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Ten books

Chosen by George Szmukler

It is to see the 'big picture' that I read psychiatric books – to see the wood despite the trees. Forests of the latter are felled to keep us abreast of new knowledge in the form of mostly ephemeral journal articles. By the 'big picture' I mean principles and assumptions: the methods we use to understand the subject matter, the key organising ideas, analyses of the contexts in which we practise (social, political and ethical), and so on.

I have belonged to book groups for over 25 years. However, although books have always been central to my life, I think I am probably more inclined to the visual. Cinematic images, for example, can illuminate emotions and relationships with a special immediacy. Where the power lies in the relationship between a professional and client is instantly exposed when the social worker in Mike Leigh's film *Secrets and Lies* explains to her client that her special expertise and sensitivity are required to assist in the search for her biological mother, while at the same time surreptitiously sneaking a glance at her watch to see how long it is until her next engagement. A film like Kirostami's *Ten*, recording conversations between a woman driver and a sequence of passengers, reveals with perfect economy practically all we need to know about the position of women in Iranian society, as well as countering pernicious 'them' and 'us' polarities spurred on by our tabloid press. Is there a better basis for training in cultural diversity?

I feel honoured to have been invited to discuss my 'ten books'. At the same time I know I shall be inadvertently revealing much about myself in my choices as well as my omissions. What weight do I attach to novels, for example? I will leave that to later. These are the ten books that I believe have most influenced my professional development. The order is not ranked; I have grouped them as far as I can by theme.

The law and mental illness

When I was a medical student I thought that psychiatry was by far the most interesting specialty. However, its potential for social control troubled me. In fact I wrote a paper on this subject with Sid Bloch, a registrar at the Royal Melbourne Hospital at the time, for the Melbourne University magazine. Perhaps fortunately, I can't find a copy to re-read. My MD thesis was on the subject of compulsory admissions, and the issue has remained a preoccupation with me.

The report of the Percy Commission (Her Majesty's Stationery Office, 1957) is a laborious read, but it is a model of how to approach a major change in the law relating to the tricky subject of mental illness. The Royal Commission took evidence from all relevant parties for almost 3 years. It recommended fundamental changes commensurate with the huge changes that had occurred in psychiatric thinking and practice. The report presented a detailed account of mental health philosophies, practices, prejudices and services. The conclusion that the default treatment conditions should be 'informal' was revolutionary, as was the reliance on medical judgement in determining involuntary admission in the first instance. Its discussion of the status of 'psychopathy' and whether it justified compulsion under a mental health act is comprehensive. The circularity of the diagnosis, famously highlighted by Baroness Wootton – mental abnormality is inferred from the antisocial behaviour, while the antisocial behaviour is explained by the mental abnormality – was a major concern (as was the question of whether such a personality disorder was treatable). It was concluded that if training or treatment in hospital were to have any hope of success, it must occur early in life. The use of compulsory powers for this group was thus supported only if there were evidence of treatability and for those under 21 years of age.

Practice has changed dramatically since the 1950s. Nevertheless, the thoroughness of the approach then contrasts sharply with the current approach to reform of mental health legislation. The Richardson Committee was given 3 months for its 'root and branch' review, not 3 years. In government consultation papers, where fundamental issues are addressed (usually they are not), this is done superficially. History is ignored. The discussion about 'personality disorders' is a good example; numerous unquestioned assumptions are made.

Paternalism or discrimination?

Mental Illness: Prejudice, Discrimination and the Law (Campbell & Heginbotham, 1991) made me realise that despite all my attention to the details of mental health law, I had missed something obvious and shocking. This, rarely appreciated point is that mental health legislation, by singling out the mentally disordered for special attention, becomes inherently discriminatory. The principle of paternalism that governs non-consensual treatment for physically ill people who lack the capacity to make treatment decisions for themselves should apply just as well to those with mental illness. Instead, we have special legislation for people with mental disorders which does not respect their autonomy in the same way, and which allows us to enforce treatment on patients who retain capacity for making treatment decisions, without needing to ask whether the treatment is in their best interests (as viewed from their perspective, not of the doctor or team).

