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MENTAL HEALTH AND MEDICAL CARE: FOUR CULTURES AND A SINGLE THEME

We are now slowly re-discovering the conclusion reached by Alfred Grotjahn in his remarkably prescient *Soziale Pathologie,* namely that "*zwischen dem Menschen und der Natur die Kultur steht.*" [1]. In some measure this maxim affects every branch of modern medicine but to none is it more relevant than psychiatry, which is so closely embedded in the social matrix in which the subject is practiced. A comprehensive study of this matrix would have to touch on a number of disciplines, including history, economics, social anthropology and sociology, but for our immediate purpose these multiple influences can be canalized by reference to the available systems of medical care which exist to deliver the two broad types of service offered by contemporary medicine: on the one hand, the specific products of biomedical research—a surgical operation, say, or a new drug—which are impersonal, often expensive and ideally directed at the cure of disease; on the other hand, the "non-specific" psychosocial contribution of medicine, intensely personal and more often directed towards alleviation or support. These two categories do no more than reflect the derivation of modern medicine from its twin

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sources of science and magic whose respective attributes were etched so sharply by Malinowski: "Science, even as represented by the primitive knowledge of savage man, is based on the normal universal experience of everyday life, experience won in man's struggle with nature for his subsistence and safety, founded on observation, fixed by reason. Magic is based on specific experience of emotional states in which man observes not nature but himself, in which the truth is revealed not by reason but by the play of emotions upon the human organism. Science is founded on the conviction that experience, effort and reason are valid; magic on the belief that hope cannot fail nor desire deceive. The theories of knowledge are dictated by logic, those of magic by the association of ideas under the influence of desire". [2]

The relevance of this analysis was heightened when, ten years ago, Karl Evang outlined and described the four main types of system for the delivery of health services in the post-war world. [3] These are: (1) The so-called "American" system in which "as much of the health services as is found compatible with health conditions is, as a matter of principle, left to private enterprise and free competition." Here, as Evang points out, there is a split not only between curative and preventive medicine but also "a split in the curative health services between those patients who can afford to pay the price for medical care in the open market, and those who cannot: the indigent." (2) The so-called "Western European" type in which "society has gradually taken over a great deal of responsibility for health," though the dualism between curative and preventive medicine remains resolved in various degrees. (3) The system of the so-called peoples' democracies of Eastern Europe and Asia, which is dominated by "the taking over by society of the full and undivided responsibility for all parts of the health services." (4) The system of the technically under-developed countries which are at an altogether more primitive and ill-developed level.

Evang's four categories of health service can be matched by four types of socio-medical ethos which, for the purposes of simplification, may be designated respectively the commercial, the egalitarian, the political and the magical. The differences between them depend partly on the nature of the links between the doctor and society, and partly on those between the doctor and his patient. Even where the physician's primary responsibility to the

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patient is recognised as axiomatic, as in most of the industrialized Western world, it may be modified by economic factors which determine whether treatment reaches all members of the population in sufficient quantity or quality. The central objective of the welfare state in this field is to reconcile the general demands of society with the individual demands of the patient, and the success or failure of a particular system depends largely on the balance struck between them. Where medicine is subordinated to a political system, as in Eastern Europe, the needs of the individual patient may be deemed less important than the good—real or imagined—of society. Where medicine is most clearly associated with religion and prescientific thought, as in many parts of the developing world, the systems of shared belief assume great importance regardless of their scientific validity.

How do such considerations bear on what we know of the practice and development of psychiatry in recent years? From the standpoint of medical care the administrative distinction between institutional and extra-mural services corresponds roughly to the clinical distinction between psychotic and neurotic disorders. If we take first the major disorders and their management, even a crude comparison between the most elaborate and least developed systems may serve to illustrate the need to exercise some caution in evaluating patterns of medical care. Thus, in North America the recent growth of psychiatry as a specialty is attested by its many hundreds of institutions and spectacular increase in personnel: as Lawrence Kolb pointed out in his 1969 presidential address to the A.P.A. the membership of the Association had increased five-fold (from 3,600 to 17,000) over the previous twenty-five years. [4] By contrast, there are no more than a handful of psychiatric institutions in many Asian and African countries, and trained psychiatrists are correspondingly rare.

