Chapter 2

The International Context

Edward Shorter

Introduction

There is a distinctive British tradition of psychiatry that goes back to the earliest days embodied in such institutions as the York Retreat. What is the definition of 'insanity'?, asked James Sims in 1799. It is, he said, 'the thinking, and therefore speaking and acting differently from the bulk of mankind, where that difference does not arise from superior knowledge, ignorance, or prejudice'.[1] It is a definition that has never been surpassed.

The late 1950s and early 1960s were a period of dynamic change in British psychiatry. The Mental Health Act in 1959 saw a vast expansion of outpatient care and made it possible for clinicians to admit patients without the intervention of the magistrate. Eliot Slater, editor-in-chief of the *British Journal of Psychiatry* and head psychiatrist at the National Hospital at Queen Square London, said in 1963, 'Rehabilitation and new treatments are already reducing the bed numbers throughout the country, allowing many of the old "asylums" built in the last century to close within the next 10 to 15 years.'[2]

Michael Shepherd stated in 1965, 'The term "social psychiatry" has come to designate a distinctly British contribution, much as "psychodynamic psychiatry" has characterized American thinking.' Shepherd flagged such British innovations as the 'open-door' system, the 'therapeutic community' and the emphasis on rehabilitation.[3]

Seen in international perspective, British psychiatry is best set against the American. This is the fundamental difference between American and British psychiatry: American psychiatry is for those who can afford it unless they receive forensic referrals. Maxwell Jones, instrumental in creating the 'therapeutic community', commented in 1963 after a guest stay at a mental hospital in Oregon, 'About 50 million people in the United States have no health insurance whatever, mostly because they cannot afford it.'[4] In Britain, psychiatry, of course, is funded by the state.

Equally crucial in the United States has been the evolution of psychopharmacology. In pharmacotherapeutics, the palette went from a supply of genuinely effective agents around 1960 to a limited handful of drugs around 2010 that are now either of disputed efficacy, such as the selective serotonin reuptake inhibitors (SSRIs) 'antidepressants', or toxic when used inappropriately or in children and the elderly, such as the so-called atypical antipsychotics (or second-generation antipsychotics (SGAs)). In diagnosis, US psychiatry went from an eclectic group of indications that had accumulated over the years to the 'consensus-based' system of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The result in the United States was that the psychiatry of 2010 was scientifically in a much more parlous state than in 1960.

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Travellers between the UK and the United States

In the mid-1970s, the American psychiatrist Jay Amsterdam, later head of the depression unit at the University of Pennsylvania, spent a year training at the Maudsley Hospital in London. He said, 'Back then, my Maudsley teachers called their diagnostic process a "phenomenological" approach, and rarely seemed to have difficulty distinguishing folks with true, melancholic, biological, cognitive, physical depression from other types of depression. In London, it all seemed so obvious and "Schneiderian" to me, it just seemed like the correct way to diagnose physical from mental disorders.' What a shock when he re-entered the world of psychoanalysis in the United States. 'It seemed so, well, undisciplined to me, compared to my days at the Maudsley!'[5]

Yet the traffic went both ways. In 1955–6, Michael Shepherd, a senior psychiatrist at the Maudsley Hospital, spent a year travelling across the United States. He was overcome by the differences from British psychiatry. The American world lived and breathed psychoanalysis. 'In the U.S.A. a remarkable attempt has been made in many centres to inject the whole system, python-like, into the body of academic opinion.' By contrast, 'In Great Britain psychoanalysis has been in contact with, rather than part of, academic psychiatry; its concepts have been transmitted through a semi-permeable membrane of critical examination and testing, and the rate of absorption has been slow.'[6] This was a gracious way of putting the substantial rejection of psychoanalysis on the part of British psychiatry. Medical historian Roy Porter concluded, 'The British medical community as a whole long remained extremely guarded towards psychoanalysis.'[7]

David Goldberg contrasted in 1980 typical hospital visits to a psychiatrist in Britain and the United States. In the latter, 'He will wait for his interview in a comfortably furnished waiting area usually complete with armchairs, fitted carpets, and luxurious potted plants. He will be interviewed by an unhurried psychiatrist who will be sitting in an office which looks as little like a hospital clinic as he can make it.' Eighty-six per cent of such patients will receive psychotherapy, drugs are prescribed in only 25 per cent. In Britain, by contrast, the patient will be interviewed in an office 'which looks most decidedly like a hospital clinic. He is relatively more likely to be physically examined and then to have blood tests and X-rays.' About 70 per cent of British psychiatry patients will receive drugs.[8]

In retrospect, it is hard for British clinicians to imagine the hold which psychoanalysis once exercised on US psychiatry. The psychoanalyst, or 'my shrink', became the standard go-to figure for any mental issue. The parents of Jason, age eight, feared that he might be gay and took him to the 'psychoanalyst', where he remained in treatment for his purported homosexuality for four years.[9] These were all private practitioners.

