Perspective

An occasional series in which contributors reflect on their careers and interests in psychiatry.

Exchanges with the Humanities

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Psychiatrists, who in their treatment of mental disorder apply theories, concepts and method drawn from many branches of knowledge, have shown remarkably little interest in the humanities. Distinct from the natural and social sciences, these are concerned with human behaviour and culture. Their neglect contrasts with the keen interest in psychopathology shown in many humanities departments in universities, from which flows a stream of publications on the psychopathology of the famous, writers and artists, and the characters they create. The data on which such studies are based are similar to those making up case-histories, as Jaspers (1913-46; English translation 1963) pointed out, although the selection of the latter tends to be more focussed by a theory.

Many writers and artists have made studies of madness in order to reveal mental processes at times of crisis. Consider, for instance, Aeschylus's *Oresteia,* Shakespear'e *Hamlet* and *King Lear,* Ibsen's *Ghosts,* and Edvard Munch's paintings of despair and jealousy. Creative works like these are subjected to disciplined study by literary or other critics in order to answer questions about what the writer or artist (or musician) expresses, or what a particular passage means, and to put what is expressed into a wider context. These critical interpretations are similar to the diagnostic interpretations made by psychotherapists and are subjected to similar tests of their validity (Cheshire, 1975).

The collaboration of a literary critic and a psychiatrist in such studies is worthwhile when both agree that the symptoms to be examined are not the capricious product of a brain whose function has broken down but have meaning in relation to past experience or present circumstances. This view towards symptoms, which is essential to psychopathology, gained strength at the beginning of this century as a result of the development of psychoanalysis. There was at this time a renewed interest in the mental processes of the famous. One pioneer was Moebius, who introduced the term 'pathography'. His work on Rousseau, Goethe and Nietzsche was published in the first decade of the century. Another was Jaspers, who wrote on Strindberg and Van Gogh (1949) and also on Nietzsche. Freud (1933), who admitted to 'a particular fascination in studying the laws of the human mind as exemplified in outstanding individuals', wrote about not only artists and writers, e.g. Leonardo da Vinci and Dostoevsky, but also such fictive characters as Lady Macbeth and Rebekka West.

A particular reason for the emphasis on the exceptional, the creative and the abnormal has been curiosity about the relationship of abnormality to achievement (e.g. Brain, 1949). Another is that in the biographies of such people we may see, as Jaspers put it, 'what can never be observed for the average patient or institutional inmate, and what will add depth to our knowledge'.

Strindberg, Van Gogh and Dostoevsky are of special interest because in their work they were concerned, less with representing the outer world they shared with others, more with expressing their own inner reality. (This tendency is a theme in the development of Expressionism in the first quarter of the century.) Biographies, whatever disadvantages they may have as material for study, have some advantages over case-histories. The lives they deal with have usually been well documented and researched. The data, circumscribed in their scope, are available equally to all. Creative work can be examined independently. And a critical reception for new studies is ensured by a body of interested scholars.

Science and method

The separation of psychiatric centres from their universities, except perhaps for their medical schools, has hampered collaboration. Psychiatrists, lacking opportunities for regular contact, have often underestimated the quality of the scholarship in humanities departments. Also, the teaching has tended to be in one direction. Ernest Jones (1949), for instance, at pains to show what contribution psychoanalysis can make to the understanding of *Hamlet* by revealing the hidden motives in Hamlet's procrastination, neglected the other side of the matter, the lessons psychopathology can learn from *Hamlet*. The contemporary need is to promote two-way exchanges—conversations—between psychiatrists and scholars in humanities. This asks more of psychiatrists than to provide 'specialist reports for the use of professional biographers or historians', as Slater (1971) has put it.

A more important hindrance to collaboration has been the idea, derived from 19th century distinctions between Geistes- and Naturwissenschaft, that the moral and the natural have to be studied by different methods. Moreover, psychiatry has been dominated by the reductionist view that the objective of scientific medicine should be the discovery of the underlying internal disorder and the specific treatment for it. This model is too narrow. The distinction between what is science and what is not on the basis of the form of the explanation is arbitrary. What matters, equally in both humanities and psychiatric departments, is adherence to the rules of science as a discipline, with its three essentials: fidelity to the evidence, rigour in logical formulation, and scepticism. Also,

the gap between the understanding appropriate to Geisteswissenschaft and the explanation appropriate to Naturwissenschaft has been spanned by cybernetics (or systems theory), which achieves what has been called 'the causalization of teleology' (von Wright, 1971).