Nonetheless, although socio-economic factors are partly reflected by the statistics of trained medical manpower and of the institutions where they work, to conclude that the mental health of the population of the developing countries is necessarily inferior to that obtaining in more economically advanced countries requires some qualification. The growth of so-called "trans-cultural" psychiatry has drawn attention to the special problems posed by mental ill-health in such societies. It is now evident that while the basic forms of the major psychiatric disorders

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are universal, a low economic standard of living goes with such conditions as malnutrition, encephalitis or trypanosomiasis which are themselves associated with psychiatric disabilities. To the extent that the level of mental health is linked with the general state of public health an amelioration of socio-economic conditions leading to the provision of specific physical factors—food, for example, or antibiotics—must indirectly raise the level of mental health. With regard to a large volume of major psychiatric disorders, however, including the senile psychoses and the functional psychoses, the picture is more complex. In the first place, the deep-rooted suspicion of institutions found in many parts of the world is understandably directed at psychiatric hospitals whose function is often more custodial rather than therapeutic since, as Tooth has pointed out, their "primary function is to protect the public from anti-social behaviour". [5] On the other side of the coin, the distaste for institutions often goes with a social attitude on the part of the community which supports many mentally sick people who, even with ample means, would find life difficult in more developed countries. A genuine respect accorded to old-age and a genial tolerance of feeble-mindedness can, for example, do wonders for bed-occupancy and burdens on family life. The elaborate, and mostly unrealised recommendations of community-care and rehabilitation programmes have long been anticipated by the social structure of some supposedly unsophisticated societies.

It may, however, be argued that while such measures must be applauded on humanitarian grounds they cannot compensate for the failure to provide specific forms of treatment, especially, perhaps, pharmacotherapy which has been the spearhead of the treatment of the major mental illnesses since the mid-fifties. Modern psychotropic drugs are expensive and they do not reach large sections of the population in developing countries. It is, therefore, of some significance to outline the conclusions of a distinguished international panel which met in 1969 to consider the epidemiological and social aspects of the so-called "neuroleptic" drugs. [6] Since the fall in hospitalised patients was first attributed to large-scale pharmacotherapy in the late 1950's there has been considerable division of opinion about the relative importance of the specific, or pharmacodynamic, as opposed to the non-specific, or psychosocial, effects of these compounds. [7]

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The opinion of the panel a decade later was that the demonstrable impact of psychotropic drugs on hospital populations was inversely related to the staffing and social facilities already provided by individual institutions. Emphasis was laid on such social implications of pharmacotherapy as the transformation of the hospital atmosphere, the increasing possibilities of extra-mural care and the raised social status of both the doctor and the patient. Paradoxically, the resultant effect in the economically developing societies would seem to have been beneficial on balance because the majority of hospitals in these countries are poorly staffed and equipped.

The implications of the large-scale use of psychotropic drugs for the treatment of mental illness, however, extend beyond the institutional walls and enter the socio-cultural structure of medical practice. Indeed, a shift in the delicate balance between the roles of the modern physician and the traditional native healer has already occurred. The opinion of the panel makes this clear: "In a number of countries—for example, French-speaking Africa—there is a good working relationship between the physician and the native healer. One may almost speak in terms of bifocal treatment, psychotherapy being the province of the native healer and pharmacotherapy that of the psychiatrist." We are surely reminded here of an old issue which was identifiable in ancient Greece where the prototype situation has been described in the following terms: "A religious formulation of therapy indicates a personal divine mediation in every cure. The god enters personally into the therapeutic effects in each individual case. But when some drug is prescribed there is a new dimension. There arises the significant question, to what extent does essential medicinal virtue lie in the will of the god, to what extent in the prescribed medicine? Certainly, as emphasis rests more and more on drugs, the divine importance tends to recede. Then we have a changing attitude towards disease. When it is the medicine which cures, it is the priest who indicates the medicine while the god merely reveals which medicine is most appropriate for the given case. When the gods played a role secondary to the activity of drugs, when the ability to treat successfully became a function of the priest rather than of the god whom the priest served, then a long step had been taken towards scientific medicine." [8]