Matters are even worse when it comes to compelling treatment for the 'protection of others'. Here mental health legislation conflates paternalism and 'public protection'. Public protection turns on the question of risk to others: at a level of risk to others that is deemed unacceptable to society, all members posing that risk should be equally liable to detention or forced remedial interventions. The fact of mental disorder might contribute to the risk, but is mainly relevant when disposal is at issue. However, what mental health legislation permits is the detention and compulsory treatment of those with the label 'mental disorder' even when the risk they pose would be judged insufficient to detain someone without this label – who would need to be convicted of an offence before detention.

Campbell & Heginbotham point out that underlying our blindness to this discrimination are prejudicial stereotypes of people with mental illness: that they are inherently incompetent to make significant choices, and that they are dangerous. What is worrying is that mental health professionals are just as blind to this

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as are lawyers, politicians and taxi drivers. Generic 'incapacity legislation' covering all classes of patient, as well as generic 'dangerousness legislation' covering all risky persons, is the only approach that respects the principle of justice.

Lessons from history for doctors

The Nazi Doctors by Robert Jay Lifton (1986) is a chilling book describing the extreme case of doctors – psychiatrists sadly prominent among them – acting in the service of the state instead of their patients. Evidence presented by Proctor (1988), in his excellent history of medicine under the Nazis, indicates that 45% of doctors joined the Nazi party; they were seven times more likely to join than the rest of the employed population. Seven per cent joined the SS (*Schutztaffel*: the Nazi paramilitary force) and 26% of male doctors were in the SA (*Sturmabteilung*: the Nazi terrorist militia). How can this be explained? There were socio-economic factors to be sure, but most significant was the fact that doctors were offered, and embraced, a special role in the Nazi state. Rudolf Hess called National Socialism 'applied biology'. Doctors were 'biological soldiers' imbued with a biomedical vision of the state that was to be created. This involved the purification of the race, a special kind of public health policy based on 'scientific' principles. A sequence of policies involved increasingly extreme behaviours on the part of doctors: enforced sterilisation; killing impaired babies and children; 'euthanasia', a euphemism for killing 'impaired' adults with 'lives unworthy of life'; killing of impaired and racially undesirable inmates of concentration camps; and finally, the mass killing of entire racial groups in *Einsatzkommmando* operations and death camps. By this point doctors had accepted an extraordinary paradox, which Lifton terms 'killing as healing'.

The major part of Lifton's book derives from interviews with Nazi doctors employed in Auschwitz, as well as survivors from the medical blocks, including 'prisoner–doctors'. He explores in detail how the Nazi doctors could believe that they were acting as doctors, despite a host of activities directed to mass killing, and 'research' of unimaginable cruelty. It is amazing that hygiene in the camp was discussed seriously and suicides were followed by an official inquiry. Lifton analysed a mental mechanism, termed 'doubling', which allowed the Nazi doctor to maintain two selves: first, an 'Auschwitz self' in which the killing–healing paradox was maintained through an almost transcendental biomedical vision buttressed by a sense of duty, routine and loyalty to the group; and second, a 'prior self', which allowed doctors to behave 'normally' with their family outside. The account is powerfully written and very persuasive. An extreme case, certainly, but there have been many other instances of doctors forsaking their duty to their patients to serve the interests of the state. Lifton argues that the same processes that doctors use to distance themselves emotionally from the suffering of their patients to help them more effectively may in certain circumstances be extended to denying their patients' interests.

