Henry Miller

The Abuse of Psychiatry

I MUST BEGIN with a qualification introduced by any writer about to discuss a persecuted minority. Many of my best friends are psychiatrists. This statement is more than a formality in the present context, because as a clinical neurologist I have had the good fortune over the years to work with and learn from a team of eclectic psychiatrists of outstanding calibre. They are the sort of hard-headed psychiatrists who would send the patient back to me with the polite suggestion that I have another look for the cerebral tumour—and they had an infuriating habit of being right. This is certainly one of his important functions, and the psychiatrist whose knowledge and experience of the many disguises of serious organic disease are too insecurely based for its exercise is a danger to his patient.

A few years ago a senior psychiatric colleague and I founded the "Society for the Abolition of Psychiatrists." Before I am overwhelmed with applications to join—and they have already come from some of Britain's most eminent psychiatrists—as well as, predictably, from a number of patients—I must point out that the society has not yet received its charter, and does no more than epitomise our conviction that the psychiatrist must be first and foremost and all the time a physician, expert certainly in unravelling the complexities of mental symptomatology, but also at least as adept in general medicine as his cardiological or neurological colleagues. In fact psychiatry is neurology without physical signs, a difficult branch of medicine that calls for diagnostic virtuosity of the highest order. Indeed, since the psychiatrist is concerned with disorders that carry a considerable mortality and a serious morbidity it is truly alarming that his is the only one of its branches that can be practised at a responsible level without a thorough training in internal medicine—without such a background of general clinical experience as is demanded, for example, of the skin specialist.

THE PATTERN OF BRITISH PSYCHIATRY has its roots in history, and especially in the traditional isolation of psychiatrists in mental asylums, physically removed from the stimulating environment of the great general hospitals where the most advanced clinical medicine was developed and practised. On the continent of Europe this situation was tempered by the close association between psychiatry and neurology. Most universities had combined departments, and indeed many of the great figures of the nineteenth and early twentieth centuries were equally expert in both disciplines. The same applied initially in the United States, and the separation of the two disciplines is fairly recent. The association with neurology gave psychiatry an academic foothold, and ensured that the best of continental and American psychiatry retained a firm basis in medicine and neurology. The isolation of the British psychiatrist was partly due to the historical accident that clinical neurology developed in Britain as a branch of internal medicine rather than as a close associate of psychiatry.

In 1939 Britain could boast no more than a handful of physicians fully trained in psychiatry as well as in medicine, and they were mostly either in London or in Scotland. The war-time realisation of the magnitude of psychiatric illness and disability, and the coincidental therapeutic revolution in psychiatry, effected a radical change in this situation. The mental hospital psychiatrist was translated to wider

fields of activity especially in the Armed Forces, improving his old skills and developing new ones, while the years immediately following the War saw the invasion of psychiatry by a regiment of well-trained young men. But the supply of high-grade recruits to the subject remained far short of meeting requirements, and the need to employ a large body of mental hospital medical officers for routine clinical duties has sustained a double standard of psychiatric practice. At one end of the scale is the consultant who has had a basic training in scientific medicine and probably several years of work in a general medical clinic before taking up psychiatry, already a Member of the Royal College of Physicians. At the other end is the mental hospital psychiatrist who has acquired a specialist diploma in psychiatry, but who has often had little training or practical experience in internal medicine, and whose professional life has been spent almost entirely in mental hospital practice. Doctors of the latter group are often highly skilled in the institutional management of severe mental illness; but they are less equipped for the extra-mural functions of the psychiatrist, whose consultative and outpatient practice comprises an enormous range of clinical problems, poses extremely difficult diagnostic issues, and demands immediate clinical decisions of great urgency and importance.

