PSYCHIATRY – ART, SCIENCE OR BUNCOMBE?

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THE greatest surgeon of the eighteenth century, John Hunter, made a statement with which I must record my profound sympathy when he said that "definitions are damnable".

The title of this paper makes use of four words calling for definition (and a fifth which is probably in need of correction), and research into literature has revealed none that are entirely satisfactory. We may, however, commence with psychiatry as a branch of medicine whose special province is the study and treatment of all types of mental ill-health, however produced, and we may say that mental ill-health is experienced *subjectively* as a substantial impairment of comfort and happiness, and is shown *objectively* as a substantial impairment of efficiency *or* of the capacity for satisfactory social relationships (Curan and Guttman). Such a definition may appear to cover more than has been accepted as the province of psychiatry in the past, and a very brief historical survey may be of interest.

In primaeval times all sickness was due to supernatural causes and treatment was in the hands of the magician-priest and it was only in the sixth century B.C. that a rational practice of medicine began to develop amongst schools of healing in ancient Greece. For the next thousand years this development proceeded and amongst the works preserved for us we find numerous references to psychiatric disorders, the most famous being that of Hippocrates regarding the "sacred disease", epilepsy, of which it is stated that it "appears to me to be nowise more divine nor more sacred than other diseases, but has a natural cause from which it originates like other affections. Men regard its nature and cause as divine from ignorance, and wonder because it is not like other diseases."

Associated with this development there was, however, a persistence of magical and religious practices associated with a deity, Aesculapius, whose temple worship was widespread. The belief in being possessed of evil spirits to be coaxed or driven

from the patient is apparent in New Testament writings, and rational medicine has at no time succeeded in overcoming the primitive fear and superstition in the minds of the bulk of the population of either ancient Greece or present day communities. The belief in tokens and amulets as a cure of disease still shows up in the pathetic out-patient requests for a bottle of medicine, and in recent Commonwealth legislation to supply it—the first and, it seems, the most important step, in the minds of our legislators, towards a national health service.

Magic and superstition, thanks to Hippocrates and his successors, have however been largely driven from intelligent minds when dealing with the ailments of the flesh, but not to the same extent when mental ill-health is considered, and many views of abnormal behaviour are still reminiscent of the primaeval forest.

Unfortunately for mankind the Middles Ages descended upon medicine and for some thirteen centuries (i.e. third to sixteenth A.D.) tradition, witchcraft, magic and superstition combined to prevent any further great development of medicine. Rather there was decadence and decay, though interest in anatomy and dissection revived early in the fourteenth century and the development of the mediaeval hospital system gave us some well known names, e.g. Bethlem, where six lunatics were cared for in 1403. However lunacy legislation appeared in England in 1320, when it was enacted that the property of lunatics should be vested in the Crown.

The treatment of the insane throughout the middle ages and beyond was dominated by the belief in possession, and treatment was directed to driving out the devil himself. Witches, who were also possessed, suffered severely unto death by burning, and throughout three centuries the belief in the Witches' Sabbath, with its sexual orgies and the stories of sexual torment suffered by the victims of witches, speak clearly of the ignorance and superstition as well as of the sexual phantasies of the huge majority of the population. King James I wrote a book on "Daemonologie" and it contains a warning against the increase of doubt in the reality of witchcraft, quoting the damnable opinions of an Englishman, Michael Scot, who had published a protest against the common beliefs. Scot insisted that witches needed "physic, food and necessaries rather than torture". This marked the beginning of the end of a period of three centuries during which a quarter of a million people are estimated to have been killed and tortured as witches. During this period there

had been critics such as Montaigne who saw that witches were in reality mentally deficient, insane or highly suggestible individuals, but such views were overwhelmed by the mass.

The return of the true Hippocratic practice of medicine in the seventeenth century is associated with the name of Sydenham, who prescribed bleeding, rest in bed and a cordial for a case of mania, but even in 1769 Professor Cullen, a leader of medical thought in Great Britain, felt it necessary to state that "the species (of demonomania) are melancholy or mania, feigned disease or diseases falsely lived by spectators."

At the time the care of the insane was a topic of great interest in England, owing to the recurrent mania of George the Third and the nature of the rather violent treatment prescribed, and the House of Lords appointed a committee to investigate the matter.

During the French Revolution, Phillipe Pinel, on being appointed superintendent of the asylum in Paris, made a dramatic gesture by striking off the anklets and chains from the chronic insane under his care; he forbade violence, brought humanity to the madhouse, and taught that an insane person was sick. His lead was followed by the Society of Friends, who in 1796 established the famous Retreat at York under Samuel Tuke, for the care of mental patients. He emphasized the value of "moral therapy, encouragement and judicious kindness", but it was not till the latter half of the nineteenth century that the barbarous methods of restraint were generally accepted as harmful.

