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Psychiatric stereotypes

Originally given as a Presidential Lecture, Belfast, July 1987) by the outgoing President (Thomas Bewley). It was not published and this online archive is a revised and shortened version of that lecture.

Psychiatrists are aware that people view them differently from other doctors. They may be seen as strange individuals, sometimes odd or figures of fun. They can be seen as repressive agents who incarcerate others for societies' good. They are also at times believed to have almost magical insights into the human soul or psyche. Finally it has been widely believed that they are preoccupied, if not obsessed, by sex. This appendix reviews the evidence that people have such beliefs, looks for the reasons for them and consider whether there are justifiable grounds for holding them.

There are not many quantified reports about the image of psychiatrists, but medical students have been surveyed both early and late in their medical training to obtain their views about doctors in different specialties. They see psychiatrists as differing from other members of the profession. Their views do not change over time, even after they have worked with psychiatrists as part of their training. They start with a view of psychiatrists that they have obtained elsewhere, and this view is not changed by experience. It may be reinforced by the views of doctors from other specialties who teach them. The 1986 Christmas Edition of the *British Medical Journal* had a paper (A.F. Furnham) outlining medical students' beliefs about nine different specialties. Some 450 students at three Medical Schools in London were asked to complete a questionnaire similar to one that had been used in Manchester (C.M. Harris) and

Oklahoma (Bruhn J.G. and Parsons O.A.). The students' views about psychiatrists were very clear. Psychiatrists and Surgeons came at opposite ends of a spectrum of ideas and beliefs about doctors. Over half of the 50 items in the questionnaire showed psychiatry at one extreme. Thus, compared with the other specialties, London students were of the opinion that:

‘Psychiatry had advanced least in recent years; psychiatrists were less stable than other doctors; psychiatry was the least expanding frontier in medicine; psychiatry had the lowest status in medicine; psychiatry was the most unscientific and imprecise specialty; psychiatry was more of a waste of a medical education; psychiatrists were fuzzy thinkers; psychiatry was unrewarding; psychiatrists were more concerned to establish rapport with their patients and psychiatrists talked a lot but did little; furthermore, the students thought that psychiatric treatment caused patients to worry too much; psychiatric facts were mere speculations; psychiatric treatment was basically fraudulent; few results were replicable; psychiatric theories were far removed from practice; research in psychiatry showed less patient improvement; psychiatrists tended to overconceptualise their patients' problems; psychiatry was more of an art than a science; psychiatric patients got better less often; there were too many doubts about psychiatry; psychiatrists were held in poor regard by other doctors; psychiatrists tended more to treat the whole patient; psychiatry was the least important area of medicine and psychiatric patients tended to make more emotional demands than other patients. Nevertheless, psychiatric patients' problems were particularly important and challenging; psychiatric patients were the most interesting and psychiatrists were less dogmatic than other doctors.’

SOURCE OF STEREOTYPES

Similar findings had been reported by Bruhn and Parsons from Oklahoma in 1964 and by Harris from Manchester in 1981. There was little change over time in views. Whether they were surveyed at the time they came into medical school or at the time they left made little difference. Stereotypes of a psychiatrist might be found in literature, drama, films, newspapers and humour. It is presumably from such sources that most people (including medical students), who have not had professional or personal contact with a psychiatrist, get their ideas. Professor Neil Kessel wrote an article in the *Lancet* called ‘Beknighted Psychiatrists’ describing three psychiatrists who in his view represented three of the stereotypes of members

of the profession. The first of these was Sir Roderick Glossop who, in the words of P.G.

Wodehouse,

‘toddles round, gives the patient the once-over, talks about over-excited nervous systems, and recommends complete rest and seclusion and all that sort of thing... I suppose that being in that position – I mean constantly having to sit on people’s heads while their nearest and dearest ‘phone to the asylum to send round the wagon – does tend to make a chappie take what you might call a warped view of humanity.’

Wodehouse describes Sir Roderick....

‘Having had so much to do with loonies has given him a rather sharp and authoritative manner on occasions ... There is something about the man that is calculated to strike terror into the stoutest heart ... His eyes go through you like a couple of Death Rays ... He has a head like the dome of St. Pauls and eyebrows that want bobbing or shingling to reduce them to anything like a reasonable size ... I suppose he must have taken about a nine or something in hats. Shows what a rotten thing it is to let your brain develop too much’.