THE PROBLEMS RAISED by this double standard are very much in the minds of all psychiatrists. The higher examinations in internal medicine are searching. They require considerable and extended practical experience of clinical work in a variety of fields, as well as a grasp of basic medical science and fairly high intellectual capacity. They are often beyond the reach of the less outstanding recruits to psychiatry, and the Royal Colleges have been reluctant to make the minor concessions in the examination for psychiatrists that could have ensured at least a general improvement in the specialty's standards. The characteristic inertia of the established bodies has led to the impending establishment of a separate college. Although this has been delayed by internecine strife, it now seems virtually certain. Such a development will consolidate and perpetuate the double standard. The best psychiatrists will continue to seek the status of physicians, and will undertake the arduous clinical apprenticeship that leads first to a higher qualification in medicine. The remainder will acquire a qualification orientated towards psychiatry as an autonomous discipline, superior certainly to the present Diploma in Psychological Medicine, but short of furnishing any kind of guarantee that the psychiatrist will also really be a physician. It is hard today to evoke great enthusiasm for either Royal Colleges or examinations, but when one considers the psychiatric disguises in which liver failure, brain tumour or inflammation, and lung cancer may present themselves to the psychiatrist, he is perhaps the best of all possible excuses for the continued existence of the searching higher examination in internal medicine.

I HOPE I HAVE already made it clear that I have a high respect for psychiatry and that I regard it beyond doubt as the most important as well as the most fascinating branch of medicine. Unfortunately it is also the most abused, and there is little consolation in the reflection that much of the abuse of psychiatry is self-abuse: many psychiatrists lend it their wholehearted collaboration.

In a nutshell, most of the abuses of the psychiatrist arise from his reluctance to restrict his activities to the field in which he is genuinely qualified to operate. The Oxford Dictionary definition of a psychiatrist is "one who treats mental disease." Not, you will observe, one who prevents wars, cures anti-Semitism, offers to transform the normally abrasive relations between men into a tedium of stultifying harmony, is the ultimate authority on bringing up children or selecting managing directors—or misuses his jargon to pronounce on every issue of the day in an incessant series of television appearances.

If we look again at the dictionary definition we must consider the term "mental disease." What does it mean? It means *disease with mental symptoms*. Mental disease is no more exclusively a disease of the mind than rheumatoid disease is exclusively a disease of the joints. In both there may be widespread disturbances of other body systems—and both are conveniently categorised on the basis of their most conspicuous symptoms. To the lay public, mental illness used to mean (and perhaps to some extent still means) *insanity*, a social rather than a medical term, suspect because of its spurious definitiveness, but on reflection perhaps still better defined than its successor "mental illness"—which is used to cover everything from

shop-lifting to the psychological signs of a brain tumour. What mental illness means to the physician, of course, is illness with mental symptoms, illness that presents as a psychological disturbance. To practically all novelists and playwrights, to many laymen, and to a mercifully shrinking band of metaphysical psychiatrists, this means illness due to "emotional causes." But the experienced physician knows that illness with mental symptoms often results from physical causes, and indeed that nearly everything we know *with certainty* about the causes of mental disease has been gleaned from information at this level.

1. WHEN, FOR EXAMPLE, the spirochaete of syphilis invades the brain tissues it evokes an indolent inflammatory and degenerative response, with gradual loss of function and ultimate disappearance of thousands of brain cells. The clinical picture is fairly characteristic, though it begins mildly and innocently enough and more often than not is at first misinterpreted and treated as "neurotic." In the fully developed case this progresses through insidious decline in intellect and behaviour to a deteriorated, often expansive and over-cheerful mental state in which the patient endows himself with the physical prowess of Cassius Clay, the intellect of Einstein, and the amorous virtuosity of Casanova.

FOLLOWING a minor surgical operation in hospital a middle-aged commercial traveller became wildly confused and held prolonged conversations with non-existent visitors. Enquiry revealed a history of personality change and a deterioration in occupational efficiency during the preceding six months.

Before this time he had been highly successful in his business activities and he had in fact won several annual national awards in his line of business. About nine months before this unimportant operation he began to complain of easy fatigue and three months later consulted his doctor with a vaguely neurasthenic syndrome. He was given simple medical treatment and some psychotherapy by his practitioner, without improvement. Neither the patient's family nor his medical practitioner appreciated the serious significance of an insidious decline in his personality and habits. Previously a highly respected figure, grave and dignified, he outraged his wife and neighbours by telling dubious stories in mixed company. He appeared late for work, and on more than one occasion exploited his complaint of fatigue to spend the day in bed. His business efficiency had declined so seriously that his employers were considering his dismissal.