Shepherd noted with wonder the large amounts of funding available to psychiatric research in the United States. Yet the National Institute of Mental Health (NIMH) had barely opened its doors, and shortly enormous amounts of money would start sloshing across academic psychiatry in the United States. British psychiatrists comforted themselves with their beggar's pittance. Aubrey Lewis said, 'To buy a little piece of apparatus costing £5 was a matter which one had to discuss at length and go to the highest authority in order to get approval.'[10]

Finally, Shepherd found curious the American fixation upon 'mental health', which seemed more a hygienic than a medical concept. The British, at that point, felt more comfortable with the notion of mental pathology than mental health, and even though

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Aubrey Lewis preached the ethics and sociology of social and community psychiatry, in Britain the study of psychopathology had a high priority.[11]

Jumping ahead fifty years, in understanding 'the British mental health services at the beginning of the twenty-first century', certain perspectives have been lacking: 'The scope and rapidity of change has left many developments in social policy, legislation, medico-legal practice, service design, service delivery and clinical practice without systematic historical analysis.'[12] In studying the history of psychiatry in Britain from 1960 to 2010, a most interesting question is, to what extent did the British escape the American disaster?

Diagnosis

At the beginning of the period, there were striking international differences in diagnosis. As Swiss psychiatrist Henri Ellenberger noted in 1955,

> The English call almost any kind of emotional trouble 'neurosis'. The French apply the diagnosis of feeble-mindedness very liberally; in Switzerland we demand much more serious proof before using it ... Child schizophrenia is a rare diagnosis in Europe, but a rather frequent one in America; Americans diagnose schizophrenia in almost all those cases of children whom we would call 'pseudo-debiles'.[13]

Yet as early as the 1960s, psychiatry in Britain was alive with innovative thinking about diagnosis. There were a number of systems in play, and in 1959 émigré psychiatrist Erwin Stengel in Sheffield classified them.[14] It was a *mise au point* of the richness of the international offering. Michael Shepherd led efforts to foster an 'experimental approach to psychiatric diagnosis'. The Ministry of Health published in 1968 a 'glossary of mental disorders' that presented in concrete terms the nosology of the eighth edition of the *International Classification of Diseases* by the World Health Organization (WHO) (which made it apparent how inadequate the diagnoses of DSM-II were).[15]

This innovation came to an end with the American Psychiatric Association's publication of the third edition in 1980 of the DSM, which erected gigantic monolithic diagnoses such as 'major depression' and, in later editions, 'bipolar disorder', while retaining the hoary age-old 'schizophrenia'. The Americans soon came to dominate the world diagnostic scene with DSM-III. This represented an extraordinary demonstration of the prescriptive power of American psychiatry: that a consensus-based (not a science-based) nosology such as DSM could have triumphed over all these other systems.

There has always been an academic tradition in England of distrust of abstract diagnostic concepts, such as manic depression, in favour of the clinically concrete. This would be in contrast to the Americans' initial fixation on psychoanalysis, which they then re-exported back to Europe. Following the psychoanalysis vogue came the wholesale US plunge into psychopharmacology. The British were resistant to both these trends. In 1964, E. Beresford Davies, in Cambridge, urged colleagues to switch out disease thinking in favour of just noting symptoms and their response.[16]

Cautiousness in the face of novelty can spill over into a stubborn resistance to innovation. Catatonia, for example, has for decades ceased to be considered a subtype of schizophrenia;[17] but not in the Maudsley Prescribing Guidelines, the 2016 issue of which continues to include catatonia in the chapter on schizophrenia. Melancholia, a diagnosis that goes back to the ancients and has experienced a recent revival, is not even mentioned in the index.[18]