Sir William Bradshaw from Virginia Woolf’s novel *Mrs. Dalloway* was an unattractive figure.

He had a ‘reputation of sympathy, tact and understanding of the human soul’ but he was ‘not a

nice man’. Where Sir Roderick would do his locking-up for the good of the patient, Sir

William shut people away because they threatened society.

‘Worshipping proportion, Sir William not only prospered himself but made England prosper, secluded her lunatics, forbade childbirth, penalised despair, made it impossible for the unfit to propagate their views until they, too, shared his sense of proportion. Naked, defenceless, the exhausted, the friendless, received the impress of Sir William’s will. He swooped; he devoured. He shut people up. It was this combination of decision and humanity that endeared Sir William so greatly to the relatives of his victims’.

‘He could see the first moment they came into the room ... He was certain directly he saw the man; it was a case of extreme gravity. It was a case of complete breakdown – complete physical and nervous breakdown, with every symptom in an advanced stage, he ascertained in two or three minutes (writing answers to questions, murmured discreetly, on a pink card)’. ‘How long had Dr Holmes been attending him? Six weeks. Prescribed a little bromide? Said there was nothing the matter? Ah yes (these General Practitioners! Thought Sir William. It took half his time to undo their blunders. Some were irreparable). If Mr Smith would wait, said Sir William, he would speak to Mrs. Smith in the next room. Her husband was very seriously ill. Did he threaten to kill himself? ... It was really a question of rest, rest, rest; a long rest in bed. There was a delightful home in the country where her husband would be perfectly looked after. Away from her? She asked. Unfortunately; yes; the people we care for most are not good

for us when we are ill ... Shortly and kindly Sir William explained to her the state of the case. He had threatened to kill himself. There was no alternative. It was a question of law ... We have had our little talk said Sir William ... We have been arranging that you shall go into a home ... We all have our moments of depression ... Try to think as little about yourself as possible, said Sir William kindly. Really, he was not fit to be about. Trust everything to me, he said, and dismissed them'.

Virginia Woolf herself had had much mental illness, so her views of this psychiatrist may have been coloured by her own experiences.

The third titled psychiatrist that Professor Kessel referred to in his paper was Sir Henry Harcourt-Riley, T.S. Eliot's omniscient-seeming psychiatrist from the *Cocktail Party*. He was a very different type of psychiatrist from the first two and was of the type thought of as being able to look into someone's eyes and see that their soul was rotten. Eliot lets him describe himself:

'I do not trouble myself with the common cheat,
Or with the insuperably, innocently dull.
My patients such as you are the self-deceivers
Taking infinite pains, exhausting their energy,
Yet never quite successful. You've both of you pretended
To be consulting me; both tried to impose upon me
Your own diagnosis, and prescribe your own cure.
But when you put yourself into hands like mine
You surrender a great deal more than you want to'.

'I always begin from the immediate situation
And then go back as far as I find necessary.
You see, your memories of childhood –
I mean, in your present state of mind –
Would be largely fictitious; and as for your dreams,
You would produce amazing dreams, to oblige me.
I could make you dream any kind of dream I suggested,
And it would only be to flatter your vanity,
With the temporary stimulus of feeling interesting.
I could make you feel important,
And you would imagine it a marvellous cure'.

'How did you know all this'

'That I cannot disclose.
I have my own methods of collecting information.
About my patients. You must not ask me to reveal it –
That is a matter of professional etiquette'.
'I often have to make a decision.
Which may mean restoration or ruin to a patient.
And sometimes I make the wrong decision'.

In his paper, Professor Kessel asked how we could reconcile these 'caricatures' with ourselves, and was concerned that our medical colleagues might see us as those authors saw us. Psychiatrists may be seen as odder than their patients. They may also be seen as gaolers. They are also seen as magical healers with greater insights into the mind than other human beings, spiritual guides or noble magicians.