The place of witchcraft in public imagination was filled by the discovery of electricity and magnetism, and the latter half of the eighteenth century saw the epidemics of belief in the personal magnetism of Mesmer and the Celestial Magnetico-Electrico Bed of Graham, which gave the reward of eternal vigour and fecundity to those sleeping in it, for fees as low as £100. .Elisha Perkins, with his metallic tractors that sold all over America and England, followed, with other spectacular cures, to the horror of the orthodox. Mesmer in particular created such a storm that the Academy of Science and the Faculty of Medicine in Paris, as well as the Royal Society of Medicine, investigated his cures, but found the practice dangerous to morality and its cures founded in imagination, and this of course had no place in science. The Academy had a further investigation in 1831 which resulted in a decision that the Academy should "encourage

researches into personal magnetism since it is an interesting branch of psychology and natural history."

In 1841 James Braid, a medical practitioner of Manchester, discovered that the mesmeric state of stupor could be induced without magnetism. He coined the word hypnotism, and used the methods still in vogue to cure a wide variety of complaints. His attempts to demonstrate his method before the B.M.A. were however, rebuffed, and in later years he himself was led astray by phrenology. Hypnotism, however, was saved to become almost dignified in the famous clinic of Charcot at the Saltpetriere, where the science of modern neurology may be said to have been born. Unfortunately he did not appreciate the significance of suggestion and concentrated on physical changes in his patients. His work with hypnotism has been discredited, though it gave an apparently scientific aura to the subject.

A more rational approach to hypnosis was that of Bernheim and for a while public enthusiasm was aroused and far-reaching curative claims were made in its name. Some distrust existed and the danger to morals was again stressed and publicized, following Du Maurier's "Trilby" with the sinister Svengali in control of the patient's mind. Hypnosis still persists as a legitimate method of treatment but with limitations due not to danger to morals but to the superficial nature of the changes induced.

The end of the nineteenth century saw the schools of hypnotism, suggestion and persuasion striving for supremacy, and each producing cures of those left over from those with more material interests, who could find no evidence of disease of isolated organs which could be dissected out or corrected by drugs. In the twenties of this century all were submerged by a flood of autosuggestion emanating from Coue, a humble apothecary of Nancy, and for a while everyone went to bed repeating "Day by day in every way I grow better and better."

While these mass movements and spectacular developments of treatment were developing, other physicians were at work and various beliefs were developing which are still widely held, e.g., the belief that all mental and nervous disorders, as well as criminality, are due to degeneracy of the stock, which could generally be traced to some moral obliquity in previous generations, or that sexual excesses or masturbation led directly to insanity. The discovery of spinal reflex activity led to treatment of this region with massage and manipulation, cauterization,

electric shocks and other pseudo-scientific procedures. Other specialists found the cause of nervous disorders in displacement of fallen viscera according to their special interests, and had ample scope for their efforts in the widespread hysteria of the well brought up ladies of the Victorian era. Rest cures and spa treatments were helpful to many, but there was no real appreciation of the fact that the neurasthenia and hysterics of these ladies were in any way akin to those alienated from reason and their fellow beings in an asylum.

Emphasis on neurological disease and in 1913 the discovery of the spirochaete in the brain of the general paretic did much to rouse scientific interest in the problems of insanity, while the psycho-analytical work of Freud threw a flood of light on the obscurities surrounding neurasthenia and hysteria.

Everyone here must have a smattering of psycho-analytical knowledge and terminology, and for a time dinner tables were desecrated by discussions on sex and complex, while orthodoxy in pulpit and press thundered, just as it had in defence of witchcraft and against the evils of mesmerism and hypnotism. The limitation of Freudian dogma is now being realized but the basic mechanisms are still very much in current use and it seems they will survive.

Early in this century the work of Adolph Meyer in Baltimore and his appeals for a commonsense investigation of the whole psycho-biological functions of the individual, in his relations to the environment, sounded the death knell of artificial demarcations between body and mind. At the same time William Healy in Chicago was showing that juvenile delinquency could be investigated and treated along psychiatric lines.

Such, gentlemen, is a very sketchy review of what to me is a very fascinating study in human progress, and we have now, I think, reached the stage with psychiatric wards and out-patient departments in all modern hospitals, with the co-operation of psychologists, psychiatric social workers and occupational therapists, and a reasonably enlightened public, where we can say that psychiatry is at least on the way to being respectable. In this public enlightenment the recent spate of psychiatric films is playing a part.