Also a proper and useful approach is to define the context of a behaviour and the part it plays in exchanges between man and machine or man and man, as cybernetics does without saying anything about what happens inside 'the black box'. The context and associated behaviours show whether reddening of the face is a blush of modesty or a flush of anger, or whether, to take Cheshire's example, when he raises his hand a man is greeting a friend or stopping the traffic. Stevie Smith (1975) gives as the context 'much too far out' for the plea she makes in her poem that she is 'not waving but drowning'. Behaviours like these, reported or observed, are fitted into a pattern of interaction. This is the hypothesis, which is then tested. Does it accommodate them? Is it belied by other behaviours? The testing may be no more elaborate than that applied in doing a crossword puzzle: do the down words and the across words corroborate one another?

The strategies of psychotherapy

Biographies, novels and plays provide models for psychotherapy. Plays especially describe crises in a system of relationships. Typically in the middle acts the implications and consequences of a disruption in a system are explored, and in the final act there is movement towards either disaster or reorganization of the system, with reconciliation and the re-establishment of the relationships on new terms. In *Hamlet* the crisis is brought to a head by the appearance of the ghost of the dead king, in *Ghosts*, by the burning down of the orphanage, which means the destruction of the son's illusions about his father. Of special interest to psychotherapists are those plays in which reconciliation is mediated by an outsider, and in which as a result there is remission or recovery in an illness (Watzlawick *et al*, 1968; Davis, 1968; 1979).

In the *Oresteia*, Orestes recovers when pursuit by the Furies, representing the pangs of conscience, is called off as a result of Athena's mediation and his examination in a court of justice. Ellida in Ibsen's *The Lady from the Sea* recovers from her depressive illness when her general-practitioner husband is persuaded by a third party to take what for him is the extreme measure of offering her freedom and responsibility. Instructive descriptions of the processes of recovery after a bereavement or other distressing life event are to be found in many biographies and novels. Strindberg surveys in diary form in *Inferno* and in dramatic form in Part 1 of *To Damascus* his second marriage (Meyer, 1975, p. 14), and describes how his psychosis remitted when his study of Swedenborg's writings dissipated his sinful feelings about the breakdown of this marriage and his failure to provide for his children.

The phenomena of illness

Another area in which collaboration can be fruitful lies in the description and explanation of the phenomena of illness. A model is provided by Oliver Zangwill's (1945) study of the déjà vu experience recorded by Nathaniel Hawthorne in his English memoirs *Our Old Home*. Hawthorne explains the paramnesia by reference to a letter, received many years previously, which contained a description of his old home. Arguing that this explanation is incomplete, Zangwill, a psychologist, poses the question: why did that particular memory exert so potent and abnormal an influence? In a critical study of Hawthorne's writings he identifies the accident of circumstance on each occasion and the fantasy it revived. The defensive repudiation of this fantasy led to the paramnesia. This instance throws light on the mechanism of déjà vu in general.

The déjà vu experience recorded by Strindberg in *Inferno* appears to be similar. It was evoked by a landscape of 'numberless hills, spiky with pine trees ... like the craters of volcanoes' (Chpt. 8, p. 206). He explains it by reference to a landscape he had seen as a warning in a pattern in a zinc bath, 'formed by the evaporation of salts of iron' while he was trying to synthesise gold (Chpt. 6, pp. 163-4). His comments elsewhere (e.g. Chpt. 9. p. 211) show that on both occasions the circumstances had aroused his sense that he was damned, and that both scenes had evoked an image of Dante's hell.

In *Inferno* Strindberg gives an account of the disorders of perception from which he suffered during his illness. These may be summarized as the disintegration of the perceptual field, piecemeal perception of small details, into which special significance is read, such as strange coincidences, and heightened personal reference. He saw pansies as human faces mocking him (Chpt. 6, p. 149), dry twigs as letters, such as P representing Popoffsky (Chpt. 6, p. 155), the husband of a woman with whom he had had an affair, and, in the grain of the wood, 'a goat's head ... upon which I instantly turned my back. Pan himself, whom the Middle Ages had transformed into Satan' (Chpt. 7. p. 199).

