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Ten books

Chosen by Linda Gask

Books educate us, shape our opinions, stir our emotions and provide us with solace and hope in hard times. I've carried books from place to place throughout my life. Books are my friends, no Kindle for me. I love the smooth dust cover, the firmness of the embossed spine and the smell of the paper inside a hardback. However, I do confess to committing the crime of turning down page corners and marking key paragraphs in pencil or even ink on the pages of my paperbacks. Choosing only ten is a peculiar form of torture.

Growing up

Our household had very few books, apart from the traditional set of encyclopaedias in the 'front room'. However, there were three shelves in my bedroom on which I kept those that I owned and a few dusty tomes, including Lewis Carroll's *Alice in Wonderland*, that I was allowed to choose from the collection of a deceased great uncle before his house was cleared. It was from the public library and the ever-present television that I learned about the rest of the world beyond the edge of Lincolnshire. At school we read the classic Victorian novelists and, with everyone else, I watched all the BBC dramatisations too.

I read *Middlemarch* by George Eliot[1] after seeing the 1968 adaptation (in black and white,) and I was both fascinated and horrified by the absurd degree of attention paid to social class and rank in a small provincial town. It caused so much unnecessary pain and misery. We follow the idealist Dorothea Brooke and Tertius Lydgate, an ambitious young doctor, as they struggle against these rigid social strictures to try to achieve some sense of meaning in their lives. It's a complex story of people facing moral and emotional dilemmas and, as the narrator says:

> 'if we had a keen vision and feeling of all ordinary human life, it would be like hearing the grass grow and the squirrel's heartbeat, and we should die of that roar which lies at the other side of silence' (Book 2, p. 351).

I borrowed that last phrase, 'the other side of silence', as the title of my memoir of being both a patient and a psychiatrist living with depression (and remember, when training as a psychiatrist, meeting someone who *could* hear the grass grow).

Middlemarch resonated not only with my sense of frustration in not being able to find my own way, but also with my increasing recognition of both my own painful emotions and those of others around me in another small provincial town. Writing in *The Times Literary Supplement* (of 20 November 1919) Virginia Woolf described it as 'one of the few English novels written for grown-up people', although I still doubt that I qualify as a 'grown-up' even now. I've always found fascination in complex life stories. Perhaps that's why I decided to become a psychiatrist.

Becoming a psychiatrist

At the interview for a training post in Manchester in January 1980 I was asked 'What have you been reading recently?' Deciding not to mention frequent glancing at the *Daily Record* (it memorably reported our case of tetanus apparently contracted in a dirty operating theatre as 'killer virus hits Scottish Hospital') I was at least able to talk about *Psychiatry in Dissent: Controversial Issues in Thought and Practice*, by Anthony Clare,[2] which I read during precious hours off-duty in my surgical house job. It provided a thorough overview of the state of British psychiatry in the late 1970s and was far more engaging than my undergraduate textbooks. At the time, psychiatry had been 'under fire from all angles' and Professor Clare's text both critiqued and defended contemporary psychiatric practice, not only robustly challenging the views of the 'anti-psychiatry' movement during the 1970s but also addressing controversial treatments such as electroconvulsive therapy (ECT) and psychosurgery. It helped me to understand what lay ahead of me.

Fish's Clinical Psychopathology in the 1974 edition revised by Max Hamilton[3] was a considerably drier text than Clare's book but was an essential companion in learning about the signs and symptoms of psychiatric disorder. I wish I could tell you that I read the English translation of Karl Jasper's *General Psychopathology* with the same fervour, but I didn't. I found it overwhelming. Frank Fish, the first Professor of Psychiatry at the University of Liverpool, had, with tremendous skill, brought together the key concepts of descriptive psychopathology into a small volume that could easily be carried around. The philosophical problems underlying psychological phenomena were only briefly addressed at the beginning of the book but expanded upon during lectures, discussions and further reading such as Hirsch & Shepherd's *Themes and Variations in European Psychiatry*.[4] My copy, underlined in pencil throughout, provided me with a mental framework for my learning as I listened to many, many patients describe their experiences to me.