All this was attributed to psychological causes, but routine tests in hospital confirmed the presence of active cerebral syphilis. He showed a rapid response to penicillin and made an excellent recovery. Had the correct diagnosis not been reached accidentally because of his hospital admission in another connection, his mental deterioration would soon have become irreversible.

2. PORPHYRIA, on the other hand, is an inborn error of metabolism in which the periodic overproduction of a pigment in the blood-stream causes acute episodic mental illness of alarming degree, possibly by provoking intermittent spasm of blood vessels in various parts of the nervous system, and often in association with very severe abdominal pain. This was almost certainly the disease that caused George III's intermittent madness. At that time the condition was unrecognised, and the sometimes brutal mismanagement of the royal illness makes gloomy and pathetic reading.

AN INTELLIGENT YOUNG professional woman went on a summer cruise. She had a rough crossing and was given some tablets by a fellow passenger to settle her vomiting and dizziness. The next morning she suffered severe abdominal pain and became very emotional and mentally confused. The ship's doctor gave her further sedatives which made matters worse rather than better. She saw a doctor at each of several ports of call. Each administered a sedative, and after each such treatment her condition became worse again.

Arriving back in England the history was repeated. Intermittent abdominal pain continued, while she was still very agitated and occasionally seemed to be hearing voices. She was intermittently and violently emotional, which was quite out of keeping with her normal personality. This was the story, and apart from her abnormal emotional condition there was nothing to find on examination. Like most of those who had previously seen her, her own doctor considered the whole situation "hysterical." This diagnosis seemed quite incompatible with her previously resilient and effective personality, but I could think of no convincing alternative.

Halfway home the penny dropped: I turned my car round and returned to the house, where examination of her urine clinched the presence of porphyria. She was a mild case, though careful enquiry disclosed previous episodes of pain and mental disorder, sometimes one and sometimes the other predominating. As in many such cases her condition was activated by a number of

drugs, amongst which barbiturates are conspicuous. The amytal and phenobarbitone administered for sedation during her sea trip intensified the biochemical abnormality and provoked symptoms of the latent disorder.

The diagnosis of an inborn anomaly was clinched when examination revealed a similar condition in her mother, who had several times been briefly admitted to a mental hospital. With careful avoidance of drugs known to exacerbate the biochemical fault the patient has subsequently avoided serious trouble.

3. The presence of a tumour in the pancreas intermittently secreting large amounts of insulin not only causes occasional fits quite indistinguishable from those due to epilepsy, but also leads to bizarre psychiatric illness, initially intermittent but ultimately persistent and irreversible. Confusion and excitement often alternate with periods of stupor or coma, and this is ultimately followed by intellectual deterioration of severe degree in untreated cases.

A MIDDLE-AGED WORKMAN watched a popular medical television programme based on the history of a case of this kind. His wife had been in a neighbouring mental hospital for nearly a year. As the programme unfolded he was dumbfounded by the similarity of the television dramatisation to the course of his wife's illness.

The next morning he presented himself at the gates of the mental hospital, asked to see the medical superintendent, and told him the story. The superintendent was a shrewd and percipient man. Within a week the husband's diagnosis was confirmed, the pancreatic tumour was successfully removed at operation, and the woman made a perfect recovery.

To quote such cases is not to maintain the untenable claim that gross structural disease will be found in *every* patient with serious mental illness, though a scrupulous search will reveal significant physical abnormalities much more often than might be suspected. What these cases demonstrate is the order of the main causal factor in these psychoses, which are clearly accessible to physical rather than to psychological investigation and manipulation.

