research. Nevertheless, I learned much more when I read the book. Indeed, one of my reasons for choosing it is that it shows how the significance of a programme of research can be explored so much more fully in a book than in a series of papers and reviews. This scope for greater background and discussion was especially important because Brown & Harris were using approaches from sociology that, at the time, were rather unfamiliar to psychiatrists. I learned from the book that sociological research can be quantitative as well as descriptive. I was impressed by the authors' clear analysis of the several ways in which social factors can exert a causal effect and by their emphasis on the meaning of events, and I found this way of thinking very useful when I saw patients as well as in relation to research. Largely because of the work of Brown and his group, these ideas are now well known and I need not write more – except perhaps to reflect that it may be difficult for today's readers to appreciate how great was the impact of the book when it first appeared.

Lessons from the past

The first book on my list is from the past; the last is about the past. When I was a trainee, most books on the history of psychiatry were written by psychiatrists. Now, psychiatric history is largely the province of social historians. I have enjoyed several historical books written by psychiatrists, including Denis Leigh's *The Historical Development of British Psychiatry*, which I read when it came out in 1961. Later, I was impressed by a book written by an Oxford colleague. William Parry-Jones (1972) studied the Oxfordshire 'private madhouses' between the last quarter of the 18th century and the first part of the 19th. He showed that, despite the low standards of care reported in many of the madhouses in London at that time, those in Oxfordshire were humane and well run. Rehabilitation and early discharge were emphasised and lengths of stay were not very different from those of comparable patients in the 1950s, when the book was written. Parry-Jones suggested that the better standard of care in the Oxfordshire houses was related to their smaller size and to their closer relationship to the local community – a lesson that applies equally today.

I have read and enjoyed some of the many books on the history of psychiatry written by historians, but I have chosen for my list a book that shows the value of collaboration between a historian and a psychiatrist. The former is Virginia Berridge, a social historian; the latter is Griffith Edwards, an expert on substance misuse. Together they studied the use, misuse and regulation of opiates during the 19th century (Berridge & Edwards, 1981). By studying the past, they brought a new perspective to the debate about the regulation of opiates and other substances that was taking place at the time the book appeared. The work shows clearly the value of combining the perspective and special investigative skills of a historian with the specialised knowledge of a psychiatrist. The book made me think afresh about my ideas about and attitudes towards the role of psychiatrists and of society in the control of substance misuse. Although written to contribute to the debate on the control and treatment of opiates 20 years ago, the general lessons of the book are still highly relevant and they convinced me of the value of a historical perspective when thinking about current problems.

Conclusion

These are my ten books. As I explained at the beginning, I have chosen books that influenced me, not books that others should necessarily read. I could have chosen

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impressive textbooks such as Rutter, Taylor & Hersov's (1994) *Child Psychiatry*, or Lishman's (1998) *Organic Psychiatry*, or important monographs such as Goodwin & Jamison's (1990) *Manic–Depressive Illness*, from all of which I have learned much about the factual basis of psychiatry. Instead, I have chosen ten books that helped me to develop an approach to the subject and to my patients.

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