Virginia Woolf's novels are another rich source. In *The Waves* and *Mrs Dalloway* she describes the draining away and then return of meaning and colour in the fictive character's world (Poole, 1978, p. 195). In *Mrs Dalloway*, written between 1922 and 1925, which she calls in her diary (Woolf, 1979, p. 217) 'a study of insanity and suicide, the world seen by the sane and insane side by side', Septimus represents her as she was when acutely ill. Several of the events in the novel have counterparts in her experiences at the height of her illnesses. Septimus sees in the middle of a fern an old woman's head (p. 60) and on some drawn blinds 'a curious pattern like a tree' with 'the gradual drawing together of everything to one centre ... as if some horror had come almost to the surface and was about to burst into flames' (p. 15). A sparrow chirped, 'to sing freshly and piercingly in Greek words how there is no crime ... no

death' (pp. 23-24). During one of her illnesses she had listened to the birds singing in Greek. There are profuse references to Greek in her writings, and Poole has reviewed these in order to answer the questions: what did Greek mean to her? With what experiences was it associated? Septimus's eventual suicide by jumping from a window has its counterpart in her own action many years earlier. Septimus's meetings with doctors are also based on her own interviews, and in the novel she protests against the crude medical view taken towards her illness by her doctors. She was sure that the anxieties and insomnia were due simply to her own faults, but she was prescribed, after little enquiry, "rest and food, 'Robin's Hypophosphate' and mulled wine at night" (Bell, 1976, pp. 13-15). This underlined for her husband, Leonard, his concern over 'the excruciating business of food' (Woolf, L., p. 163). Both Bell, her biographer, and Leonard commented in retrospect on the doctors' lack of understanding of the nature of her illness, which would nowadays be regarded as a manic-depressive psychosis. The information now available in letters, diaries and novels enlarges our understanding of the psychological factors, and Poole has discussed the origins of her overwhelming sense of guilt in her relationships with her half-brother, George Duckworth, and with Leonard, identifying several circumstances that led her to doubt her adequacy as wife and writer.

The second self

Splitting, an elusive but crucial concept in the psychopathology of psychosis, is illuminated by the critical work on the second self or the double in literature (e.g. Keppler, 1972; Rogers, 1970). Strindberg in *Inferno* reports an experience, while at the Hotel Orfila, of a second self in the form of a stranger in an adjacent room: 'He repeated my every movement in a way that suggested that he wanted to annoy me by imitating me' (Chpt 6, p. 172). In *To Damascus* 'the Stranger' has a second self in the 'Beggar' (Meyer, p. 17, Keppler, p. 104). In his preface to *A Dream Play* he says about *To Damascus:* 'The characters split, double, multiply, evaporate, condense, disperse, assemble. But one consciousness rules over them all, that of the dreamer' (Meyer, p. 553).

Many other writers have made a more or less controlled use of decomposition by linking characters so that 'as two disunited parts of a single psychical individuality' they represent different aspects of the conflicts engaging the writer's attention (Freud, 1916, p. 324), e.g. Dostoevsky in *The Double* and *The Brothers Karamazov*. Those who have made most use of the theme of a second self are known to have had experience themselves of mental illness. What they have written about a second self is close to what they have lived through while ill (Rank, 1971).

Conclusion

Fascinating problems are raised for psychiatrists by the accounts writers and artists give of the phenomena of mental illness and of the courses illnesses take. There are, of course, hazards in discussing fictive characters as if they were living persons. However, the pity is that psychiatrists have contributed so little. In the case of Strindberg they have been preoccupied by controversies over nosology (e.g. Hedenberg, 1961; Anderson, 1971). Was Jaspers (1949), a philosopher, right to diagnose schizophrenia? Conventional medical views have tended to divert attention from the interactional processes, as it seems they did in the case of Virginia Woolf. In the case of *Ghosts*, the supposition, held to despite the facts against it, that Oswald suffered from neurosyphilis delayed recognition that Ibsen was describing the severe disabilities, not only in sons, which may result from interactional processes in families (Davis, 1963; Davis and Thomas, 1978). Shakespeare makes a similar point (anticipating R. A. Laing) when Hamlet reproaches his mother: 'Lay not that flattering unction to your soul that not your trespass but my madness speaks' (III. 4. 145-6).