EVERYTHING WE HAVE LEARNED from the last three decades of rigorous psychiatric research favours the view that the important mental illnesses—*e.g.*, depression and schizophrenia—originate in disturbances of biochemistry and metabolism. The illness is coloured and its symptomatology to some extent determined by the patient's personality and previous experiences, but the patient has become ill for physical reasons and his symptoms can be controlled only by manipulation of the physical component of his illness. The layman often objects that to treat the psychiatric patient with drugs is merely to treat symptoms and not to deal with "the root cause" of the illness. Such fundamentalism is foreign to medicine. It is the symptoms that are troubling the patient, not the latent vulnerability—which he bore with cheerful insouciance until it impinged on his consciousness—and, in any case, treatment in *every* field of medicine is more often directed to relief of symptoms than to the unrealistic aim of rebuilding the organism.

Even our prevailing mood depends on the level of certain identifiable chemical substances deep in the brain. A drug such as amphetamine (Benzedrine), which increases the concentration of cerebral catecholamines, excites an all-too-transient elation; one that destroys or blocks these chemical compounds may evoke gloom to the point of suicidal rumination. Indeed, models of some types of mental disease can be induced with reasonable predictability by the use of certain drugs. Especially in patients with a strong family history of depression, the drug reserpine, occasionally used for the control of high blood pressure, quite often produces a classical depressive illness. Prolonged and excessive dosage with amphetamine on the other hand evokes an illness that approximates to an experimental and reversible schizophrenia. The patient may well believe himself "spied on" and "persecuted." Although clearly conscious he may suffer fluctuating and variable delusions and be tortured by auditory hallucinations which terrify or threaten him. Furthermore, although the amphetamine addicts susceptible to such illnesses are often emotionally unstable, there is no evidence that this rapidly reversible schizophrenic-type illness itself has any constitutional component. It appears to be entirely due to the drug, and fades when it is withdrawn.

We know that both general diseases (such as lung cancer) and neurological illnesses (such as multiple sclerosis) may evoke serious psychiatric disturbances even before they have become evident in physical disability.

We know that certain drugs like sodium amytal, Librium, and Tofranil have specific and predictable effects on certain psychiatric symptoms such as insomnia, tension, and depression, respectively.

As a matter of fact this is really about all we know. Since the flight into so-called "dynamic psychiatry," with its speculative and entirely affirmative basis in psychological determinism, psychiatry has suffered from a surfeit of complex and unprovable theory and a dearth of simple testable hypotheses. Not unnaturally, the psychiatrist who believes that the phenomena of mental illness can be explained on the basis of *a universal prefabricated theory*, rather than by building a growing structure of certain knowledge on the basis of controlled observation and experiment, finds little difficulty in blowing up his theory to explain not only mental disease but also normal human behaviour, interpersonal relations, and ultimately world affairs. The results of such exercises are not impressive.

THE PSYCHIATRIST is, of course, encouraged in his universal pontification by the inexplicable veneration with which his views are regarded by many who ought to know better. Socially, this surely springs in part from the priest's loss of prestige and from the collapse of religious values. Certainly the highly wrought and arcane structure of psycho-analysis betrays its man-made origin as transparently as does that of any religion. Nor is it fanciful to note the similarity that obtains in the wordy battles so full-bloodedly enjoyed by adherents of competing faiths whether religious or psychiatric.

But at a simpler level the popular endowment of the psychiatrist with universal omniscience also arises from a basic lay fallacy that few psychiatrists make any attempt to dispel. There are many quite well-educated people who really believe that psychiatrists have special and mysterious methods of finding out what is going on in their patients' minds that are denied to the rest of the profession and indeed to the rest of humanity. Such people do not appreciate—because they have never been told—the simple fact that a psychiatrist is *a physician who takes a longer history*, partly because he sees fewer patients. Does the psychiatrist know more about the roots of normal human behaviour than anyone else? His claim to do so arises from the fact that he studies the caricatures of normal human behaviour that present as psychoses or neuroses. He can certainly theorise about normal behaviour, but when he moves outside his strictly professional field there is little evidence that his views are any more interesting or his conclusions any more reliable than those of the rest of us. They are certainly less illuminating and less convincing than those of the novelist.