Let us now see something of the methods and material of psychiatry. The method of examination of a patient with a mental illness is very like that of one with a physical illness. Firstly there is the taking of a history from the patient and

relatives in an attempt to discover the complaints of the patient as seen by himself and those around him, i.e., what is felt to be wrong. The development of these complaints with the nature of onset and their duration is important, as well as the past history of the individual as regards any previous illnesses, and school and social adjustment. The family history as regards the same factors is also desirable so that we may have some idea of the social background from which he comes, with emphasis on constitutional factors and difficulties due to broken homes, poverty, crime and illness.

A physical examination is necessary and should be exhaustive, for many mental states are largely influenced by bodily disorders, such as arteriosclerosis, endocrine and metabolic disorders, to mention only the more obvious. During this time information is gained as to the mental state, for we can often observe signs of emotions such as anxiety, fear and suspicion, and obtain insight into many of the mental mechanisms at work. This general observation, e.g., of facial expressions, tensity of attitude, restlessness, mannerisms and speed of thought, is as important as the history we obtain, though evaluation may be difficult. The patient's conversation will be rambling and disordered in the confused patient, repetitive and garrulous in the demented, irrelevant and scattered with the schizophrenic, retarded in the melancholic and distractible in the maniac. The mental content may be found to contain the hallucinations and delusions beloved (though often mistakenly identified) by the barrister. Hallucinations may be defined as mental impressions of sensory vividness without objective stimulus: e.g., voices may be heard in schizophrenia and visions seen in deliria, but they may also occur in normal people and hysterics. Delusions are of many types and origins, but may be defined as false beliefs which cannot be corrected by an appeal to reason or logic and which are not in accord with the education and environment of the patient. They may suddenly arise in an emotional atmosphere of peculiar intensity, in schizophrenia, or may be secondary to hallucinations in toxic states, but they may also arise from real events by a process of emotionally biased reasoning. They may be of grandeur, of poverty, of persecution, of disease, or anything else, they may be systematized or unsystematized, and they may be temporary or permanent, but they are *never* partial. They are only to be found in a state of disorder of the whole mental life of an individual. The legal belief in partial delusions

(enshrined in the McNaughton ruling) could in fact be described as a mass delusion, if it were not for the peculiar background of legal education, but then it has been truly said that "No man is happy without a delusion of some kind—delusions are as necessary to happiness as realities."

There may be evidence of sudden impulsive actions resulting from delusions or hallucinations or long mental unrest of a psychotic or neurotic nature, e.g. obsessive rumination. Some impulses associated with a subjective feeling of compulsion to do them, either "with or without intention or desire", may be quite harmless or definitely anti-social and criminal. They are a very good example, probably the best, of unconscious motivation, but this is not, of course, to say that all impulsive acts are irresistible. In certain circumstances and disorders, many are wholly uncontrollable and are not preventable by punishment though possibly curable by treatment.

Impulsive acts due to lack of control of instinctive urges are often due to lack of cerebral development and associated defect of intelligence, but they may also be due to lack of satisfactory control in the home and faulty example, to active psychosis or to brain disease due to trauma, infection or old age, and it needs more than the wisdom of Solomon to say when these are controllable or irresistible. The whole setting of the act, as well as the previous history of the individual, is essential if we are to weigh its significance and determine a mode of management and treatment. Disorders and perversions of the sexual impulse may be revealed and these may lead to overt sexual activity, though this is often controlled, with perhaps odd manifestations in other spheres, e.g. thieving.

We may find in our examination evidence of undue suspicion and a paranoid tendency to seek for hidden meanings, or of undue elation and self-confidence which leads to grandiose schemes which may succeed, only perhaps to be followed by depression with suicidal attempts, or of an instability of mood and emotion which may be indicative of early senile decay or paralysis of the insane.

We may find evidence of mental deficiency or intellectual subnormality, which renders the task of social adjustment extremely difficult, or of complaints of loss of memory for recent events, significant of organic deterioration. We may also hear of "blackouts" associated with loss of memory for events that have occurred, and are faced with a diagnostic problem in deciding

whether this is just plain lying to evade responsibility, or a truly hysterical repression of events unbearable to the individual, or the result of an epileptic automatism or of a cerebral catastrophe or disorder. Once again it is necessary to review the whole background of the act and associated symptoms before deciding to which of these classes the impulse belongs. The statements of patients and relatives may at times be reasonably correct but care is required to make allowance for wilful distortions as well as for those due to wishful thinking and the well known errors that may occur in giving testimony regarding past events, in even the most neutral and intelligent observers. Completely fanciful statements may be encountered in the fabrications of a chronic alcoholic and the romances of an hysteric, as well as in the delusions of the insane.

Often we find no complaints of mental disorder or emotional unrest but a long history of rather ill-defined somatic disturbances, with innumerable pathological investigations with often quite irrelevant findings, and it is only on careful investigation that we find evidence of a deep-seated emotional conflict which has led to faulty function of viscera with accompanying symptoms, or to undue preoccupation and introspection leading to conscious appreciation of normally unconscious visceral behaviour.