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Other distinctively British approaches have also battled to preserve themselves. One was, in contrast to the DSM tendency to treat the clinical picture as the diagnosis, a British reluctance to leap directly from current presentation to diagnostic determination. As Felix Brown, a child psychiatrist in London, pointed out in 1965, 'I have seen many patients who have given an early history of neurosis and they have appeared twenty years later with a really severe depression.' Syndromes, he said, were valuable: 'But I do not believe that they necessarily represent disease entities, especially as the syndromes vary at different times in the lives of the patients.'[19]

Epidemiology

Lest it be thought that Great Britain was limping along behind some mighty US powerhouse, there were areas where the US NIMH squandered hundreds of millions of dollars, such as the very modestly helpful at best trials of SSRI 'antidepressants' in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. In contrast, at the same time, on much smaller amounts of funding, British investigators made significant progress in areas that mattered in patient care, such as the amount of psychiatric morbidity in general practice. In 1970, David Goldberg and Barry Blackwell assessed with the General Health Questionnaire some 553 consecutive attenders in a general practitioner's surgery. They found that 20 per cent of these patients had previously undiagnosed psychiatric morbidity. This study became an international epidemiological landmark.[20]

Goldberg was among Britain's leading psychiatric epidemiologists; but here, there was a deep bench. Myrna Weisman, a social worker turned leading US psychiatric epidemiologist, commented from her ringside seat, 'The UK led in psychiatric epidemiology. In America we didn't think you could make diagnoses in the community . . . The leaders in the field were all English. There was John Wing, who developed the Present State Examination, Norman Kreitman and Michael Shepherd. These were giants in the field.'[21]

Therapeutics

At a certain point, the therapeutics baton is passed from the UK and France to the United States. In the 1960s and 1970s, the Americans were still enmeshed in psychoanalysis and the English had more or less free run internationally. Malcolm Lader, a psychopharmacologist at the Institute of Psychiatry said, 'The United States was not interested in drugs. I was lucky, we had almost a 30-year clear run in the 1960s and 1970s when the Americans were not doing much psychopharmacology. It was only then that they finally gave up their flirtation with psychoanalysis and moved into psychopharmacology, and of course with their resources they've swamped the subject.'[22]

There is one other area of psychopharmacology where there seem to be, alas, few international differences and that is the influence of the pharmaceutical industry over education and practice in psychiatry (see also Chapter 17). One would not be far afield in speaking of the 'invasion' of psychiatry by Pharma, given the companies' influence over Continuing Medical Education and over 'satellite' sessions at academic meetings. Joanna Moncrieff deplored industry's influence on both sides of the Atlantic, on the grounds that it led to over-biologizing psychiatric theory and over-prescribing psychotropic drugs. Moncrieff concluded, not unjustly, that 'Psychiatric practice is now firmly centred around drug treatment, and millions of other people, who have no contact with a psychiatrist, are receiving psychotropic drugs in general practice.'[23]

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Yet in terms of the classes of psychotropic medications prescribed, there are international differences, and there have been major changes over the fifty-year period. The conservatism of British clinicians with regard to new diagnoses extended towards new medications. In contrast to Germany, where prescriptions of new drugs in 1990 amounted to 29 per cent of total prescriptions, it was in the UK about 5 per cent (down from 10 per cent in 1975).[24] (Yet English clinicians were not actually shy about prescribing psychotropic medication; as one observer noted, 'In 1971, in order to make patients feel happy, keep calm, sleep or slim, about 3,000,000,000 tablets or capsules of psychotropic drugs were prescribed by general practitioners in England and Wales.')[25]

In the central nervous system (CNS) area, there was once quite a bit of divergence between the UK and the United States. In the years 1970–88, only 39.4 per cent of drugs were introduced in both countries, one of the lowest overlap figures for any therapeutic class.[26] Later, this divergence narrowed as the pharmaceutical industry became more international.