Social meanings of illness

For a slim volume, *Illness as Metaphor* by Susan Sontag packs quite a punch. Sontag (1983) examines the metaphorical uses, mainly in literature, of two diseases, tuberculosis and cancer. A large array of quotations build up a striking web of connections in the popular imagination between illness and a host of personal attributes. Tuberculosis was somehow viewed as refined, spiritual, or soulful; Katherine Mansfield was described on the day of her death as more beautiful than ever before. By way of contrast, Sontag shows how cancer spawns metaphors of a negative character: of emotional weakness, repression, inhibition, depression, of failure to achieve satisfaction in life. People with cancer and their families are commonly stigmatised. Many of its metaphors are an incitement to violence – to wage war against invading cells, to kill them by bombarding them with radiation. Nazis used this metaphor against the Jews in the state. If metaphors of such power attach to these two diseases, how much stronger are they for mental disorders? As doctors we often forget about the social meaning of illness that patients and their relatives have to face. Sontag draws some worrying conclusions; for example, she claims that 'it is diseases thought to be multi-determined (that is mysterious) that have the widest possibilities as metaphors for what is felt to be socially or morally wrong'. Perhaps the only way of purifying illness from metaphoric thinking is by revealing its causes. Some hope may be drawn from the fact that attitudes to both tuberculosis and cancer have changed. Arguably this has now also happened to a significant extent in Alzheimer's disease, and may happen for other mental disorders. Research into causes has added social value.

Understanding and explanation

Michael Shepherd claimed in 1982 that *General Psychopathology* by Karl Jaspers 'remains the most important single book to have been published on the aims and logic of psychological medicine'. In my view this still holds true in 2003. The aims of *General Psychopathology* were ambitious – to 'survey the entire field of general psychopathology and the facts and viewpoints of this science'. This required an account of the scope of psychopathology, its empirical findings, a critical analysis of its research methods and their range of application, and an evaluation of its theories. As Jaspers put it: 'In the midst of all the psychopathological talk, we have to learn to know what we know and do not know, to know how and in what sense and within what limits we know something, by what means that knowledge was gained, and on what it was founded. This is so because knowledge is not a smooth expanse of uniform and equivalent truths but an ordered structure of quite diverse kinds of validity, importance and essence'. For me, the distinction between *verstehen* (understanding) and *erklären* (causal explanation) is an indispensable organising principle. Causal explanation follows the methods of the natural sciences. It seeks to discern regularities between phenomena that are objective, law-like and general. Understanding – that is, grasping meaningful connections – follows different principles. How 'one psychic event emerges from another' is understood by us directly, irreducibly, by empathy – that is, by imagining oneself in the shoes of the other. Understanding is not law-like; it is particular: 'anything really meaningful tends to have a concrete form and generalisation destroys it'. Jaspers went on to examine the relationship between understanding and disorder. Understanding sometimes reaches an end-point where despite every effort to empathise with a person's predicament, his or her experiences or behaviour are 'ununderstandable' – 'one psychic event follows another quite incomprehensibly; it seems to follow arbitrarily rather than

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emerge'. Thus, we encounter signs of a mental illness, and to take things further we must resort to 'causal explanation' – to see it from 'the outside'. Hence the distinction between 'process' and understandable 'reaction', the former representing a discontinuity or breach in the subject's psychic life.

Jaspers's distinction between understanding and explanation is, of course, problematic from a research perspective. We may find it difficult to agree where the limits of the meaningful lie. Jaspers saw a claim of sorts for impartiality when '*understanding* is fair, many sided, open, and critically conscious of its limitations'. The problem remains recalcitrant. A book that considers the problem from a contemporary viewpoint is *Mind, Meaning and Mental Disorder* by Bolton & Hill (1996). McHugh & Slaveney's *The Perspectives of Psychiatry*, inspired by Jaspers, is an excellent, accessible book for the younger trainee (McHugh & Slaveney, 1996).

The origins of depression

Unhappy events clearly can make us sad; but can life events cause mental illness? The answer would seem to be yes, but this apparently simple hypothesis is difficult to test scientifically. In part this is because of one of the key Jaspersian problems: the link between understanding and causal explanation. *Social Origins of Depression* by George Brown and Tirril Harris tackles the problem head-on: 'It is clear we must accept that what is going on in a person's life, a person's perception of this, and the way change and the perception of change are reported by him may all differ . . . whose perspective do we take about life events and the changes they entail? . . . Much will depend on what we are trying to do but it is difficult to contemplate any way of dealing with such multiple perspectives without the investigator at some stage imposing his *own* viewpoint of the world' (Brown & Harris, 1978).