Throughout the investigation of the mental content we must be aware of the common psychopathological mechanisms with which it is here impossible to deal in detail—the rationalizations, regressions, repressions and suppressions, projections and introjections, dissociations, displacements, substitutions and symbolisms—if we are to gain a true picture of the disorder.

Recently interest has arisen in the emotional causation of somatic disease, e.g. gastric ulcer, asthma and rheumatism, and as a result patients are referred at times for a psychiatric opinion, often to their surprise and dismay, associated with disclaimers as to insanity, nerves or guilty conflicts. Such an opinion may not be easy to obtain owing to the patient's lack of insight and inability to co-operate, but these of course may be significant in themselves. There seems little doubt that emotional factors are often of considerable importance in the causation of somatic disease, but caution is required in their evaluation.

Running through the picture we create of the environment and the past history, family history and present condition of the patient there are to be found modes of reaction to stress, and

tendencies to behave in a particular way when confronted with difficulties. The origin of these reaction types can often be traced back through the years to childhood, and sometimes to others in the family tree. Some of these reaction types have been clearly differentiated and may be found in pure culture but sometimes we find more than one associated in the present picture or one being supplanted by another. Various classifications exist but there is considerable uniformity in essentials, though they must still be regarded as provisional.

There are in the first place the organic reaction types due primarily to somatic damage which may be acute or chronic. The *acute* changes are shown mainly by disorders of consciousness ranging from a difficulty in concentration and ready fatigue to a state of delirium with visual hallucinations and disordered behaviour. They may result from infectious disease, metabolic disturbance or drugs such as alcohol. The *chronic* changes due to cerebral damage show mainly failure of memory, emotional instability and a deterioration of behaviour, and in this group we find general paresis, senile and pre-senile psychoses, as well as those due to changes in the blood vessels or to the effects of trauma and encephalitis, as well as epilepsy. These organic disorders present a definite type but variations in the clinical picture due to the previous personality are always present.

The so-called functional or biogenic psychoses are those reaction types in which no consistent pathology has yet been found, and in these the constitutional and environmental factors are of considerable importance. Such are the manias and melancholias with the marked swing of mood that gives the name affective reaction types. Here also we find the schizophrenics who form the most common type of severe breakdown with the "split personality" which has become such a feature of the cinema and legal arguments, though generally applied falsely to other conditions. Here also we find the paranoid states with their relatively fixed delusions, and personalities which superficially seem intact, the subjects of the "partial delusions" already mentioned.

Some place anxiety states also in this group though more often they are classed among the neurotics with hysteria and the obsessive compulsive neuroses. Here we have the big bulk of the chronic sick with their somatic complaints due to anxiety and fear, the material dear to the psycho-somaticist.

The tyranny of the hysteric who finds through the signs and symptoms of ill-health the mastery of current difficulties as well as of emotional conflicts is not so common as in former years but it is still a very real problem in many a home.

The obsessive disorder with its feeling of subjective compulsion is not very common in its fully developed state, but minor degrees are widespread among the over-scrupulous and house-proud and may cause great distress.

The realization that the origin of these reaction types was often to be found in childhood has led to a widespread interest in the development of behaviour in childhood, with the growth of child guidance clinics as a valuable method of investigation and treatment. Such problems as feeding difficulties, bed wetting, over-aggressive or passive behaviour, lying and stealing, truancy and educational retardation are all of interest to the psychiatrist and often of considerable importance for the future development of the child.

Some patients show types of behaviour characteristic of constitutional defect, e.g. the mental defective with his lack of foresight and inability to manage his affairs without supervision and control, and the psychopathic individual with his instability of purpose and tendency to drift into vagrancy, delinquency and crime, while others with no apparent inherent defect of intellect or emotional control may, owing to faulty home conditions and unwise parental management, show disorders of character and conduct which are a source of trouble to their fellows and lead to offences against the law. Such cannot always be regarded as suffering from one of the above groups but their anti-social behaviour appears to be just as much in need of investigation and treatment as the anti-social behaviour of the defective or psychotic.

The methods of treatment in psychiatry range from environmental adjustment and medication through occupational therapy and emotional ventilation and readjustment, to the use of therapeutic convulsions, insulin coma and prefrontal leucotomy.

The results of treatment naturally vary, but although few would claim with Dr. Willis, Crown Physician to George the Third, that he could cure nine out of ten madmen, figures approaching this have been claimed with some justification for for the early treatment of schizophrenia and of involutional melancholia, and the general attitude nowadays is reasonably optimistic for at least the amelioration of the unhappy lot of

the neurotic, provided that constitutional and environmental factors are not too heavily loaded in the scale against recovery and that time for treatment can be obtained.