One curious phenomenon concerns "insight." This is the subject of so much discussion in psychiatric circles, in clinical formulations, and especially amongst those psychiatrists who lay great store on introspective data, that one might imagine it would be a quality carefully cultivated as well as highly valued by psychiatrists themselves. I have no hesitation in saying quite categorically that this is not so. Personal experience confirms the rather unexpected finding that the practice of psychiatry in any of its forms does not necessarily confer any insight whatever. Whether mechanist or psycho-analyst, there are many psychiatrists who manifest that insightless insensitivity to audience reaction that is the hallmark of the bore.

I HAVE EMPHASISED the psychiatrist's eagerness to account for psychological phenomena on the basis of some universal theory as evidence of his rejection of the methods of science; and indeed lack of objectivity is probably the main reason for the reluctance with which the typical psychiatrist is accepted into the scientific community. An eminent British professor of psychiatry recently went so far as to explain to an audience of lawyers, judges, and doctors that since the taking of a psychiatric history and the making of a psychiatric formulation involve the psychiatrist so intimately with the patient at an emotional level it was quite impossible for him ever to act as an objective expert witness in a court of law. He must always, according to this authority, be "on the side of" the person examined—a sort of perpetual prisoner's friend. Needless to say, this remark was greeted with alarm by one group of lawyers and with hilarious relief by others (who felt it fully confirmed everything they had long felt about psychiatric evidence in court). There are, of course, many psychiatrists who do not share this view. It is perfectly possible for a clear-headed psychiatrist with some expertise in forensic work to give a balanced and indeed an absolutely invaluable clinical opinion in a court of law. However, one must admit that there is a tendency for the psychiatrist to regard as a patient any individual whose history he takes—under whatever circumstances. The word "malingering" is conspicuously absent from the index of several standard textbooks on psychiatry, and we all know of appalling instances where the lying statements of criminals were given spurious authenticity by being incorporated in the text

of a psychiatrist's report as though they were matters of fact.

Readers of Freud will recall that his theory of hysteria rested on the basis of accounts of sexual assaults in infancy, revealed during analysis, which were later shown to have been entirely fabricated by the rather curious patients concerned. However, psycho-analytic casuistry enabled Freud to preserve the fabric of his theory intact—by the simple expedient of substituting the *fantasy* of assault for its *reality* as the prime cause of subsequent developments. Freudians have quoted this as an example of the master's genius, though there are of course alternative interpretations. At any rate it is hardly surprising that the judge in court has so often to point out that the psychiatric assessment is based in essence on what the person examined told the psychiatrist, and that if the subject of the examination is endeavouring to escape from the consequences of a criminal act, to avoid an unpalatable social responsibility, or even to elicit sympathy, it would be as stupid to regard his statements about himself and his feelings as necessarily valid evidence as it would be to accept without question a criminal's uncorroborated account of his crime. I have also observed that, even outside a medico-legal situation, quite sophisticated psychiatrists in search of a psychological basis for a mental illness will cheerfully accept the patient's (usually creditable) account of the origin of his troubles, even though the same doctor would contemptuously brush aside the patient's equally insupportable theories as to the origin of his gallstones or cerebral thrombosis. Unless one accepts that psychogenesis is a game for amateurs the two situations seem to be not absolutely different.

A FURTHER VEXED ISSUE concerns how far the psychiatrist should permit his subject to be used, loosely and sometimes cynically, to ensure the smooth working of society. The term "psychopathic personality" lost its meaning in the Hitler war because it was used as a medical label for ridding the armed forces of inadequate or uncontrollable soldiers. Whether we lost much thereby is another matter. The term shares with some other psychiatric categories all the vices of a circular definition: irresponsible behaviour is caused by psychopathy, which is a diagnosis based on the subject's irresponsible behaviour. In this context no great harm was done. It was more important to ensure the survival of civilisation than to worry about terminology. However, in peace-time, the psychiatrist should perhaps be less ready to act as a garbage can for the problems of society and the law in connection with anti-social behaviour. If the middle-aged shoplifter is genuinely suffering from an agitated depression, hospital treatment is more appropriate than prison; but this does not justify the speculative attribution of all stealing and swindling to mental disease. What society does is to make the most convenient common-sense disposal of such cases. If the blanket application of any particular theory were shown to yield a better pragmatic result it would no doubt be hailed with relief as the basis of forensic practice; but so far there is no such glow on the horizon.