Throughout the 1980s, moves to close the asylums and develop community services in their place continued in the face of constant pressure from Thatcher's government on National Health Service (NHS) finances. My bookshelf is evidence of my continuing fascination with some of psychiatry's critics, particularly R. D. Laing. However, it was when Peter Sedgwick came to speak in Manchester around 1982 to talk about his book *Psychopolitics*[5] that I began to understand how the alternatives proposed by various voices within anti-psychiatry, far from offering realistic alternatives to traditional public psychiatry, were failing to address the very real problem of how we could provide humane care for people with severe and enduring mental illness in our communities. Not only that. These voices, despite often being vociferously supported by those on the left of politics, were playing into the hands of the right-wing politicians who were keen not only to shift spending away from mental health, as the huge hospitals closed, but to slash NHS budgets altogether. Sedgwick's writing remains utterly relevant to the position we find ourselves today, as he exposes the conservative undercurrents in the thinking of popular 'critical' thinkers, particularly those aligned with Thomas Szasz.

A deeper understanding

Throughout the decade before I became a consultant psychiatrist, I received regular supervised training in psychodynamic psychotherapy and fully expected to become a medical psychotherapist. Although I didn't eventually choose this route, my time training in psychotherapy, during which I was also in therapy for my own mental health problems, greatly influenced my future practice. In *On Learning from the Patient*,[6] Patrick Casement showed how a dynamic understanding of the consultation informs and enriches our interactions with our patients and how much we must learn to really *listen* and learn from what the patient is saying. Rather than falling into 'thinking we know best' we should be working in

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collaboration. Ostensibly a book about formal psychotherapy practice, it's really about the skills necessary to work relationally in any setting, focusing on the technique not the theories. Indeed, Casement warns that 'when a therapist thinks he can see signs of what is familiar to him, he can become blind to what is different and strange' (p. 4). I know from my own therapy experiences how much our patients try to 'read' us, and Casement refreshingly talks about his 'internal supervision' process of trying to analyse what is happening from the patient's perspective, so learning from them what might be going awry in the therapeutic process.

Many of the patients I met during my career, or supervised others caring for, were experiencing complicated grief. The nature and impact of a loss is something I have spent many hours discussing with patients, from my time as a psychiatric trainee working with Peter Maguire in Manchester right through to when I was training and supervising counsellors during the COVID-19 pandemic, on returning to work to help set up a telephone bereavement support service. It's also something I understand personally – I suffered a delayed grief reaction following the death of my father. I've turned to J. William Worden's *Grief Counselling and Grief Therapy*[7] throughout my career, as Worden provides the most comprehensive text for helping to understand the nature of grief, the mourning process and how bereavement may be complicated. His straightforward description of the four tasks of mourning – accepting the reality of the loss, processing the pain of grief, adjusting to a world without the deceased and finding an enduring connection with the deceased amid embarking on a new life – is so useful in beginning to understand what a grieving person is struggling with. It's a much more practical approach than thinking in 'stages' of grief and just makes clinical and personal sense to me. Worden's book is thoughtful, comprehensive and informed both by his considerable clinical experience and by research. It's justifiably now in its fifth edition.

Prozac Nation by Elizabeth Wurtzel[8] wasn't at all well-received by the critics when it was published in 1994. However, I found this memoir of a chaotic young American woman's struggles quite compelling, not only because her emotional turmoil resonated more than a little with what I had faced in my own earlier life but also because several of my patients were so-called 'difficult' women who could so easily be labelled as having 'personality disorder' in addition to, or instead of, depression. As the psychotherapist Jonathan Shedler has so wisely commented,[9] how can depression really be separated out from the personality dynamics that fuel it, when working with people experiencing 'difficult to treat' depression? I particularly empathised with Wurtzel when she talked about wanting to find a therapist who could help her learn to be a grown-up and show her how to live in a world where the phone company didn't care that you were too depressed to pay the bill. In *Prozac Nation* she tells how she finally managed to find a psychiatrist who not only successfully engaged her but stayed with her and helped her move forwards in her life. I am so pleased that I had the opportunity to build relationships and work together over long periods with many patients and receive the gift of seeing their lives change for the better.