Psychoanalysis in the orthodox sense is restricted to a very select group of patients and practitioners but some exploration of the forgotten or overlooked past of the patient is often essential.

Such, gentlemen, is psychiatry. How far should it be considered a science? We may perhaps define a science as a body of knowledge which is arranged, classified and orderly, for which formulae can be found and communicated to others. In the growth of any science there are three stages—the collection of facts, the classification of facts and the formulation of laws with suitable concepts to predict and control similar facts.

In the year 1600 Giordano Bruno was burned at the stake and he has been acclaimed as the martyr of science. He had offended orthodoxy by removing the boundaries of the Universe to an infinite distance and his death ushered in an era of physical experiment. In that year Gilbert published his work "On the Magnet", in which he shows the properties of magnets and that the earth itself is a magnet. Some of the false theories resulting from this have already been glimpsed in our sketch of history. Gallileo was at that time also engaged in questioning accepted theories of the Universe and in laying the foundation of the science of Mechanics. It is to him that we owe the conception of primary qualities of things which can be measured, i.e., size, shape, quantity and motion, as opposed to the secondary qualities, e.g., colours, smells, tastes and sounds, which were to him mere words, and it is to this that we owe the concept of science as being an exact process. "Science is measurement." The seventeenth century that followed was a time of great scientific discovery in medicine and from that time on till our own day we find an emphasis on the physical attributes which can be measured and made to fit into a scheme of science and a neglect of the mental attributes which cannot.

Only in very recent times has there been widespread criticism of such a science as the sole course of knowledge with an emphasis on the falsity of the underlying philosophy as applied to the problems of biology and psychology. This criticism does not decry the advances that have followed measurement and experiment in these studies but has expressed a conviction that the arbitrary selection of certain facts which can be measured

has led to the neglect of other facts characteristic of the individual as a whole and just as important.

John Hunter may again be quoted as having said in favour of experiment, "Do not think – try", and it has been said that the medical profession for well over a hundred years has been trying not to think! This may be slightly unjust but it does appear that we have been trying to avoid thinking of some of the inconsistencies forced upon us by our materialistic education, with its neglect of any interest in those diseases which could not be seen on a plate and measured – which were functional or imaginary or mental.

Psychiatry has a very real interest in facts which can be collected, classified and arranged and a keen desire to find laws or formulae which will enable the prediction and control of similar facts. These facts are not solely the facts of physical science but neither, it seems, are the facts of any biological science, though by the creation of an experimental situation these facts may seem to give a satisfactory explanation of the behaviour of isolated organs or even of an individual divorced from his normal environment.

Some facts of psychiatric interest are those of general medicine–disordered function and structure of organs and metabolic activities–but it is to the credit of psychiatry that general medicine is coming to the view that other facts, those of higher level integration, our mental life, are also of interest and must be taken into consideration if we are to have a true science of medicine.

Moreover, the stress that psychiatry has laid on the need to consider the constant interaction between the total environment and the whole individual is now regarded as essential for an understanding of many problems of aetiology, diagnosis and treatment. If we are to regard psychiatry as a science some of the facts will not be those of physical science, but neither are all those of general medicine or indeed of any biological study.

There are, however, quite a few orderly classified facts and formulae, though these cannot be regarded as being as exact as Newton's laws of motion–and even these we are now given to believe are false. Some of our formulae rely on the concept of an unconscious part of our mind wherein many conflicts take place, and though this may appear fantastic, it is no more so than the weightless and frictionless ether on which we placed our faith in Natural Philosophy. It has however been truly

said that underlying the whole concept of science there is an act of faith: namely, that there is an "Order of Nature".

Some of the facts with which we deal have already been enumerated; they are the symptoms and signs of disordered behaviour. Some of these, such as physique and posture, speech and writing, may be measured and so may some of the intellectual processes, such as speed of thought, attention span and accuracy. Other facts deal with some aspects of inheritance and disorders of metabolism and the tendencies inherent in reaction types: e.g. that some tend to an intermittent course, others are self-limited and others again tend to dementia and chronicity. We know that intelligence appears to depend on the complexity and organization of the cortical brain cells and that the brains of most mental defectives show macroscopic and microscopic variations from normal. We also know that diffuse changes in the brain lead to dementia with certain basic characteristics and have recently learned that severing most of the frontal lobes from the rest of the brain has surprisingly little effect on intelligence as measured by formal tests, or on memory for past events, but that a freedom from anxiety and tension generally results. With the electro-encephalogram, changes from normal are to be found in many with psychopathic tendencies, and in infections or other damage to the basal ganglia emotional changes occur.