With the device of 'contextual' ratings of life events for 'threat', Brown & Harris ingeniously manage to bring together the perspectives of the subject and the observer, the subjective and the objective. A model of the origins of depression is constructed relating life events, 'vulnerability' and 'symptom formation' factors and is subjected to rigorous testing. Today, a more sophisticated statistical approach would be used, and the contextual ratings would have been further refined, but the study remains seminal. The writing is also a model of clarity.

Popper and the role of scientific testing

What constitutes science is difficult to define. When I read Karl Popper's book *The Logic of Scientific Discovery* (Popper, 1959), I began to understand the relationship between the play of creativity and imagination in science on the one hand, and the nature of hypothesis-testing on the other. In *Conjectures and Refutations*, Popper (1963) described how he came to contrast the nature of Einstein's theory of relativity with psychoanalysis. (After personal contact with Alfred Adler, he was for a while involved in social work with deprived youngsters in 'social guidance clinics' in working-class districts of Vienna.) Popper argued that to be scientific, a theory had to be empirically testable, but that the relationship between falsifiability and verification was 'asymmetrical'; only the former can be conclusive, and even if a theory is consistent with one set of observations predicted by it, there always remains the possibility that it will not be so with the next. The best theories are 'risky' ones – that is, ones from which follow many testable (that is falsifiable) predictions, especially if novel or unexpected. A single instance in which a prediction fails to be observed is sufficient to invalidate the theory. Psychoanalysis is not scientific, he argued, because it could be made consistent with virtually all possible predictions. However, he recognised that non-scientific theories may still be of value. Popper noted that theories do not arise inductively from systematic observation, but imaginatively, from attempts to solve problems. The science is in the testing.

Popper's ideas have been severely criticised and he later modified them to take account of Kuhn's (1962) description of how scientific theories rise and fall in the real world. Popper admitted that testing of theories depends on observations, but that observations are theory-laden, and that disputes easily arise about whether or not a particular result should count in falsification. In psychiatric research, theories seem to die out because research funding based on them dries up. Nevertheless, Popper's theory continues to define, at the very least, the direction of travel for the scientist.

The 'Maudsley approach'

Michael Rutter's book *Maternal Deprivation Reassessed* (Rutter, 1972) had an enormous impact on me. It is a model of a critical review. A 150-page *tour de force* of systematic and rigorous examination, it redefines a key research area. Further, numerous hypotheses are proposed, and are in turn tested for inconsistencies against the evidence available (around 450 publications). In this respect, the approach would no doubt have met with Popper's approval.

The book also represents the 'Maudsley approach' at its finest. Aubrey Lewis in an interview once stated that 'Maudsley psychiatry' is 'concerned with empirical clinical methods strengthened by the results of research, which then enable theory to be formulated and eventually applied to practice . . . [the approach] is a balanced one, avoiding the extremes of enthusiasm and bold claims, but not settling down into a stagnant acceptance of things as they are'. Many might see Rutter's conclusion, that both the 'maternal' and the 'deprivation' in the term 'maternal deprivation' are misleading, as typically 'Maudsley'. However, the dissection of the various ways in which bonds between a child and a range of other people can be disrupted or distorted, in a range of contexts, and with a variety of outcomes to which subsequent events contribute, marks a major advance in thinking. On re-reading this book, I was struck by the fertility of the hypotheses; many adumbrate themes central to research in developmental psychiatry today, for example, the study of individual differences, or gene–environment correlations as well as interactions. Reductionism does not work well in the study of development, but this book shows that scientific rigour need not therefore suffer.