Successive Mental Health Acts of 1983 and 2007 in England largely addressed psychiatry's custodial and coercive functions and will not be considered here, except that the 2007 Act stipulated that electroconvulsive therapy (ECT) must not be administered to patients who had the capacity to refuse to consent to it, unless it is required as an emergency. This continued the stigmatisation of convulsive therapy that has governed British psychiatry over the years: when you must *not* use it. In contrast, in the United States, ECT legislation, if any, is decreed at the state level, and here the tendency has been towards a growing acceptance of ECT as the most powerful treatment that psychiatry has on offer. A NICE Guidance in 2003 begrudgingly consented that ECT might be useful in certain circumstances (after 'all other alternatives had been exhausted'), but its use must not be increased above current levels (imposing a ceiling on it, in other words). Of maintenance ECT there was to be no question.[27] (An update in 2009 moderated only slightly this forbidding approach.) These recommendations contravened international trends in this area.[28]

Research

Before the Second World War, with the exception of the psychiatry unit at the National Hospital in Queen Square and perhaps the Maudsley, there was virtually no psychiatric research in England. Even at the Maudsley, Aubrey Lewis, who declared a pronounced interest in social rehabilitation, kept aloof from drug research. The phrase 'Maudsley psychiatry' meant social psychiatry, epidemiology and statistical methods.[29] It did not refer to a special approach to clinical care or pharmacotherapeutics.[30]

The first real step forward in psychiatric research originated after Eliot Slater's arrival in 1931 at Queen Square. There he was soon joined by several eminent émigré German psychiatrists of international reputations. Otherwise there was silence on the British psychiatric research. (However fabulous Aubrey Lewis might have been as a teacher at the Maudsley, he was not a researcher, and his famous paper on the unitary nature of depression got the story exactly wrong.)[31]

The basic medical sciences were, however, another story, and the history of British psychopharmacology must be seen in the context of a long history of interest in neurophysiology at Oxford and Cambridge. The work of Charles Sherrington, Richard Adrian and Henry Dale attracted worldwide attention. Derek Richter discovered monoamine

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oxidase at Cambridge, and John Gaddum at Edinburgh thought that serotonin might play a role in mood regulation.[32]

The big British leaps in this area were achieved at Oxford and Cambridge but also at the established 'red-brick' universities in Birmingham, Manchester and Liverpool as well as at London. In 1954, Charmian Elkes and Joel Elkes in Birmingham at the Department of Experimental Psychiatry – the world's earliest dedicated laboratory for research in psychopharmacology – reported the first randomly controlled trial for chlorpromazine.[33] In 1970, Hannah Steinberg became Professor of Psychopharmacology at University College London, the first woman in the world to occupy such a chair. She pioneered research on the effect of drug combinations on the second-messenger system in the brain.[34] The work of Malcolm Lader at the Institute of Psychiatry, Martin Roth at Newcastle upon Tyne and Eugene Paykel as Professor of Psychiatry at Cambridge, helped lay the foundations of clinical psychopharmacology. The efforts of Alec Coppen, Max Hamilton and others led to the foundation of the British Association for Psychopharmacology in 1974.

In sum, British contributions to drug discovery and development in CNS were immense. As a joint government–industry task force reported in 2001, 'Companies based here maintain a significant presence in all the major markets in the world and the UK has consistently "punched well above its weight" since the 1940s . . . In terms of overall competitiveness, the UK is second only to the US and well ahead of its main European competitors.'[35]

Deinstitutionalisation and Community Care

Among the most dramatic international differences is that, in Britain, services were transferred from the asylum to local hospitals and, in the United States, from the asylum to the prison system (see also Chapters 1, 23, 30).

In Britain, the locus of care was shifting from the old mental hospital 'bins' to general hospitals. This process began before the Second World War as the Maudsley set up clinics in three big London hospitals.[36] It continued with the District General Hospitals created by Enoch Powell's 'Hospital Plan' in 1962. No longer mere waystations before the transfer to the asylum, the general hospital departments provided comprehensive care. An early innovator here in the 1960s was the Queen's Park Hospital in Blackburn a borough in Lancashire. Its 100 beds were divided into three sections: emergency, ambulatory-chronic and acute. The acute section was divided between male and female. All sections were 'open' and the hospital provided lunch for the emergency and ambulant-chronic patients. Maurice Silverman, the consultant psychiatrist, noted with some pride in 1961, 'This has been largely due to the pioneering work of the Regional Hospital Board in forging ahead with comprehensive psychiatric units in general hospital centres throughout the region.'[37] In contrast to Britain, in the United States 'The overall proportion of the population with mental disorders in correctional facilities and hospitals together is about the same as 50 years ago. Then, however, 75% of that population were in mental hospitals and 25% incarcerated; now, it is 5% in mental hospitals and 95% incarcerated'.[38]

The Psychiatrist of the Past versus the Psychiatrist of the Future

It is training that stamps the clinician's whole mindset, and here the change in training objectives has been dramatic and resulting UK/US differences wide.

