Right of reply

Richard Fox
talking to John Payne

Controversy surrounding methods of treatment in psychiatry—centred on R. D. Laing's theories on 'schizophrenia' which have had such a popular appeal—is well illustrated in the film *'Family life'*. But the mass media seems to be polarising psychiatrists artificially, yet the silent majority of the profession persists in remaining silent.

Question Would you agree that the 'Laingian' concept of psychiatry has effectively captured the imagination of the media? It's good 'meat' for dramatic material – whereas so-called 'conventional' psychiatry isn't really putting its case about why it treats people the way it does.

R.F. I think this is true, for two reasons. Firstly, I find the nature of television is that you get a good programme by producing a conflict. There are political reasons for this too; you can't have a Panorama programme, say, putting only the conservative point of view. But it's good interviewing if you can produce a tension situation so that you have (a) countered by anti (a), and (b) countered by anti (b), with a good old studio punch-up. The whole of television thinking tends to be built around this concept.

Secondly, in psychiatry, the extremes are represented by men who go down well on television, one extreme being Dr. William Sargant who, I felt, was very much the model for the second psychiatrist in 'Family Life' – they even looked the same. I know, and like, Sargant, and hope we think no less well of each other as the result of disagreeing about some things – I think his contribution, in terms of better use of physical treatments, has been invaluable. The other extreme is represented by Laing, Cooper and Esterson, who seem, on the whole, less flexible than the 'physical treatment' exponents, less willing to discuss things in an open rational way and admit that they may be wrong.

They seem to rely much more on the smart catch phrase, like a remark I heard Laing make years ago, 'If the patient is disturbed you prescribe a tranquiliser – and give it to the nurse'. This is clever, it makes people laugh, it makes people sit up – but is it in fact *fair*? So much Laingian psychiatry relies on this type of clever polemic which is what it is, it's not science, it's not objective and it makes me angry.

When you have a school of opinion that exists so much in terms of reviling its opponents, which it does, I've heard some people be very abusive privately and publicly towards those who do not share their views – it's good material for controversy. Now these psychiatrists, it seems, have captured the imagination of the mass media, and, inevitably, whenever anything psychiatric comes up, the producers and so on tend to seize upon these two extremes and try to set them in opposition.

It is not easy to make a fascinating television programme out of good, middle-of-the-road psychiatry. They tried it with a programme on schizophrenia a few years ago and although everyone tried hard, it came over to me as rather dull.

Question It would be fair to say of conventional psychiatry wouldn't it, that most psychiatrists use something of both 'schools' and combine the physical and psycho-therapeutic techniques?

R.F. Sure. I don't see that one can conceivably treat a person in complete isolation from his social background, even if he has got the most organic of physical diseases, because the physical disease will interact with his background and his background may exacerbate it or help it; you've got to take social measures to alleviate the results of his disability. But because one takes this social (or psychological) view in terms of trying to understand the person in the setting of his personality and whole life experience, one doesn't necessarily have to be Laingian; one could perfectly well be Adlerian or Jungian or Uncle Tom Cobley-and-all-ian and do the patient good.

To say that we're all of us Laingians *a little bit* I'm not sure follows, but I reckon 99% of psychiatrists are eclectic. We treat our psychotic depressives with ECT, we treat neurotics and personality disorders as best we can with whatever psychological methods we have time for – with drugs as an ancillary maybe. I doubt if more than 1% or so of psychiatrists never use drugs to treat their patients at all and any general psychiatrist who does this would, I think, be failing in his duty to his patients. It would be bad psychiatry.

Question Presumably Laing wasn't the first person to be aware of the importance of family background and social pressures on the individual. It's almost as though he developed a philosophy which came as a blinding revelation and radically changed the way in which people thought about treating mental illness; wasn't this always the case for the good, industrious psychiatrist?

R.F. Oh yes. He has gone farther than the conventional 'couch' psychoanalysts who used to represent the extreme one side of the argument. Laing has taken psychotherapy off the couch and into the family situation and tried to see the disorder much more in terms of family interactions than in a one-to-one therapeutic situation with its transference and counter transference. This is a very important development, but it's not confined to Laing. Howells has been doing this for years in Ipswich and so have lots of others.