PSYCHIATRISTS IN NOVELS

Dr Marjorie Meehan reviewed twenty-two novels. These depicted psychiatrists as useless nonentities, villains or noble characters (magical or spiritual guides). She ended her article pointing out that it was 'certainly true that many authors tended to disparage psychiatrists, but by no means all'. The body of fiction did not present a single or consistent image of a psychiatrist. Charles Winwick, who reviewed thirty-five novels, found an Institutional Psychiatrist was often a fool who was less intelligent, and far less attractive as a human being than his patients. The picture was of an inept and inert professional staff. The least attractive member was its Director. Those in private practice did not help their patients much. All practitioners had grave sexual and marital difficulties. Science fiction might be expected to give more extreme examples. A novel *Mind Alone* showed how such writers viewed psychiatrists. Dr Waterson, 'one of the new electronic psychiatrists', hummed like an electric

motor as he worked. His little black eyes glittered like nuclei and his black hair perpetually stood on end, as if charged with electricity. Another gave the same impression of being a machine himself. He took a sheaf of paper from the bottom of a pile and began to deal them out on the desk like a pack of cards. He then collected the papers he had dealt out and fanned them out like a bridge hand. 'I do this because I want to pile all the papers together and set fire to the lot. Impossible by my own decision, so I relieve my feelings by controlling them, destroying their significance, then restoring it'. This unusual display of occupational autotherapy did not lower him in his visitors' eyes. He solved their problems and all ended happily.

PSYCHIATRISTS IN FILMS

Irving Schneider reviewed films depicting psychiatrists. The first made his appearance in 1906, the imposing but harried superintendent of *Dr Dippy's Sanatorium*. Schneider identified three types of 'movie psychiatrist', whom he called 'Dr Dippy', 'Dr Evil' and 'Dr Wonderful'. Dr Dippy was crazier or more foolish than his patients. His treatment methods tended to be bizarre, impracticable or unusual. Some of the better known doctors in this category were Wyrley Birch, in *Mr Deeds Goes to Town*, Fritz Field in *Bringing Up Baby*, Fred Astaire in *Carefree*, Peter Sellers in *What's New Pussycat?*, Mel Brooks in *High Anxiety*, Richard Benjamin in *Love at First Bite* and Peter Bonerz in *Serial*.

The second type was Dr Evil. He was a familiar figure in the history of horror movies and had his first appearance in the early *Cabinet of Dr Caligari*. Dr Caligari was the model for the

psychiatrist who became evil because he dabbled in the forbidden, dangerous area of experimentation. Other Dr Evils were psychiatrists who used their powers for personal profit. From the *Criminal Hypnotist* to *Nightmare Alley* to *Shock Treatment* to *I, the Jury* and beyond, there had been a line of psychiatrists who used authority or skill to bilk patients of their money. The last type of Dr Evil was the psychiatrist who was sufficiently mad, neurotic or insecure to abuse his profession and perform evil deeds. An example, was the doctor played by Michael Caine in *Dressed to Kill*, a psychiatrist who, when sexually aroused, became a homicidal transvestite amnesiac. Another famous homicidal psychiatrist was played by Leo G. Carroll in *Spellbound*. Others of this group appeared in *Frances* and *One Flew Over the Cuckoo's Nest*. *Silence of the Lambs* involved a psychiatrist who, as a serial killer, ate his victims' corpses. The chief characteristic of Dr Evil was his willingness to use what have been viewed as coercive tools available to psychiatry. These included commitment of patients to an institution, experimentation, E.C.T., lobotomy, heavy medication and hypnosis. These became tools for control, manipulation power, revenge and financial gain. In the public's mind these methods have all become associated with nefarious pursuits. It was hard to find sympathetic presentations of these treatments.

Dr Wonderful was a more recent arrival, invariably warm, humane, modest and caring. Patients could see and talk to him at any time. In his treatment Dr Wonderful was a specialist skilled at improvisation, coming up with the appropriate, if often unorthodox, manoeuvre or interpretation, at just the right time. This was especially useful in that favourite device the uncovering of the traumatic event, the royal road to the instantaneous cure (the buried treasure

school of psychotherapy). Dr Wonderful eschewed E.C.T. Lobotomy and heavy use of psychotropic drugs were not in his armamentarium. Occasionally he would use hypnosis or 'truth serum' but only in a deeply caring manner, never manipulatively. His chief method was the talking cure.

Schneider (1985) reviewed two hundred and seven American films. He calculated the prevalence of each type of psychiatrist. He found 35% of the practitioners had been Dr Dippys, 15% Dr Evils, 22% Dr Wonderfals, 14% were unclassifiable and 9% hapless or inept with 5% effective but not easily typed. If exploitation movies had been included, the percentage of Dr Evils would have increased. This was not a flattering distribution of therapists. Only 27% of practitioners were judged to be effective and up to 20% cruel or dangerous.