In many contemporary societies a belief in soul-loss, taboo,

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sorcery or spirit intrusion will determine the choice of treatment for what we would call minor mental disorders. Even if they are treated by methods based on unacceptable assumptions by scientific standards it is arguable, nonetheless, that they are managed as effectively and in larger numbers than their counterparts in more industrialised parts of the world. In the view of one highly qualified observer of one of the better-studied African cultures, for example: "It seems clear that there is no good reason to encourage indigenous healing practices for physical illness in any culture. Western diagnostic technique and Western pharmacological and surgical knowledge far outstrip every other known system of medicine. In addition, Western practices are universally applicable. They are not culture-bound. Psychological medicine is different, however, in a number of ways. Western psychiatric techniques are not in my opinion demonstrably superior to many indigenous Yoruba practices. I feel confident that investigation of the indigenous psychiatry of other groups will lead to the same conclusion. Psychotherapeutic techniques fit with the cultures in which they have developed and cannot cross cultural boundaries so successfully as can physical therapies. [9] Again, Lambo writes, "We have repeatedly found that in the sphere of psychoneuroses some illiterate patients who have failed to respond to our kind of approach have recovered under the influence of 'native psychotherapists at the native treatment centres.'" [10]

Turning back to less exotic cultures we must now face two uncomfortable facts: first, that the heterogeneous procedures grouped together as the psychotherapics in the native centres of developed societies are, as some of their more honest proponents now reluctantly concede, scarcely justifiable on grounds of scientific validity and, secondly, that no convincing evidence has been furnished as to their specific therapeutic value. [11] In the competitive market of commercial medicine, however, a commodity gains from a scientific label and advertising techniques emphasise efficacy and novelty. The treatment of minor psychiatric illness in too many industrialised societies illustrates principally the economic advantages of assuming that in medical therapeutics there is an answer to every question posed. An eminent British physician has commented on the consequences of this assumption: "If you admit to yourself that the treatment you are giving is frankly inactive, you will inspire little confidence in your patients

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(unless you happen to be a remarkably gifted actor), and the results of your treatment will be negligible. But if you believe fervently in your treatment, even though controlled tests show that it is useless, then your results are much better, your patients are much better and your income is much better too. I believe this accounts for the remarkable success of some of the less gifted but more credulous members of our profession, and also for the violent dislike of statistics and controlled tests which fashionable and successful doctors commonly display." [12]

The opportunities for this trend to effloresce in the sphere of what used to be called "functional nervous disease" are magnified by the general inadequacy of the services which exist for their control among the public at large. Evang draws attention specifically to this problem: "Most striking are perhaps the shortcomings of the health services even in the most advanced countries in relation to what are sometimes euphemistically called 'minor mental illnesses,' meaning the large group of neuroses, psychopathies, character anomalies, 'problem children,' hypochondriacs, etc.... In no other field does the inadequacy of institutions come more to the foreground than in dealing with neuroses and related conditions." [3] One reason for this verdict can be related to the observations of several inquiries into the relative qualities of the principal systems of medical care. Since minor mental disorder is principally an extra-mural problem it impinges most closely on what is known as "primary" medical care. In his recent book, *Medicine in Three Societies*, John Fry, a British general practitioner, has taken a hard look at the relative merits of the American, Soviet and British provisions for medical care on the basis of his personal observations. [13] In all three societies the hospital services for declared illness are comparable in number and scope. The major variations reside in the sphere of primary medical care for the processes of initial medical contact differ markedly.

On the provision of extra-mural services Fry is uncompromisingly blunt: "Such progression as has occurred in the USSR and the UK is not apparent in the USA, not because the idea of community care is unacceptable, but because of the system of free-enterprise medical care." This is, in turn, related, in his view, to a "...national philosophy, based on free enterprise and individual liberty with responsibility, (which) has allowed a policy

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of *laissez-faire* to develop which has been reasonably satisfactory to those who have been successful, but very hard on those who have failed."