Question Why then are 'conventional psychiatrists' so loath to put their case?

R.F. This puzzles me because there are people far better able than I to quote the sort of data which suggests very strongly that Laing's theories of schizophrenia are beside the point.

In the Mental Health Research Fund Lecture some years ago, Professor Devereux demonstrated pretty clearly that the patterns of communication in families where one member was schizophrenic were distorted. This was done carefully, scientifically and objectively. The other non-schizophrenic members (so called) did show evidence of schizophrenic thought disorder – concreteness, loosening of associations, ambiguities and all the rest. But he accepted that schizophrenia was basically a genetic disorder.

In another important American study, they followed up children with one parent who was schizophrenic but who had been adopted and reared in a family where there was no schizophrenia; they found exactly the same existence of schizophrenia (14%) in those children compared with children brought up with their schizophrenic parent. This was very carefully done and it seems to knock the whole Laingian hypothesis right on the head. The psychotherapists, it seems to me, have a long history of making families – especially mothers – feel guilty about things for no good reason. Hooray for the Schizophrenia Association!

This is not to say that factors in a family with a psychotic child may not make the psychosis worse or better, which is why very often in disturbed families one has to get the patient out and into a halfway hostel or other communal home.

Question In the context of 'Family Life', was the treatment that girl got, reasonably accurately portrayed? It has been suggested that not enough diagnostic work was done before treatment began.

R.F. Well – they were telling a long story in a short time and I think managed to get a tremendous amount across with implications and hints. If they had shown a full diagnostic interview, from the 'Tell me about your father' stage, it would have taken the whole of the film time. One has to take a lot on trust. The way the first analytic psychiatrist approached the parents in terms of trying to understand relationships, I thought rang very true, though the psychiatrist I went with, also eclectic, was unconvinced.

I thought that the older psychiatrist, the Sargant figure, came over as quite a kindly, well-intentioned man, but my colleague saw him as malignant and thought he had been deliberately portrayed like that by the film director, so these judgements are very subjective. The nurses, I thought, were clearly intended to appear as kindly authoritarian figures although not very empathic, not in the way that the first psychiatrist was. What I thought was totally unreal about the physical treatment situation, was the exclusion of social background – the fact that we never see the G.P. or a social worker. It's as if the girl lived two completely different lives – a hospital life where she has physical treatment and a home life where she becomes disturbed. The relationship between the hospital and home seemed far more divided than it would be in practice in, again, 99% of cases – I hope.

Question Do you think that what was portrayed in the film is liable to make people even more reluctant to seek psychiatric treatment?

R.F. Very. I have had this already. A man I saw in the out-patients last week had been studying depression because his wife was so clearly suffering from it and was thoroughly put off by the ECT sequence. *For a doctor or nurse* this was a low key sequence – seeing a tooth pulled is much more horrific than what was shown there – but it was enough to put an inexperienced layman right off and I think this was anti-social.

Question Would it be common practice to give someone with Janice's symptoms ECT?

R.F. Yes. Quite common.

Question It would. On what basis?

R.F. Practice varies in this. Mine is to start off with just hospital environment, hospital rehabilitation and phenothiazines, and if we don't seem to be making much progress then ECT will often, as it were, 'jerk' the mental mechanism back on the rails again.

Some doctors use it more readily than others. It depends on the acuteness of the disturbance too; ECT acts quickly and you want to get the sickest patients better fast as a kindness to them, their relatives and the nurses.

Question Is it used as a way of speeding up treatment? Given the ideal situation, the sufficiently small caseload and all the ancillary services would you use it less?

R.F. I suppose honestly one is bound to say yes. With one-to-one nursing and that kind of thing one probably would need to use it less.

Question Talking about the practicalities of treatment for a moment – in the therapeutic community unit very little seemed to be happening, an impression you often get going into these units; is there any reason to think that a person like Janice would ultimately finish off feeling 'better', having worked out all her conflicts and family problems in that unit without any drug treatment?

R.F. There is a lot of doubt really, as to how far this therapy is relevant for schizophrenia. If it is, then I reckon it is only so for a minority. In Shenley where David Cooper had his Villa 21, on which I think the first part of the film was modelled, there was some doubt as to whether the cases in the Villa really should be classified as schizophrenic, or whether they were pseudo-psychotic hysterics or whatever.