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A UK survey in the mid-1960s established the teachers' principal learning objectives for their students: 'scientific attitude regarding behavior', 'factual knowledge about psychiatric illnesses' and 'treatment skills'. For example, within the category of scientific study of behaviour, the lecturers were asked to rank various attainments. 'Students must be taught psychopharmacology and neurophysiology as an essential part of their psychiatric training' was number one; systematic history-taking and 'methodical examination of the mental state' was number two; and learning the 'importance of diagnosis and systematic classification for effective practice of psychological medicine' was number three.[39]

Now, no training programme would ever ignore any of these objectives, but we see how the goals sought for trainees have changed today. In 2008, one observer at the Institute of Psychiatry listed the attributes of the future psychiatrist.[40] It was a list that would have made Aubrey Lewis, the earlier professor and himself an advocate of community care, blink:

'Working in partnership' – this was long thought to have been self-understood.

'Respecting diversity' – diversity was a newcomer to the list.

'Challenging inequality' – this gave psychiatry a decided political spin.

'Providing patient-centred care' – Aubrey Lewis, rightly or wrongly, believed that he and his colleagues at the Maudsley offered such care, in that competent treatment in the community was inevitably 'patient-centred'; yet it was the physician's intuitive sense of ethics, values and professional responsibility that decided what was patient-centred, not a climate of opinion that demanded it.

On the other side of the coin, we have surveys of the reasons students *don't* chose psychiatry. One survey of the literature concluded, 'The major factors that appeared to dissuade medical students/trainees from pursuing psychiatry as a career included: an apparent lack of scientific basis of psychiatry and work not being clinical enough, perception that psychiatry is more concerned about social issues.'[41] In Aubrey Lewis's generation there were complaints that psychiatry was *too medical*, with its insistence on seeing illness as brain disease (treatable with electroshock, phenothiazines and tricyclic antidepressants); in the current generation, there are complaints that psychiatry is *not medical enough*, with views of the field as an extended arm of social work.

In the 1960s, the term 'diversity' was as yet on no one's lips, but concern was already stirring about the low number of women in psychiatric training. One tabulation showed the percentage of female trainees as low as zero in the Welsh National School of Medicine, 0.3 per cent in St Thomas's Hospital and 0.4 at Leeds. (The maximum was 2 per cent at Bristol.)[42]

The putative deterioration in NHS services and decline in psychiatric care became a major theme. Brian Cooper wrote in 2010, 'British psychiatry, it appears, flourished as long as the NHS remained secure and in good hands, but then, despite ongoing scientific progress, it has gone into decline since the national service infrastructure began to disintegrate under sustained political pressures.'[43]

Interestingly, US training has developed in a quite different direction. Rather than emphasising a progressive agenda, as in Britain, the accent in the United States has been on 'professionalism', not necessarily as a humanitarian objective but as a defensive posture. Several observers at Emory University wrote in 2009, 'Most medical educators would agree that learning how to deliver care in a professional manner is as necessary as learning the core scientific data'. Here, the themes of diversity, equality and partnership are completely

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absent, although, if queried, the authors might have agreed to the importance of these as well. What was really on their minds, however, was that 'Patient complaints, malpractice lawsuits, and media stories that depict the inequity and high costs in the U.S. health care system' are the real agenda.[44]

Conclusion

Roy Porter noted that, 'Deep irony attends the development of psychiatry within twentieth-century British society. The public became more receptive towards the fields of psychiatry and psychology.' The asylum was dismantled; new modes of care more congenial to 'service-users' were conceived. 'Yet the longer-term consequence', continued Porter, 'has not been growing acclaim, but a resurgence of suspicion.'[45] The challenge of the future will be demonstrating that psychiatry really is capable of making a difference in people's lives.

Key Summary Points

- British psychiatry is almost entirely publicly funded; in the United States, a tradition of well-remunerated private practice has prevailed.
- Despite similar therapeutics and nosology, psychiatry in Britain and the United States has developed in strikingly different ways.
- Psychoanalysis once dominated US psychiatry; in a big swing of the pendulum, it has been almost entirely replaced by psychopharmacology.
- In Britain, the research tradition in the past was weak; in the United States, it has been fuelled by large amounts of government funding. A British hesitancy about embracing large abstract theories has no US counterpart.
- In terms of training, a progressive agenda has been emphasised in Britain, more defensive postures in the United States.

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