A survey of lay attitudes to ECT (O'Shea 1983) indicated public hostility and a tendency to accept adverse publicity without questioning. The majority of those who had seen 'One flew over the cuckoo's nest' reported being 'put off ECT' by the film. Television was no better. Louis Appleby (1991) reviewed ITV's weekly psychosoap *Shrinks* (the case book of a plush clinic in North London). There was a middle-aged Lothario, a grieving Father, a kidnap victim and a man who could think only of money (these were the psychiatrists). *Shrinks* was unrealistic, presenting them as magicians. Despite the personal traumas, the foibles and feet of clay, the 'shrinks' were heroes: mind readers who could look inside their patients, see what

they were hiding, and out-manoeuvre them with irresistible mind games. This caricature of 'Dr Wonderfals' might be one that psychiatrists secretly encourage.

PSYCHIATRISTS IN JOKES

Some insights into views of psychiatrists and their work come from looking at the terms used to define them. These are not always complimentary and Roget's *Thesaurus* (1982) shows the word 'psychiatrist' as alienist, psychotherapist, psychoanalyst, head shrinker, shrink, trickcyclist, mad doctor and such like. Also stigmatised are psychiatric units, lunatic asylum, mental home, psychiatric hospital, mad house, locked ward, padded cell, bedlam, boobyhatch, loony bin, bin, nuthouse and funny farm. Defensive ridicule plays a part in jokes. These suggest that members of the profession are odd, over interested in sex and (particularly if American) over concerned with money. Psychiatry was to do with split minds. 'Psychiatry is the care of the id by the odd'. 'Anybody who goes to see a psychiatrist needs his head examined'. 'My psychiatrist and I agree that when we both think I'm ready I'll drive my car off the Verizano Bridge'. 'A psychiatrist goes to the Folies Bergères to look at the audience'. 'You go to a psychiatrist when you're slightly cracked and keep going till you are completely broke'. 'Most shoplifters aren't rich enough to be diagnosed as kleptomaniacs'. 'A neurotic builds a castle in the air. A psychotic lives in it. A psychiatrist collects the rent'. Further jokes confirm the over-interest in sex. 'I've all my clothes off, where shall I put them?' Psychiatrist: 'on top of mine'. 'Kiss you. Certainly not, that would be unprofessional. Surely you realise I shouldn't be on this couch with you' (Mini Ha Ha 1968). Some were hardly psychiatric jokes. 'The psychiatrist who died in Custer's last stand wasn't in the fight. He went along to

complain about the noise'. This could be told of anyone but a psychiatrist can be a paradigm for the foolish. The nadir in low esteem was a Times leading article in 1982 saying 'At last somebody has defined the value of a psychiatrist: a man holding hostages at gunpoint at St. Jude's Research Hospital, Memphis released one of them, a psychiatrist, in return for five hamburgers, five cheeseburgers and some potato crisps'.

STEREOTYPES: ODDNESS

People have difficulty distinguishing between psychiatrists, psychologists, psychoanalysts, psychotherapists, social workers, lay therapists and 'mind experts' of every sort. They do not always know which are medically qualified. The media image of psychiatrists remains confused – gaolers, analysts, mind readers, or eccentrics come to mind. This confusion is a fertile ground for fear and stigmatisation. A straw poll of patients attending an emergency department showed strange concepts about psychiatrists. Only 50% thought that psychiatrists were medically trained. 75% thought that all psychiatrists were analysts. None knew the difference between a psychologist and a psychiatrist. Worse of all, 75% thought a stage hypnotist was a psychiatrist (McKenzie, 1994). Alan Gregg looked at the status of psychiatrists at the end of the asylum era. He stated:

'Most of you spend too many of your working hours among your intellectual inferiors and occupy positions rarely exposed to the criticisms of your equals in maturity or rank. Many of you have had long experience of power and authority not commonly challenged. All of you possess intellectual subtlety, quite adequate to dispose of almost any accusation, and an emotional imperturbability and professional serenity which has had diurnal exercise in walking through your wards. Your major limitations would be these: you are badly recruited, you are isolated from medicine, you are overburdened, and you are too inarticulate and long suffering to secure redress from the public of some of the handicaps from which you and your patients suffer'... 'Most psychiatrists are so ill trained in medicine that they cannot command the respect which would welcome them as collaborators in the wards of a general hospital. The

young doctors entering the state hospital services are assigned to work on their wards on the assumption that, though untrained and unsupervised, they would be competent. Such a procedure would disgrace even a very quiet surgical service'.