Some years after reading *Prozac Nation* I heard Elizabeth Wurtzel speak in Manchester. She was gracious enough to answer a question from the audience about whether she was still taking Prozac. She wasn't, but she said she was still on an antidepressant. Tragically, she died at the age of 52 from cancer.

A researcher and teacher

During my career as a clinical academic I researched, taught, wrote about and practised liaison psychiatry with primary care. I was fortunate that my PhD supervisor was the late Professor Sir David Goldberg and two books he co-authored more than 20 years apart have been incredibly useful to me.

The classic text *Mental Illness in the Community*, by David Goldberg & Peter Huxley,[10] first published in 1980, has, in retrospect, provided me with a mental framework for much of the research that I have carried out in my career. Goldberg & Huxley described the five ' levels' where people experiencing common mental health problems are situated, from living in the community, through to attending primary care, being treated for a mental disorder by their general practitioner (GP), under the care of mental health services in the community and out-patient clinics and finally admitted to hospital. Along this 'pathway to care' there are four filters to pass through: attending the doctor, having their mental disorder recognised, being referred to mental health services and getting admitted. Such models help us to understand the world, but they are fluid and change with time. Subsequent research in different countries over the next couple of decades demonstrated how 'pathways to care' differed across the world in various cultures and healthcare systems.

What I've come to realise during my career is how the five levels of the pathways model represent very different worlds in mental healthcare and the four filters between them are the points where people, patients, carers and professionals struggle to negotiate with each other about the requirements to pass through while speaking in languages or using concepts that they do not mutually understand. Psychiatrists often have little idea how different the culture in which they work is from a GP's practice in primary care, or from a voluntary agency or social enterprise in the community, unless they have spent time working in that setting during their training.

In 1992 Goldberg & Huxley revised their text to include a model for conceptualising mental disorders using the terminology 'vulnerability, destabilisation and restitution'.[11] Then in 2005, in *The Origins and Course of Common Mental Disorders*,[12] David Goldberg with Ian Goodyer went on to expand this model, incorporating the latest scientific knowledge, providing a concise account of what is known about the genesis of common mental health problems – not only 'internalising disorders' such as depression and anxiety but also 'externalising disorders' such as drug and alcohol problems and conduct disorders in childhood. They explore the genetic factors that lie behind both vulnerability and resilience and how life experience can increase or decrease vulnerability. All this is done in what Leon Eisenberg, in the foreword, describes as a 'remarkably lucid style'. Using a life cycle approach, the authors provide a coherent overview of the interactions between genes, biology and psychosocial factors, providing the basis for a truly biopsychosocial approach to care. It's an antidote to the reductionism that so frequently dominates discussion on social media, and I do wish it had reached a much wider audience on publication. It has helped me to conceptualise the nature of common mental health problems and mental illness in my research and clinical work.

Reflecting on the past

As the years have passed, I have become increasingly fascinated once more by the history of psychiatry and its role within society. Looking back at my own career both as a clinician and researcher working in the field of common mental disorders it's hardly surprising that I've spent so much time with women – as both patients and, during my time with a psychological therapy service in the community, as therapists – given that women experience anxiety and depression more frequently than men do. Lisa

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Appignanesi's *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present*,[13] is a superbly well-researched book. Beginning in 1796 with Mary Lamb, who killed her mother in a fit of insanity, the author takes us through the mental illness experienced by other notable women of the next two centuries, from Sabina Spielrein, Virginia Woolf, Zelda Fitzgerald and Sylvia Plath to Marilyn Monroe, and the mind doctors who treated them with varying degrees of success – not only men such as Freud, Jung and Weir Mitchell (he of the 'rest cure' prescribed almost exclusively for women) but also the women doctors and therapists, including Anna Freud, Melanie Klein and Susie Orbach. It's an extraordinarily ambitious book that asks important questions about why disorders such as hysteria, anorexia, multiple personality and even depression have been diagnosed more frequently in women than in men. However, in my opinion it falters a little towards the end. It's almost as though we have not yet reached sufficient distance from the early 21st century to look back and make sense of what lessons we can learn about the relationship between women and the mind doctors in our present era of medication, brief psychotherapy and 'evidence-based medicine'.

That is an unfinished story.

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