The findings of psychoanalysis are far removed from those of physical science as they consist of the memories revived from the forgotten or repressed substratum of our minds. Their revival may have occurred through free association, hypnosis or narcosis, or under the persuasive effect of a skilled and sympathetic investigation. Dreams are a common source of these associations. The veracity of the memories may be in doubt but they are nevertheless thought to be of value as showing aspects of the phantasy life. On these have been erected theoretical structures of considerable complexity but how far they are to be regarded as facts may be doubted. Much criticism arises from the differing results of analyses by different authorities in similar clinical material, e.g. a dream, and it has been strongly urged that the analyst finds what he seeks from a wealth of suggested phantasy to support the preconceptions arising from his own analysis. A place in the apostolic succession dating from Freud, i.e. those analysed by the master himself or by someone analysed by him and so on, is not necessarily a guarantee of scientific detachment. But this may be regarded as the comment of a jaundiced

outsider who is not in the succession. The therapeutic results of a lengthy analysis may be satisfactory but the effects are not necessarily the result of the search for "hidden treasure" and its reintroduction into current thought. They may also be the result of unconscious suggestion and environmental change due to expenditure of time and money and association with the psychiatrist.

In spite of these grounds for criticism there seems little doubt that facts of value have emerged, e.g. the reality of repression and of mental conflicts, of suggestion, dissociation, rationalization, etc., and the far-reaching effects of psychic trauma in childhood.

Some support should be obtainable from the study of children but much of the research is hampered by the preconceptions of child analysts with the forced symbolic interpretation of play and behaviour, and much further investigation is required.

Current environmental stress, e.g. bereavements and domestic difficulties, seldom produce a sufficient degree of prolonged incapacity to cause invalidity or anti-social behaviour, unless the soil has been prepared by constitutional weakness and/or faulty reaction patterns in the past and to ascribe bodily disorders, e.g. ulceration, asthma, etc., to present difficulties alone is not scientific though correction of present difficulties may be very desirable for therapy.

A cross section of the present situation confronting the individual is important, e.g. his domestic situation, vocational adjustment, recreational outlets, as well as the frustrations and boredoms to which he is subjected, but a longitudinal section through his family tree as well as his own history is essential for a truly scientific evaluation of the present. The emphasis on the past with its causative factors and its results in the present is in accord with the determinism that is often regarded as an essential of science, but the influence of purposive drives in the determination of behaviour appears definite, and a science which reduces behaviour to a blind automatism may not be a final solution.

It seems desirable at this stage to stress the fact that in the modification of abnormal behaviour the scientific approach may well take account of the possibility that an aim towards future health and happiness is often as important as a fixation on the past.

War psychiatry showed very clearly that whatever the backgrounds of the combatants might be, the influence of the morale

of the units in which they were placed played a very important role in the development of neurosis. Some units just did not develop neuroses if they were in good fettle with an optimistic outlook, while in retreat with pessimism rampant and poor leadership, with lack of inspiration, neuroses were numerous. It seems difficult to fit these facts, as well as many others, into a deterministic scheme.

May we say at this stage that psychiatry has some claim to possess knowledge of the determination of behaviour which may be called scientific and that its claims in this regard are as strong or as weak as those of the other biological sciences. Many gaps exist and statistical proof and experiment may be lacking, but there is at least to its credit that it does deal with the whole individual and not with an artefact. Moreover, the real advance of medical science can only be along the lines followed by psychiatry with a true appreciation of the importance of the emotional background and the social life of the organism in the past and present.

In any scientific experiment there must be selection of facts to be tested, and an analysis of the situation is required. If the experiment is successful a definite chain of events is uncovered which can be repeated and communicated to others. From this may come the synthesis of a formula to cover other related facts and a further advance in knowledge. The analysis of the situation, the selection of facts to be tested and the synthesis of a formula are all personal matters, and although the true scientist is content to have discovered a part of the order of nature, this discovery is a personal triumph and gives great satisfaction.

How are we to define an art? One definition is that "art is the concomitant of an impulse to express one's personality in a form of activity" and "when anything is done in a way which excites a certain kind of pleasure called aesthetic enjoyment, art is present." In this pleasure comprehension is the most important element. The term "art" is generally restricted so as to involve only two senses, sight and hearing, but it may arise from any kind of activity, e.g. the art of cooking or even the art of war. Art is personal and a capacity for art is not possessed by everyone: the talent must be there and it must be trained. In the creation of a work of art there is selection of a subject, analysis of this and a synthesis, the same process as underlies the formation of a scientific formula. In this light a scientific formula may be a work of art which gives a pleasure very similar

to, if not identical with, aesthetic enjoyment, and to thousands who have been trained to comprehend its simplicity and truth, "Science is the noblest of arts." Moreover, in artistic work scientific knowledge is often required, e.g. the creation of an architect.