Fortunately junior psychiatrists are now beginning to be better educated and trained. There are other beliefs and behaviours to support the notion that psychiatrists are inadequate, odd and overconcerned with sex. For two centuries, some psychiatrists believed that insanity was caused by masturbation. Today no-one believes this and the masturbatory hypothesis has been finally abandoned. This history is not one in which present day psychiatrists feel much pride (Hare, 1962). Psychoanalysis introduced the hypothesis that repressed infantile sexuality affected the development of character and might be important in the genesis of later neurotic illnesses. This could be a further reason for the view that psychiatrists are over concerned about sex.

STEREOTYPES: WICKEDNESS

In the USSR dissenters were detained in mental hospitals when they were not ill. Psychiatrists were involved in this and their methods of thought and the rationalisations they used were clearly outlined in *A Manual on Psychiatry for Dissenters* by Vladimir Bukovsky and Semyon Gluzman (1974). This gave advice to anyone who might be considered to be a dissenter who was referred for a psychiatric opinion. Since the doctor would endeavour to find the person mentally unstable and needing detention in a mental hospital, they advised on how to deal with the various types of psychiatrist encountered. Those included the Novice Psychiatrist, the Academic, the Writer of a Dissertation, the Voltarian, the Philistine and finally the Professional Hangman (who deliberately practised the exculpation of mentally healthy

persons). Each in different ways could find you mad. In Japan some psychiatrists condoned horrendous brutalities against patients. A patient at a hospital outside Tokyo had complained. A nurse took him into a side room and beat him with an iron pipe until he died. When his family collected his body they were told that he had hit his head against a toilet door, which was why he was so bruised. The Medical Director signed a Death Certificate stating his death had been due to a heart attack. Violence in Japanese mental hospitals was widespread. A patient in another hospital had regularly been beaten, because he did not totally accept the discipline. Until recently there was no redress for Japanese mental patients (Cohen, D. 1985b). Despite a catalogue of well authenticated abuses since 1968, the Japanese Government refused to consider radical reforms. A mission from the International Commission of Jurists visited Japan producing a report in 1985, which led to changes in legislation and practice. In Argentina murder fraud and traffic in human organs were described at a mental health institution. An investigation established that most patients were left naked, unfed and medically ignored. Bodies of former patients exhumed showing that eyes and other organs had been removed and their blood drained. The body of a 16-year-old was found in a well with his eyes missing. The institute's records showed that he 'escaped' (though he was totally paralysed and could not even feed himself).

Other examples come from Germany. In the early 1900s eugenics attracted considerable interest. The publication in 1920 of *Die Feebargen Vernikdong Lewensvurten Lebens* (The Release of the Destruction of Life Unworthy of Life) by the psychiatrist Alfred Hock and the jurist Karl Binding was a turning point. Its authors proffered arguments for the use of

ethanasia of the chronically mentally ill and the mentally retarded. Such 'scientific' propositions blended later with Hitler's racial doctrines. This led to compulsory sterilisation of around 300 000 psychiatric patients. The next phase was so-called 'mercy-killing' of those similarly afflicted. The physician's contribution was central. He selected suitable patients and supervised their gassing by carbon monoxide. When this ceased in 1941 at least a quarter of a million patients had been killed. The medical programme ended, but not the use of the procedures. The psychiatric hospitals were the forerunners of Auschwitz, Treblinka and Chełmno. The physician provided continuity with his expertise in killing. The victims changed to the Jew, the gypsy and 'other sub-humans' (Bloch, 1987; Lifton, 1987). Doctors in Chile (as documented by Amnesty International) served as torturers; Japanese doctors performed medical experiments and vivisection on prisoners during the Second World War. White South African doctors falsified medical reports of blacks tortured or killed in prison; American physicians and psychologists (employed by the CIA) were involved in unethical medical and psychological experiments involving drugs and mind manipulation; finally the authorities in Northern Ireland used methods of interrogation including 'white noise' (methods later described as torture). They must have taken medical and psychological advice about the procedures.