But in all fairness, we did see a pretty lively group meeting and a number of individual interviews. We also saw a patient lying in bed all day because he wanted to. I'm not sure that it is a particularly good thing to foster regressive behaviour in a basically regressive illness – which is what the conventional mental hospital used to do, of course, and which is what a totally unstructured therapeutic environment could also do.

Question Given the practicalities of the situation, ignoring the Utopian situation, what are the priorities? Is it important, as it seemed in the film, to have a good through-put, to get people out and functioning, or is it better to keep them in hospital as long as you need to to get the diagnosis absolutely right?

R.F. The diagnosis doesn't often present that much of a problem – there are cases where it does and where you would like to 'do a Maudsley' and observe the course of the illness over a matter of weeks before instituting any therapy but practicalities demand that you make the diagnosis and get on with it and get people better and out. This is not my research area but many people feel that the quicker you get a person with a schizophrenic illness better by whatever means – ECT included – the better the outlook, and the longer you let the process meander on, the worse the outlook; I think that is probably true.

And don't forget the results of a conventional approach are not half-bad; several studies have shown that four patients out of five are out and working two years after admission with schizophrenia.

Question And this, in practical terms, is more important than this constant digging to find out why? I mean the Laingian response to those figures would be 'Yes but you're just suppressing the symptoms' – wouldn't it?

R.F. Maybe, but at least we are not making them worse. I have participated in family therapy of this approach with a typical schizophrenic girl – very regressed and disordered in thought – who had to explore with her elderly and rather rigid father, their incest feelings for each other. This seemed more than irrelevant – I thought it was cruel and it wasn't doing her any good at all. I thought it made things worse.

Question How can conventional psychiatry brush up its image? It's not exactly tarnished it's just getting superceded isn't it?

R.F. Yes, you're right. I don't know, I would hope that more of my colleagues – who I know take the eclectic view – will have the courage of their convictions and their practice to speak up. I hope that this interview will be read by people in the mass media who will take note.

Question A course of conventional treatment, as you say, is a fairly dull procedure. It hasn't got this dramatic content which Laingian concepts seem to provide on film or television.

R.F. It's the antecedents of the illness, the events leading up to the hospital admission, where the drama really is. Any psychiatrist could describe a dozen case histories out of his head where the implications for the family were very devastating, where the behaviour had been bizarre and extremely cinematographic as it were. But once they get into hospital and start getting better it all gets rather dull, as you say.

Question If Janice had been a patient in your hospital wouldn't there have been social work going on with the parents and liaison with the local authority?

R.F. Definitely!

Question Before she went into hospital the first time presumably she had been seen by a GP and there would have been some kind of follow-up after she went home?

R.F. The urgency wasn't awfully clear. There wasn't much urgency about that first admission – when she went into the therapeutic community unit – so, under those circumstances, one would have had a home visit and home assessment. But if somebody is found praying naked in the rain then, obviously, any kind of family exploration comes later.

Question So do you think that psychiatrists have really got to start 'banging their drums' a bit at least,

or putting the other case to the well-documented Esterson-Cooper-Laing-point of view?

R.F. I'm developing the feeling that we are seeing too much psychiatry on television. I think the pendulum has swung too far from it being a taboo subject never to be talked about, to the point where there is too much of it. I can see the point of view of publicists who want more money for psychiatric hospitals and services generally, because if you want money you've got to put your case to the public so that the public will pressurise the politicians which seems the only way that you can get *anything* done. Let's face it, public disclosure and mass media scandals like Farleigh and Ely have forced the Department of Health to invest massively in the Health Services and thank goodness.

Having said that, I don't particularly want the middle-of-the-roaders to bang their drum but what the mass media are doing in polarizing us, artificially maybe, *obliges* us to bang it. Maybe we have been too preoccupied with setting up the Royal College of Psychiatry to take all this seriously. Maybe when the Royal College is properly functioning and everybody knows what they're at then psychiatrists will take more interest in publicity and their public image. It doesn't help anybody to portray a false picture of the situation; it's the patient who will suffer in the end, and that's a pity.

Cared

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