How far can psychiatry be called an art? Diagnosis is a work of art, though scientific knowledge is necessary.

Understanding of an individual is a very personal matter, requiring some talent and intuition, which must be trained, and often a lengthy process of analysis and investigation of a total situation involving past and present conditions, physical and psychological characteristics. This is followed by a synthesis of selected facts, giving them due weight, which we will describe as a *diagnosis*. Only with this diagnosis in our minds can we feel able to prescribe satisfactory treatment with suitable physical and psychological measures. Control of environment, drugs, shock therapy, as well as readjustments of instinctive drives and elucidation of conflicts, may be necessary to a better synthesis of the individual. Occasionally we may regard the resulting individual as a work of art as well as a scientific triumph.

Nowhere in medicine or surgery does the above process apply more than in psychiatry. Here the personality of the doctor and the training he receives are very important. Perhaps it is unfair to say that in no branch of medicine is his training more neglected, but there is no doubt that there is a marked lack of suitable training to create the interest in psychiatric problems which is important for either the scientific or artistic psychiatrist or physician.

And so we come to buncombe, the origin of which takes us back to 1850 when Felix Walker, the representative in the legislature of the United States of the country of Buncombe in the state of North Carolina, insisted in speaking at length on the Missouri question. It may be presumed that this was not very informative or entertaining as he had to resist many attempts to stop his speech, stating that he was bound to make a speech for Buncombe.

From this various usages have arisen but the most apt for this discussion will be "speaking or acting not from conviction".

It must be confessed that in this sense all medical practice does at times degenerate into buncombe. Perhaps we think that the practice of others does so more often than our own, but we must all admit to the fact that our own ignorance of causation and treatment, as well as pressure of time and other interests,

and the hopelessness of therapy in some conditions, does sometimes lead to action without very much conviction. The bottle of medicine or box of pills is often the refuge of the destitute, though we describe it as a placebo, and some of the treatments prescribed on the basis of the information contained on a piece of blotting paper or circular or the latest article have about as much scientific or artistic value as Perkins tractors or the magnetico-electrico bed. Faith still cures as in the days of Hippocrates, though it is no longer dispensed by the touch of kings as it was in England from the time of Edward the Confessor till the removal of the Stuarts from the throne. Attempts to give faith and healing power to a bottle of medicine may be done without conviction as buncombe and fail, but it is possible at times to convince ourselves that the bottle will help and this conviction may be communicated to the patient with resulting benefit.

Psychiatrists do at times commit buncombe in treatment but their realization of the power of suggestion probably makes them less liable than other practitioners.

There is, however, a widespread belief that psychiatry and buncombe are synonymous, too widespread indeed to be readily dismissed as a delusion. This belief probably was—but is, I hope, no longer—fixed in the minds of the legal as well as the medical members of this audience.

The reasons for this belief are many. Ignorance, of course, is largely responsible, and so is the poor presentation of our case in literature and the films, but it is regrettable that another reason is that psychiatrists and their legal friends so often meet only under conditions where scientific or artistic psychiatry can penetrate very rarely, if at all, but where buncombe rules supreme. I refer, gentlement, to the courts where justice is dispensed to criminals. Fortunately for my own peace of mind my work as an expert witness is scanty and it may be that an onlooker obtains a distorted picture. If so, there is little doubt that attempts will be made to correct this outlook to-night.

The function of the criminal courts is to act for the community in seeing that justice is done and that the guilty are punished. The conception of justice is of some interest to the psychiatric as well as to the legal mind, as it seems to be a relic of tribal vengeance. So much abnormal behaviour is due to causes in the past that even if we do not adopt a strictly deterministic attitude and allow for some guilty intent due to current

events or to hopes for future gain, it seems that this still needs treatment, not the vengeance of the tribe.

If we decide that a term of imprisonment is not really punishment but treatment, it seems that it is not very good treatment, as at present prescribed. The objects of punishment are threefold, being directed to reform the criminal, protect society and deter others, and it seems to fail in all three, though some may doubt this.

The reformation of the criminal has been claimed to have been accomplished in many cases, e.g. 80 per cent of those imprisoned once and received into prisons of Great Britain in the years 1930-34 had not yet returned to prison up to the end of 1936. If we felt that these had reformed we would say that it was fairly satisfactory treatment, but there are some doubts as to whether it is not a case of once caught twice shy, and a feeling of conviction that treatment of the individual along such unscientific lines had been successful would be welcome but is at present lacking. Only 60 per cent of cures due to Borstal treatment or detention in our own reformatories is claimed.