Nevertheless, the psychiatrist's willingness to regard as a patient anyone from whom he takes a history leads to considerable abuse. His appearance in Court to give evidence in a case of marital conflict after having talked to only one member of the marriage deprives his opinion of any conceivable value. It is probably of little value anyway. The fact that two people decide that they do not wish to spend more time together does not prove they are mad or ill, even in the mildest way. But a psychiatrist who gives an opinion in such a case without seeing both partners brings ridicule on his subject. He has in any case nothing to offer in this situation unless mental illness is present.

I WOULD DRAW special attention to three current fashions in psychiatry that may contribute to its abuse.

Medical thought is, of course, notoriously susceptible to fashion, even in the tangible realms of physical disease. Where focal sepsis and auto-intoxication once held sway, the more sophisticated concepts of auto-immunity now reign, and the idea that the patient has become sensitised to his own tissues is currently used to "explain" a wide range of diseases. Like all such explanations it is directed to elucidating the intermediate steps in the chain of events that constitutes the development of a disease, rather than to identifying prime causes; and like all such explanations it contains a hard kernel of truth. Psychiatry is at least as vulnerable to fashion as any other branch of medicine.

I would draw attention first to the concept of social psychiatry, to the vogue it enjoys here at some cost to the clinical approach, and to the way in which with characteristic American thoroughness it is tending in some circles to dis-

place the rather tarnished image of psychoanalysis as the mascot of the American academic psychiatrist.

I would be the last person to discourage epidemiological research, to which I have devoted many years of effort. There can be no doubt that this can display trends in differential prevalence and incidence; it can reveal broadly operative contributory causal factors; and it can pinpoint sensitive areas suitable for more intensive and definitive investigation either in the clinic or the laboratory. It has, for example, fully confirmed the powerful influence of the cigarette in the causation of chronic bronchitis, arterial disease, and coronary thrombosis, as well as cancer of the lung. Occasionally, also, epidemiological serendipity will unveil a truly significant rather than a merely contributory aetiological causal agent: the relationship of maternal German measles to congenital deformity in the baby is an outstanding recent example. More than this, epidemiological studies sharpen precision in diagnosis and encourage the formulation of those operational classifications that are needed to establish real differences and similarities between clinical categories. However, it must be clearly kept in mind that valid studies of illness within a community can be carried out only where there is already a firm and widely agreed basis of clinical diagnosis and classification, which is far from the case in psychiatry at the present time. Even the best of such attempts have often had to place undue and sometimes ludicrous reliance on the empirical quantification of symptoms. To grade subjective sensations on a numerical scale represents an attempt to achieve some approach to objectivity, and an advance on simple diagnostic labelling; but it emphasises the credibility gap between clinical research in this and simpler fields of medical investigation. What sort of effective classification could the heart specialist, for example, have developed if he were solely and entirely dependent on his patient's story, without the evidence yielded by physical examination, to say nothing of the crucial assistance of radiological, electrical and other ancillary methods of diagnosis? Furthermore, while epidemiological study can certainly yield useful information it is naive to expect it often to yield final answers. To shift the basis of psychiatry from medicine to general sociology on present evidence is to move from the well-lit contours of hard knowledge and clear definition into the half-light of a subject that is in its infancy, that is imprecise, that is still desperately short of basic data, and that is itself still groping for its first principles and for a clearly defined role in the scientific galaxy.

