components, with trainees asking for more focus on feedback rather than scores. This has been previously identified by Malhotra *et al*,[3] with residents' perceptions of the WPBA as an assessment *v.* educational tool and by the Postgraduate Medical Education and Training Board (PMETB) itself,[4] where they state that WPBAs must be used formatively and constructively lest they become no more than hoops to be jumped through, with the educational validity lost.

As a future consultant, I value the opportunity provided by WPBAs to discuss cases in a peer group as CbDs are the cornerstone of professional development and are useful for developing one's clinical practice. Given the concern raised by the PMETB about how WPBAs are used, I would urge the Royal College of Psychiatrists to learn these lessons and use CbD as a developmental 'formative' tool, with the focus on discussion, reflection and feedback and not let this become just another tick-box exercise.

**1** Mynors-Wallis L, Cope D, Brittlebank A, Palekar F. Case-based discussion: a useful tool for revalidation. *Psychiatrist* 2011; **35**: 230–4.

**2** Babu KS, Htike MM, Cleak VE. Workplace-based assessments in Wessex: the first 6 months. *Psychiatr Bull* 2009; **33**: 474–8.

**3** Malhotra S, Hatala R, Courneya CA. Internal medicine residents' perceptions of the Mini-CEX. *Med Teacher* 2008; **30**: 414–9.

**4** Postgraduate Medical Education and Training Board. *Workplace-Based Assessments: A Guide for Implementation*. PMETB, 2009.

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## Moving on from old frontiers

The contributions of both Szasz[1] and Shorter[2] make for depressing reading. Whereas Shorter never gets away from the dinosaur concept of mental illness as a mere 'brain disease', Szasz indeed grasps a fraction of the argument that human behaviour can only be understood and assessed in its cultural frame settings. But disintegration of those mental frames does not turn mental illness into a 'myth', as Szasz insists, nor is his disgust for society's bigotry in any way helpful in disentangling the constantly changing and complex architecture of how the patterns of biological circuits and those of social relations might be inter- or disconnected.

Mental stability is a functioning social construct indeed, as is a good marriage, a proper education or illuminating science. All of them are no 'myth' and are very much real – yet not as a substance or an observable object but as a relational order. The living architecture of those relations and their complex altering geometries should be at the heart of our understanding of mental health. Our different levels of consciousness are not simple representations of the outside world within our brain. Instead, they are the product of a creative tension between the stabilised, categorical pattern of the subject (growing in its complexity – mainly the left brain) and its social field or its sequences (continuously to be deconstructed – mainly the right brain).

What is even more crucial, the short-lived entities that both Gestalt-creating authors are dealing with, are not data in the empirical sense but symbols throughout. In general science no one doubts that human nature, our language, mathematics and our progressing tools of work specification are based on and experienced as symbolic constructs, confirming the famous quote of philosopher Ernst Cassirer that man is not the 'animal rationale' but the 'animal *symbolicum*'.

This is more so highlighted in mental crisis, when in its course the symbolic matrix breaks down, our pattern-based construct of reality gets lost, our symbolic language is severely affected and early elements of magic self-regulation and previous instinctive drives mix with the patient's frantic efforts to calm these powerful forces with his diminished cultural tools.

All this in mind, one would expect 'symbolic formation' and the loss of its complex matrix to play a major role in psychiatric diagnosis and therapy. But, strange as it is, the symbolic message has not hit home. The breakdown of 'symbolic formation' in our patients continues to be ignored. Its detectable transcultural codes of experience, its capacity as a building block of mental equilibrium and its massive impact in the make-up of healing in group settings remain unused.

This is even more surprising given that neurologist Henry Head[3] had already extensively researched symbol theories in England during the early 1920s. So did Ernst Cassirer in Germany. Cassirer thought of extracting underlying patterns from cultural development in an attempt to find a 'universal system of symbolisation' underlying human consciousness.[4]

He extended van Uexkuell's biological circuit which finds animals adapted to a certain part of their environment by adding an entirely new quality, which he calls the 'symbolic system'. Whereas in animal physiology sense perception is divided into more *v.* less variable components, differentiating basic type-specific patterns from those which are random or related to just a sole situation, the symbolic approach allows for the integration of meaning and for its anticipation in pre-planned social encounter. This unique capacity, however, is not biologically given but has to be drawn up in constant interaction by using a mental – symbolic – membrane, separating, selective, connective and protective at the same time, securing its architectural codes in a semantic link with external signs and objects. Thus, the multitude of human activities emerges from a limited number of 'symbolic forms' such as magic, myth, religion, law, science, the arts and a few others – while their underlying pattern can be used again and again – in endlessly changed settings.

Cassirer published his findings in a remarkable study, *Psychopathology of Symbolic Consciousness* (1929), which took its strength from intense clinical and theoretical discussions with neurologist Kurt Goldstein, psychologist Kurt Lewin and psychiatrist Ludwig Binswanger. Translated into clinical terms, this approach leads to a different understanding of the multilayered architecture of mental health (which German psychiatrist Blankenburg termed *natuerliche Selbstverstaendlichkeit*) integrating biological with social patterns. It allows for a sustainable point of reference in defining 'mental illness' and it might help us understand the as yet unexplained symptom changes during the course of treatment.

Seen from this 'symbolic' angle, mental health can be defined as the human ability to stabilise early patterns of personal experience, to successfully create, change and integrate 'symbolic forms' of social interaction, while

establishing an equilibrium between the demands and intentions of self-regulation and environment, adding its newly found results to the human tradition.[5]

Mental illness is the inability to stabilise and/or integrate one's own pattern of behaviour into a social framework, leading to a breakdown of (different and multiple) layers of 'symbolic formation', while the balance between cultural interaction and the emergence of inner preformed pattern is continuously (or constantly) changed towards the latter.

Clinical psychiatry is entitled to move on from Szasz's and Shorter's outdated theories, yet it is well advised to strengthen its focus on semiotic and symbolic research. This may direct us towards a 'science of meaning' (salience), beyond a mere biological function and to integrate these important sources of knowledge into the regular discourse of our discipline.

**1** Szasz T. The myth of mental illness: 50 years later. *Psychiatrist* 2011; **35**: 179–82.

**2** Shorter E. Still tilting at windmills. Commentary on . . . The myth of mental illness. *Psychiatrist* 2011; **35**: 183–4.

**3** Head H. Disorders of symbolic thinking and expression. *Br J Psychol* 1921; **XI**: 179–93.

**4** Cassirer E. The psychopathology of symbolic thinking. In *The Philosophy of Symbolic Forms. Volume Three: The Phenomenology of Knowledge*. Yale University Press, 1957.

**5** Andersch N. Symbolic form and Gestalt: Ernst Cassirer's contribution to a 'matrix of mental formation'. *Gestalt Theory* 2007; **29**: 279–93.

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# Correction

The NHS, the private sector and the future (letter). *The Psychiatrist* 2011; **35**: 354. The last line of this letter is inaccurate: the Winterbourne Hospital is owned and operated by BMI Healthcare and is a completely separate organisation that has no connection to the care home owned by Castlebeck called The Winterbourne View. We apologise for this error.

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