Fry points out, in common with many other observers, that the scope and range of psychiatric services provided by several Eastern European countries are considerable. [14] For the manifest disabilities associated with major mental subnormality the quantity, if not the quality, of care is impressive. However, the study of minor disorders in relation to health services is handicapped by being subject to a distorting influence on which Fry comments in his survey of the USSR: "The Soviet attitude to mental illness is that it presents fewer problems in a 'socialist' culture than in so-called 'capitalist' societies. It is stated that because of Soviet social achievements the prevalence of mental illness is low and will decrease further because of further social and cultural improvements. Such a national attitude influences profoundly the pattern of medical services created to deal with the mentally sick. In the case of such attitudes it becomes almost a slur to suffer from a mental illness, because it will let down the image of a happy society. For this reason it is difficult to obtain facts and data on the true prevalence of mental illness in the USSR."

Just what is the size and substance of the psychiatric component of the burden of community sickness? The conditions of the British National Health Service make it possible to go some way towards answering this question. The achievements of British psychiatry in the field of hospital services are well known. Of equal importance, however,—and much less well publicised—is the role of the general practitioner in this service, very much his own man, and with access to the community at large. In the working conditions of the British National Health Service the family doctor practising front-line medicine as primary medical care is in a unique position to furnish information about the health and sickness of most members of the population. My own research unit, for example, has shown that of some 15,000 patients at risk during a twelve month period, just over 2,000, or approximately 14 per cent, consulted their doctor at least once for a condition diagnosed as largely or entirely psychiatric in nature. [15] Further, and still more disturbing, it emerged that only about one in twenty of the patients identified in the survey

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had been referred to any of the mental health facilities despite what the general practitioners freely acknowledge to be the unsatisfactory nature of the treatment they were able to provide. Clearly, there is here a large area of unmet need, with obvious implications for clinical and administrative action. It is, for example, noteworthy that recent studies by the Health Insurance Plan of New York have shown there to be a significant increase in identified emotional disorder when free medical facilities are offered to the population. [16]

But to identify in administrative terms this large and heavy burden of psychiatric disorder is to say little or nothing about its clinical management. Our further studies of the illnesses presenting to general practitioners make it clear, first, that a majority of these patients, most of whom suffer from what must be classified loosely as neurotic or personality disorders, exhibit a surprisingly poor outcome in terms of recurrence or chronic illness over a seven-year period [17]; secondly, that their conditions are so deeply embedded in their life-situations as to render the term "medico-social" or "socio-medical" necessary for adequate description [18]; and, thirdly, that the provision of both medical and social measures is altogether inadequate at the present time. Whether the major components of the disorder be regarded as morbid reactions to intolerable situations or as inadequacies of constitutionally vulnerable individuals it is apparent from our analysis that social as well as medical measures must be adopted in the management of these conditions. It is also apparent that to undertake any large-scale programme of this type would be difficult, expensive and dependent on careful evaluation.

For this purpose, however, a direct comparison between systems of medical care must be supplemented by some recognition of the borders limiting the process whereby social factors come to enter intimately into the pathogenic substance as well as the pathoplastic form of psychiatric morbidity. It is almost twenty years since a hard-headed British psychiatrist took public issue with the expansionist view of psychiatry associated with the fashionable view of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" [19] and pleaded forcefully for what he called 'Psychiatry Limited,' emphasizing that "...a limited liability

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company is one in which the shareholders, should the company fail or go bankrupt, are not liable for more than they subscribe" [20] and attacking those speculators who "undermine the reputation of the firm by using the name to float bogus companies with grandiose prospectuses, backed up by balance sheets that do not add up to make sense." One of the more outspoken shareholders has recently given vent to a well-publicised assault on the psychiatric balance sheet in the following terms: "...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*'s 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 directors, or misuses his jargon to confuse any and every topical issue in an incessant series of television appearances." [21]