The protection of society undoubtedly fails in many cases. The sexual offender almost invariably returns to his offence on his discharge and the penalties enacted are out of all proportion to the harm he can do the population. The abnormality of the offender is generally realized and medical evidence to this effect may lead to the offender being released for treatment. Such treatment often means perfunctory attendance at a crowded out-patient department (sometimes without the consent of the psychiatrist) at lengthy intervals. Some attempt is made to keep a check on his behaviour and to provide other outlets and sublimation, but again conviction that this treatment is likely to protect the community and to correct the perversion is lacking.

Only too often the material is all wrong and the offender is a mental defective needing detention or close supervision for life, and to think that the situation is often met by the above measures is buncombe.

The object of deterrence of others is even less likely to be satisfied, though statistical proof of this cannot be given. It may be that there would be a storm of outrages, violence and theft if punishment ceased entirely, but it seems that the only people who have been deterred so far did not need deterrence.

The aim of the law "to make the punishment fit the crime" is surely in need of replacement by investigation and treatment of the criminals.

We all know, of course, that not everyone who commits a criminal act is considered guilty, for some are not legally responsible. Some, in fact, are mentally abnormal and even insane and therefore have no criminal intent, and know not right from wrong.

Figures vary as to the percentage of abnormality amongst criminals. In 1916 over 50 per cent of the inmates of Sing Sing were regarded as suffering from definite mental disease or deficiency, but the standard of mental deficiency was rather high and more conservative English figures say that 80 per cent of prisoners show general behaviour corresponding to that of the average man. The 20 per cent of definitely abnormal prisoners includes a wide variety of conditions, a few of whom were regarded as suitable for psychotherapy, as indeed were some of the apparently normal, but it is rather fantastic to think that psychiatric treatment of any value is given to many offenders in prison, and only very abnormal cases are referred elsewhere.

Criminal responsibility has been discussed before this Society previously and it should suffice to say that whether a criminal is responsible for his acts or not requires a knowledge of human behaviour that psychiatry does not possess, and that psychiatric efforts to support an outworn creed of justice must result in buncombe.

In the causation of any behaviour there are environmental and personal factors conscious and unconscious, operative in the past and present. Some free will may or may not exist, the decision depending on personal prejudice and not on scientific proof, Few, if any, psychiatrists however will be found to subscribe to a view of unlimited freedom of choice of action, and yet it seems that unless a criminal is so grossly defective or insane as to render his punishment obviously offensive to humanity he is regarded as wholly responsible. From him therefore the law demands retribution and for him dispenses punishment according to his crime, with no thought of the responsibility of the community for his past, present or future development.

It may be remembered that in years gone by mental illness was regarded as due to possession by the devil and that treatment was directed to expelling him by confinement and punishment. An attempt has been made to show the development of a more humane and successful treatment of mental illness and of a rational understanding of abnormal behaviour. Surely it is time to cease similar attempts to drive the devil from possession of the criminal and delinquent, and to attempt a scientific

understanding of the treatment required, without concern for criminal responsibility, or justice, or insanity, or any other delusional system.

The recent decision of the Court of Criminal Appeal, with its emphasis on the need for prolonged detention to protect the community and of the need for a psychiatric clinic which would give reports and recommendations for guidance of the trial judge, appear to be wholly justified. Once again, however, we find the old difficulty presenting itself, in that the court felt it could not declare the convicted man not responsible for his acts. This in spite of a long list of twenty convictions, two being for sex offences, and the fact that he was not "mentally bright".

Ten years ago this Society was congratulating itself upon the fact that the Government had at last decided to do something towards the treatment of sexual offenders, but such anticipations were decidedly premature.

Progress has been made in other countries with measures such as the twenty-five years old Brigg's Law of Massachusetts, under which any person indicted for a capital offence or bound over for trial in the superior court, who has been previously convicted of a felony, or indicted more than once for any offence, shall be reported to the State Department of Mental Diseases for examination by two psychiatrists "to determine his mental condition and the existence of any mental disease or defect which would affect his criminal responsibility". Their report is accessible to the court, the probation officer, the district attorney and the attorney for the accused.

Surely some such measure could be adopted here to avoid the "battles of expert witnesses" which are so unpleasant, and to ensure protection for the community and the individual.

Much of what I have said will no doubt appear quite foolish to both legal and medical colleagues but my plea for mercy is that though there may have been deliberate provocation and guilty intent, buncombe has, I hope, been absent.

Psychiatry, gentlemen, is a fascinating study and I trust that these remarks will be acceptable as a tribute to the scientific and artistic workers in this field of knowledge, as well as being an appeal for further developments in the education of medical practitioners in psychiatric principles, and in the better care of the mentally abnormal, whether these be in the dock or in prison, in consulting room or in mental hospitals.