THE SECOND EQUALLY DANGEROUS TREND is the deliberate inflation of psychiatry from its preoccupation with the study and treatment of mental illness to what has been euphemistically termed "the science of behaviour." I have already expressed reservations as to the extent to which the psychiatrist's experience of the abnormal can reasonably be used as a guide to general behaviour, and the description of psychiatry as comprising the "science of behaviour" can be described only as a piece of remarkable arrogance. Of course all human behaviour can be described in the psychiatrist's terminology. Equally it can be described in the terms and concepts of the anthropologist, the sociologist, the historian, the economist—or even the practical politician. In psychiatric terms Hitler was a hysterical psychopath; to the literary historian he epitomised the dark aggressive mysticism of the German soul; to the economist he was a front man for big business who unfortunately got out of hand; to the politician a potentially convenient but ultimately uncontrollable complication of the European balance of power. There is some truth in all these views and in others; but I see no conceivable reason why the psychiatrist's monarchy of the kingdom of the abnormal should endow his particular synthesis with any overriding virtue.

THE LATEST FASHION IN PSYCHIATRY—or it might be safer to say the penultimate fashion, since fashions succeed one another so rapidly that I am probably already out of date—is to divorce the subject entirely from medicine and to regard mental illness as a matter exclusively of the individual personality and his inter-personal relations. This view, which in its more bizarre manifestations regards the schizophrenic's family as more abnormal than the schizophrenic, light-heartedly begs the question of psychogenesis, and accepts disturbed inter-personal relations as the cause of mental illness on the basis of affirmation alone and without troubling to adduce the kind of evidence that would be demanded in any other field of medicine. It also comfortingly absolves the investigator from the hard exercise of diagnostic classification, and the search for other aetiological agents. It con-

verts therapy into a miasma of well-motivated and mostly bumbling interference with complex relationships subjectively assessed by a mind with no verifiable basis of authentic professionalism. Attributing everything to psychogenesis, it ignores the enzyme and the toxic chemical, or any of the other agents by which mental disturbances can be predictably provoked.

If the rest of medicine had restricted its aetiological hypotheses to those based on "interpersonal relationships" it could also have built a precarious edifice of similar causation for gallstones, piles, and baldness. It would be characterised by a vast, sprawling and inconsequential literature and it would never have developed the sleeping tablet, to say nothing of the antibiotic.

YOU WILL OBSERVE that the real issue concerns the use of the term *mental illness*. As in the case of physical illness the definition has a social as well as a semantic importance. All of us have physical and mental disabilities and for all of us they increase with advancing years. Every one of us has psychiatric symptoms. We are all symptomatic neurotics, but for the most part we endure our symptoms and expect treatment only when interference with our work or social function transforms us from symptomatic to social neurotics. And all of us occasionally magnify disabilities of both kinds to obtain our own ends. Such exaggerations range from fabricating a sick headache or pleading normal fatigue to avoid an unattractive social engagement, to simulating more serious disability for more serious purposes—madness to escape imprisonment.

The practitioner of internal medicine is fallible, but probably more sparing than the psychiatrist in bestowing the accolade of illness with its consequent privileges. This, I believe, is where he is most abused. It is axiomatic that the depressive patient should not be told to pull himself together and get on with the job. However, there are many circumstances when the patient with less serious psychiatric symptoms needs to be told quite clearly that they are no more important than the low back pains that trouble so many of his contemporaries, or the bunions that worry the rest.

I am fortunate that the psychiatrists with whom I have worked have been prepared to say this, and to make the rarest of all psychiatric diagnoses—that there is nothing seriously wrong with the patient and nothing requiring psychiatric treatment. If such self-denying stringency were more widely cultivated, abuse of the psychiatrist at every level of society would be less conspicuous.

Waiting

I opened the linen-cupboard
And found him counting every stitch of
his shroud.
And in the loft
The dying news was read to my brother.
My elder twin was waiting and flying,
A guillotined feather on the night-road.

Sitting in the pantry I wasn't done
With compote and jams.
I told him to wait
And gave him a pastry-cook
Conical hat tall as a heaven.

Here is the starched hat
And the apron of my brother.
In his new uniform
He grapples with me.
Here is the stitch of longing
In the shroud of my brother.

Dennis Silk