If, however, we are to be entrusted with the treatment of disease we should at least be able to define it. Probably very few authorities would now agree with the confident, and for long influential, outlook summed up by Kurt Schneider—"Mental phenomena should in our opinion only be associated with illness when they are conditioned by some actual morbid change in the body, or by defective structure." [22] Though this view is still detectable in the conditions governing legal compensation in some countries it fails to do justice to the complexity of a concept which, as Lord Cohen has pointed out, can be related historically to two separate themes, namely disease as process and disease as deviation. [23] The conceptual formulation of deviation is easier to postulate than to demonstrate in psychiatry where the investigator is handicapped by a lack of measuring instruments and, all too often, by lack of access to a population on which measurements can be made. Most conduct characterised as "habit disorder," "neurosis" and "behaviour disorder" in childhood, for example, represents a deviation from forms of behaviour which are widely distributed throughout the healthy population at different phases of development. In these circumstances the definition of morbidity cannot depend simply on an identified item of behaviour. Before a decision is reached on whether a

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particular item is of clinical significance it is necessary to take into account at least the frequency of intensity of the item concerned and its 'deviance' in statistical terms when compared with the norms for the child's age and sex. [24] In addition, however, we have shown it to be necessary to acquire information about (a) the presence or absence of other items of deviant behaviour, some of which may cluster to form a pattern or syndrome; (b) the duration of the behaviour, especially with regard to its tendency to spontaneous remission; (c) the attitudes of observers and recorders of behaviour; and (d) the circumstances in which the behaviour occurs. Only in this way does it becomes possible to delineate the boundaries between deviance and illness.

Even with these qualifications, however, deviant behaviour cannot necessarily be equated with morbidity since so many relevant items of conduct are invested with legal or political significance. In Eastern Europe the official position is clear enough: "It must be emphasised," according to Professor Uzunov in Bulgaria, "that there is no intention here to ascribe social phenomena to biological causes. Negative social phenomena—crime, drunkenness, prostitution, hooliganism, gambling, etc.—have deep roots in the realities of the social structure. It becomes possible to eradicate them only after a revolutionary reconstruction of society. In the process of building a socialist society, however, as is taught by Marxism-Leninism and demonstrated by practical experience, certain relics or survivals of capitalism still subsist for a certain time." [25].

One legal consequence of this outlook has been expressed by a Russian authority: "as we believe that upbringing plays a decisive role in shaping a person's character, we consequently, as a rule, recognise psychopaths as responsible individuals—that is to say as standing in need of judicial reformative influence, rather than medical care." [26] From this it is then but a step to postulate that "the educative role of the social environment... explains why a comparatively insignificant percentage of psychopaths in the Soviet Union are delinquent."

By contrast, most Western societies pay lip service to Glueck's view of the antisocial offender as "a sick person, in need of treatment rather than punishment" [27] and according to the British Mental Health Act of 1959 the psychopath, by definition, "requires or is susceptible to medical treatment." With no more

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than arbitrary distinctions between deviance and conformity, however, the issue can lead to dangerous confusion. No one has put the matter more clearly than Lady Wootton: "Pace the mighty army of American mental hygienists, the choice between conformity and non-criminal deviance is every adult's private business in which the doctor is not entitled, by virtue of his profession, to interfere. So long as drunkenness, idleness, prostitution or extra-marital conception are not in themselves criminal offences, the right to be drunk, idle or promiscuous is part of the liberty of the individual. If the exercise of this right is held to be intolerable, the proper remedy is to adjust the boundaries of the criminal law. Failing that, there can be no justification for attempts to enforce conformity in the name of mental hygiene; and if any one doubts the dangers of such a confusion between medicine and morality, let him note that *Radicals and Radicalism*, along with *Prostitution*, and *Drunkenness and the Chronic Alcoholic* is one of the chapter headings of an American textbook on Social Pathology." [27]

