and error with pilot courses in different settings.

Looking at the detailed course proposals set out in the Appendices from the point of view of the psychiatrist, one is reassured to see that they maintain a fair balance between the time given to biological and psychological aspects of training. Additional periods are devoted to research methods, social influences on behaviour and the management and administration of health care.

In summary, I think that psychiatrists should welcome and support a degree course in occupational therapy. However, it should be introduced gradually after more study and after more serious thought has been given to the far-reaching implications of an 'all graduate' entry, not only for occupational therapists but for their patients and other professions.

Teaching Psychiatry: Scientific Myth

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On the whole, when psychiatrists get together in meetings or conferences, they have a fairly good idea of what they are talking about. Discussion flows in a more or less coherent way. Even if the topic involved is problematic—say, the diagnostic criteria for schizophrenia—there is a general sense of agreement about what is meant by the words 'diagnosis' and 'schizophrenia'; even if the meanings are fuzzy at the edges. In areas of psychiatry made complex by the number of variables involved, statistical methods help to clarify the information gleaned, so that in the assessment of, for example, social factors in mental disorder, some clarity of conclusion prevails.

Nevertheless, it seems almost trite and wearisome to point out that there are profound differences of view within our discipline concerning the most fundamental issues and concepts with which psychiatrists are involved. I am not referring here to the examples given above—schizophrenia and social stress—but to issues and concepts even closer to the heart of psychiatry. In a way, I am referring to the issue of psychiatry itself.

As one reads the later papers of Sir Aubrey Lewis,[1] one is grasped by the erudition with which this great psychiatrist addressed himself to matters at once profound and everyday in their character. As he reviewed the concepts of anxiety, endogeny and exogeny, paranoia and psychogenesis, Lewis revealed a formidable repertoire of intellectual sources, a battery of cultural references. Gradually, a more dramatic theme eventuates. Could it be that these words did less than flag the way to psychiatric concepts? Could it be that the words were the concepts themselves? Fortunately, such questions are less likely to arise at a psychiatric meeting than at a philosophical one.

It is perhaps unfortunate that, in these later papers, Lewis did not take on the word 'psychiatry'; and it is strange that in his earlier lecture on Johann Christian Reil,[2] he failed to stress that this great, but forgotten, German coined the term. Had he done so, Lewis would surely have indicated that, as Reil developed the concept of psychiatry between 1800 and 1810, he indicated clearly that psychiatry was a method of medical treatment in which the doctor used his psyche as the primary therapeutic agent. The 'psyche' of psychiatry is the doctor's psyche, not the psyche of the patient. Certainly, such a usage of 'psychiatry' would render the word 'psychotherapy' redundant. It would have other, further reaching consequences also. The fact is that many psychiatrists do not comprehend the meaning of psychiatry as it was originally conceived.

Reil's invocation of the psyche to the process of medical treatment was both consonant and dissonant with the spirit of his times. Chiarugi in Italy, Tuke in the United Kingdom, Pinel in France and (perhaps) Rush in the United States of America were energetically pursuing novel methods of approach in the treatment of the mentally ill. However, while Tuke was content with the notion of 'moral' treatment, Reil, through his contacts with anti-rational, romantic, transcendental philosophy (especially as represented by Schelling), invoked a Goddess—Psyche. And, as Esquirol built on the original work of Pinel, so Heinroth refined and expanded the concepts of Reil. By choosing to use the term 'psyche', Reil and Heinroth involved their discipline with mythological modes of thought. Many psychiatrists believe that to associate their profession with the concept of 'myth' is insulting and derogatory. In fact, to characterize psychiatric matters as myths is to hit on a fundamental truth about the nature of myth.

The myth of Psyche and Eros with its details of their clandestine sexual relationship was finally spelt out by Apuleius. More recently, Simon[3] has thrown light on the early history of the psyche. He provides quotations from Homer to show that the psyches live in a 'far away place' (not the underworld), they flit about like shadows, are 'unintelligent' and can speak only after drinking the blood of slain animals. Their substance is that of figures in dreams and they live near the 'village of dreams'.