Psychiatrists have much more to offer to a partnership with scholars in the humanities than a concern with nosology. They are familiar, not only with the theoretical issues, but also, through their experience in psychotherapy, with the varied manifestations of crises in systems of relationships. Their expertise could complement that of scholars in humanities in research in fields of common interest.

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*The Nodder Report—A Scottish Psychiatrist Reacts**

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Among reports from committees and working parties, some are crisp and stimulating, while others, the majority unfortunately, are dull and sedative. The Nodder Report falls into the latter category which is a pity because some parts of it are worth reading. It is neither as good nor as useful as it should be because it fails to tackle the problem as fully and as vigorously as required. The working party have avoided difficult but essential problems such as the difficult patient, the patient concerned in criminal proceedings, the role of the consultant psychiatrist, the role of other doctors and the role of the nursing officer. They have grasped the tulips and tiptoed through the nettles.

The first disappointment, already mentioned, is the deliberate side-stepping of the problem of the difficult patient. The working group should have tackled this, because any system which does not cope with it effectively is valueless. The excuses they give for avoiding it are not good enough; they should have made time available by dropping other things if necessary, and they should have obtained the appropriate members if they did not have them.

The discussion of the management of psychiatric services as a whole is so involved with the scene in England and Wales that much of it is irrelevant to Scotland.

It is not the fault of the working group that the medical member of a management team has to be an elected chairman of a Division of Psychiatry, but there is no reason why they should not have commented on the fact that, in management terms, he will always be an amateur among professionals, and possibly a pigeon among the cats, being the only member with no contractual obligation to make the system work. In Scotland, of course, Physician Superintendents still exist—one cannot say flourish—and any Scottish system must take account of this.

This same problem crops up in connection with management within the hospital, and although there is rather more mention of the medical profession here than elsewhere it is inadequate and misleading. The abolition of the post of Medical Superintendent rates a mention, but not that more important change, the introduction to the mental hospital of the 'consultants' system on the pattern of general hospitals. This happened when the Health Service came in and long before the superintendents in England disappeared. Consultants in mental hospitals now had not only substantial responsibilities outside the hospital but full clinical responsibility inside, with the possibility, for good or ill, of different treatment regimes existing within the one hospital. In a sense, the mental hospital began to cease to be a unit, and it is this process which has perhaps gone too far and which this report seeks to reverse to some extent. The working group should have looked much more closely at the role of the consultant and especially at his responsibility. It is not enough to say that 'the diagnosis and prescription of medical treatment' is the responsibility of the consultant without saying what is meant by 'medical'. In psychiatric terms it means everything that happens to the patient of a therapeutic nature, but this is obviously not what the report means. In effect, it states that the patient's individual therapeutic programme is not the consultant's responsibility and they lay this on the multidisciplinary team. I doubt if this would hold up in law. Where the report touches on the consultant's legal responsibility, it discusses entirely the wrong issue. It is not the question of the negligence of other people that need worry the consultant, it is the question of his responsibility for what he agrees to, or allows to happen. Can he allow other people to outvote him in a team discussion and allow a programme he disapproves of to proceed? If he cannot change the programme, has he not a duty to discharge the patient from a situation he considers unhelpful or even harmful? If he does not have both the power and the

*In March 1977, the Secretary of State for Social Services set up a Working Group, multidisciplinary in composition and chaired latterly by Mr T. E. Nodder, Deputy Secretary in the department. Its terms of reference were: 'To examine the main problems arising from recent mental hospital enquiry reports and in particular the organizational and management problems of mental illness hospitals and units, in relation both to the new National Health Service structure and to the development of District Services; to examine in relation to mental handicap services those problems and solutions common to mental illness and mental handicap; and to make recommendations.'

This article is based on a paper read to a Multidisciplinary Symposium organized by Greater Glasgow Health Board at Gartloch Hospital on 11 November 1980.