The more damaging part of this comment has been fully explored by the same writer in her admirable Samuel Hamilton lecture, "Social Psychiatry and Psychopathology." [28] Her argument against psychiatric expansionism is subtle and carefully documented but the essence of her criticism is that "stripped of its thin disguise, the expansionist school is, in effect, simply identifying mental health with the moral or cultural ideas of its proponents. The implicit judgments are moral, not medical, and those who make these judgements lay themselves open to the charge that they are trying to steal the prestige of medical science for the benefit of their personal, moral or social predilections." The danger of this viewpoint resides in its erosion of the traditional distinction between the physician's ethical obligation to his patient on the one hand rather than to himself, to other individuals or to the state on the other. A personal concern with social issues, as David Mechanic has stressed, does not qualify the psychiatrist to take the best, or even a useful, role in their elimination: "as long as the psychiatrist practices his craft, he inevitably approaches the problem from the viewpoint of changing the patient rather than changing the society. This contradiction has led some psychiatrists to reject traditional psychiatric roles and instead to direct themselves towards changing society itself. These new efforts are characterised as

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preventive psychiatry. But many psychiatrists have over-reacted to their professional dilemma. In conceptually moving from the individual to the society they have argued that mental illness in general is a product of social forces and social structure and that the psychiatrist must concern himself with the community. This position will expand very widely the horizons of psychiatric work and the scope of psychiatric activity and places the psychiatrist in the political arena." [29]

The extension of psychiatry into the wider arena of public life also brings the physician into a rather undignified confrontation with those various members of the body politic who have always had a traditional interest in such matters. The wizards or 'cunning men' of mediaeval England, no less than their contemporary counterparts, purveyed their own brand of hope and salvation and claimed to improve the lot of ordinary citizens who, beset with the worries of everyday life, crossed the boundaries of distress to develop what we now regard as neurotic or behaviour disorders. No doubt they would have felt themselves, *mutatis mutandis*, well-qualified to discuss such papers as those presented at the Seventh International Congress on Mental Health on "Psychological Factors in War," "Contraception in the University," "Human Relations in the Education of Architects" and "The Knowledgeable Young" or at the recent meeting of the American Ontoanalytic Association, on "The Life and Death of Tchaikowsky," "Black Rage," "The Meaning of Rebellion" and "Why are Things Changing so Fast and What's Going to Happen to Us?". They may well have applauded the "spiritual freedom award for 1970" to an American professor of psychiatry at the 20th anniversary celebration of Dianetics and Scientology as a precursor of things to come.

Such considerations need not, of course, disqualify the psychiatrist from taking an active interest in many of the urgent contemporary social issues by which he is confronted in his daily work. Indeed, they can hardly be avoided if he accepts the view of the subject summarised by perhaps its most thoughtful contemporary representative as "the study of abnormal behaviour from the medical standpoint, irrespective of whether it arises wholly or partly from physical disease, environmental stress, disturbed upbringing, inherited abnormality or cultural circumstances." What is needed, however, is to divest the concept of

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mental health of its ethical and political content, as has been stressed by several writers and is central to the argument advanced by Sir Aubrey Lewis against the view of health as a social concept. As he points out, "...the criterion of health is adequate performance of functions, physiological and psychological... Though our estimate of the efficiency with which functions work must take account of the social environment which supplies stimuli and satisfies needs, the criteria of health are not primarily social: it is misconceived to equate ill-health with social deviation or maladjustment." [30] And not only misconceived, but potentially dangerous. We have had too many recent examples illustrating the truth of Emily Dickinson's disturbing lines:

> "Much madness is divinest sense
> To a discerning eye;
> Much sense the starkest madness.
> 'Tis the majority
> In this, as all, prevails.
> Assent and you are sane:
> Demur—you're straightway dangerous,
> And handled with a chain."

The importance of this view has been underlined by the expanding social role assumed by psychiatrists in the post-war period. Their pretensions are well illustrated by a recent editorial in the *American Journal of Psychiatry* entitled "The Psychiatrist's Role in Dealing with Social Turmoil" which defines the goal as "...to assist individuals, groups and local organisations to achieve competence, thus helping them develop the ability to command events that affect their lives." [31] In view of the very limited gains in established knowledge, however, it might be more rewarding, as it is assuredly more realistic, to accept Professor Rothman's verdict that "...unless our philosophy of science becomes more critical, experimental, more deductive and inventive, we will remain in the Renaissance period of medical history awaiting a Harvey to catapult us into the seventeenth century." [32]

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