Systems thinking

Reading Gregory Bateson's book *Steps to an Ecology of Mind* (Bateson, 1972) and the writings of others of the Palo Alto school in the late 1970s was exhilarating. I felt my thinking was hugely broadened by systems theory. The realisation that all communications have a factual (or report) level as well as a relationship-defining (or command) level has become central to my thinking about relationships – the seemingly simple statement 'the door is open' can have various meanings depending on who is saying it to whom; for example, boss

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to employee, or employee to boss. Whether this is truly an example of Russell's 'logical types' as claimed I am unsure, but the source of many problems in communication clearly lies in the levels becoming confused in the minds of the communicators. Also extremely helpful were the ideas that the behaviour of individuals may reflect patterns of interaction in a system; that the solution may become the problem; that information is 'difference'; that causes are 'circular' but capable of punctuation in many possible ways; that systems may fragment through 'symmetrical' or 'complementary' processes; and that change and resistance to it are usually best conceptualised in systems terms. The testability of systems theories in the Popperian sense remains unclear.

My interest in these ideas was originally driven by an involvement in family therapy research. I found 'paradoxical interventions' troubling; too often they seemed to be covert manipulations of the family and an abuse of the therapist's power. But sometimes, if respect for the family was preserved, they appeared to enable new behaviours. I confess that I sometimes use elements of this approach when all else has failed to 'free up' a 'stuck' system.

More recently, systems thinking has been especially helpful to me as a manager, both as medical director and dean. Getting the best out of people, quality improvement, organisational change, translating research into practice – these are essentially systems problems. The 'double bind' may not cause schizophrenia, but it is certainly unpleasant to be on the receiving end; injunctions to meet mutually inconsistent National Health Service performance indicators provide some good examples. Reading Bateson helps.

Fictional insights

I would not take any of the above books to a desert island. Shakespeare and some of the classics would be my choices there. I have not included novels in my nine books so far because, although they are indispensable to enriching our store of 'meaningful connections', in my view they rarely effectively address mental illness. This is not to deny that some novels do get close to the understandability boundary between sanity and insanity; Ishiguro's *When We Were Orphans* (Ishiguro, 2001) and Unsworth's *Losing Nelson* (Unsworth, 2000) spring to mind as recent examples. Nevertheless, mental illness itself seems elusive; but then, that is its very nature.

I include one novel as representative: *The Emigrants* (Sebald, 1996). I have selected it on the quite arbitrary basis that it is the most recent 'great' novel I have read. Born in 1944, the German W. G. Sebald died tragically in a road accident in 2001. He arrived in England in 1966, and from 1987 was Professor of European Literature at the University of East Anglia. He started writing novels late and did so in German. However, the translation of *The Emigrants*, by the poet Michael Hulse, is very fine. The book, which has been termed a 'hybrid novel', is hard to describe: a unique combination of novel, memoir, biography, history, travelogue and photography collection. It deals superbly with the subject of memory, and the ways in which people are driven at different stages in their lives to recover or obliterate it, and with the profound experiences associated with exile and displacement. The author explores these themes through four tangentially linked stories, set in 20th century Europe, dealing with attempts to establish a sense of identity and personal continuity against a background of cultural disruption. Even childhood displacement followed by a lifetime of apparent stability may leave a mark that becomes more rather than less indelible with age. The writing is at the same time limpid and dream-like, yet despite the latter, often minutely detailed in the descriptions of places, buildings and objects. Old photographs pepper the book; these add an eerie sense to locations and characters of a time lost that resonates wonderfully with the moods of the text. For a psychiatrist who practises in a society where increasingly large sections of the community are composed of immigrants, displaced persons or refugees, this book is invaluable.

A final comment

Today, the pressures on academics to produce peer-reviewed, data-based papers for eminent journals are not conducive to writing books (as distinct from editing them). Also, an impatient world in thrall to the sound bite does not incline readers to tackle big books such as Jaspers'. There will, of course, always be key questions that are best treated across the span of a book – but will there continue to be authors prepared to write them? The enterprise requires a special kind of commitment.

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