In summary, Simon indicates psyche is not a faculty or agency of the self so much as a continuation of the whole person. Furthermore, as many writers have stated or suggested, the psyche carries the connotation of the 'double'. In this way, the mirror—as 'reflected' in the pool of Narcissus—assumes its profound psychic significance. Such

considerations might be seen as having clinical relevance in, say, marital conflict, one of the great mythological themes. Similarly, the clinical interview has a visual meaning only subliminally expressed in the English word 'interview'. It is the experience of the self as another which underpins empathy in mythological terms. In these ways, far from shunning the relationship of psychiatry to myths, psychiatrists should welcome the study of myths as useful to deeper understanding of their clinical work.

It is the genuinely held belief of many psychiatrists that psychiatry is in a rudimentary stage of development, comparable to many medical disciplines at the beginning of the nineteenth century. Such views imply the growth of a large, new specialty fuelled by the proper application of rigorous scientific procedures. What kind of research would be involved? At the present time, most prestigious psychiatrists favour research in neurochemistry, neuropharmacology and social medicine or epidemiology.

There is, however, a contrasting viewpoint. Psychiatry is the systematic application of the doctor's psyche to his patient's distress—the original meaning of the term. Psychiatry is viewed as an ancient discipline, resting largely on psychological understanding and previously manifest in varying forms in many religions and philosophical systems. More accurately, it was previously manifest in many educational methods which discussed religions and philosophical matters. Such a view draws heavily on cultural history, the study of words and the systematic study of lived experience—phenomenology. This view regards much contemporary research conducted by psychiatrists as inadequately psychiatric, having lost sight of the psyche. Clearly, the implications of this view for psychiatric research and education would be considerable.

Of course, both of these views of psychiatry may be mistaken; or some combination or development of the two may prevail. It may not be necessary to adopt an 'eclectic' approach after all. Which view prevails may, in the end, depend on factors quite other than those here mentioned, such as the views of powerful and important teachers of psychiatry—whoever they may be.

References

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Talking to the Police

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The police are now the only laymen in Britain who can pass judgement on a person's mental state and compulsorily admit them to places of safety.[1] Various papers have looked at how the police use this power, and one paper in particular[2] has shown that police are as efficient at recognizing persons in need of psychiatric care among those called to their attention as are medical practitioners who are not approved psychiatrists.

Police admissions on the whole are infrequent—probably around 0.5 per cent.[2] Sims and Symonds,[3] however, showed in their Birmingham study that police referrals were forming an increasing proportion of new referrals to the Mental Health Department. The number doubled in the years 1962–67. They felt that this was in part due to a greater willingness of the police to be involved in mental illness and to view some disturbances in the city as arising from mental illness. The distribution of these referrals was found to be markedly higher in the inner city and city centre zones (i.e. areas of multiple social disadvantage) and among people living on their own. The number of those of no fixed abode was also high. The commonest diagnosis was schizophrenia. Police referrals deal with the most difficult and disturbed psychiatric population,[2] i.e. those who have done physical violence to others and to property. Sims and Symonds[3] showed that 48 per cent of police referrals were 'markedly disturbed'. It is suggested[2] that it is the qualities of personality rather than their mental illness category which prevent these patients from entering psychiatric care through conventional routes, and that community services are at present failing to detect these cases or to maintain contact with them. These people are thus allowed to deteriorate until they become a nuisance to society. The increasing number of police referrals in inner cities may be seen as a symptom of urban disorganization.

While studies indicate the police are efficient at recognizing mental illness, researchers[4] in the USA have shown that an increase in psychiatric training for police results in an increased interest and sympathy for psychiatric problems and a minimization of bias against psychiatric patients. In a good community psychiatric service, good relations and communications between psychiatrists and the police are essential.

Liaison in the Fareham and Gosport Service

In October 1982 I was approached by the Inspector of the local police college with a request for a regular psychiatric contribution to their training course for police probationers. These probationers are trainee policemen who have already