Sexual contact between doctor and patient is explicitly prohibited by the Hippocratic oath and other codes of ethics, but some psychiatrists have become sexually involved with their patients and in the USA professional liability insurance carriers have noted a sharp increase in the number of malpractice claims for sexual misconduct by psychiatrists. In a nationwide survey

of US psychiatrists, 7% (1,057) of the male and 3% of the female respondents acknowledged sexual contact with their own patients. Eighty-eight percent of the sexual contacts occurred between the male psychiatrists and female patients. All offenders who had been involved with more than one patient were male. Forty-one percent of the offending psychiatrists sought consultation because of their sexual involvement with patients (Gartrell, 1986). Sexual abuse of patients by professionals has been cloaked in silence and is rarely discussed within the professional community itself. Doctors have been induced to take part in wickedness of all kinds and psychiatrists have been no better than any other group. Their responsibility, however, is very much greater because psychiatric patients are more helpless and psychiatrists have been given much greater control over them.

STEREOTYPES: SAINTLY

There are some reasons for the belief that some psychiatrists have exceptional insights into the workings of the human mind. This partly stems from the way psychiatrists and psychotherapists work. 'Empathy is the *sine qua non* of psychiatric practice' (Storr, 1986). Psychiatrists must try to have some understanding of the minds of their patients. Thomas Widdows wrote: 'The psychological physician should be a man of the world. He should read internal characters from external signs. He should penetrate at once into the mind and to ascertain with a cautious exactness the ruling passion'. Ernest Von Veuchtersleben (1845) said of the doctor looking after the mentally ill: 'He must be able to obtain influence over the minds of other men, without which mental diseases cannot be successfully treated'. Frank Fish (1967) wrote: 'By means of introspective knowledge of our own behaviour and practical

experience of the behaviours of others we develop a special body of psychological knowledge which we call 'empathic psychology'. In order to make adequate contact with another person we must think ourselves into his situation and try to understand why he is behaving in a certain way'. Antony Storr (1986) wrote: 'Psychotherapy is an exceedingly odd profession. I don't think it has anything to do with medicine, but I have sometimes been grateful that I was once a well-trained doctor'. Psychoanalysis played an important role in the twentieth century providing a hope that a new way of understanding the mind would lead to possibilities of cure of mental distress. Its adherents became a cult which spread its fame. It was not science-based and slowly turned into a set of beliefs and dogmas which were virtually a religion to some adherents. The views of Sigmund Freud became all pervasive. Michael Shepherd compared Sigmund Freud and Sherlock Holmes, both now mythical figures as contemporary heroes of an ancient legend. He ended his elegant lecture with a quotation from 'The Seven percent Solution' where Watson bade farewell to his Viennese colleague with the highest compliment in his repertoire, 'Freud you are the greatest detective of them all'. Holmes solved criminal cases by finding links between items in the external world (footprints, blood stains, broken locks), while Freud tried to make sense of the mysteries of the mind by connection between events in the inner world of dreams, thoughts and desires (Beveridge, 1998).

Karl Popper considered psychoanalysis a 'pre-scientific, metaphysical scheme'. He wrote 'The study of such theories seems to have the effect of an intellectual conversion, a revelation opening your eyes to a new truth hidden from those not yet initiated. Once your eyes were thus opened, you saw new confirming instances everywhere. The world was full of verifications of

the theory. Whatever happened it always confirmed it, thus its truth appeared manifest'. Perhaps the time has come to take psychoanalysis out of medicine and keep it in the pages of the Times Literary Supplement where it now belongs.

Robin Murray (1979) reviewed the passing of the era of psychoanalytical supremacy psychotherapy in the United States which opened exciting yet unpredictable prospects for psychotherapy. The American consumer market abhors a vacuum and as the theoretical foundations of psychoanalysis were decredited so alternative therapies have flourished. 'A great many of us' declared Bishop Latimer in 1552, 'when we be in trouble, or sickness, or lose anything, we run hither and thither to wyssardes, or sorcerers, whom we call wise men... seeking aid and comfort at their hands'. Now they run to practitioners of the newer psychotherapies. Professor Clare reviewed Gestalt, Rolfing, Reichian therapy, sex therapy, EST, holism, Esalen, insight therapies, encounter groups, psychodrama, TA and primal scream therapy. This may partly account for the belief that psychiatrists are odd. 'Most lay people do not know if those practising the more outré therapies are doctors or not' (A. Clare).

OTHER REASONS FOR STEREOTYPES

There has been some basis for the beliefs that psychiatrists may be odd, wicked or healers with supernatural acumen. There are other explanations for these stereotypes which lie in the nature of mental illness. Alan Gregg wrote: 'The most powerful traditions or historical heritages of psychiatry are the horror which mental disease inspires, the power and subtlety with which psychiatric symptoms influence human relations, and the tendency of man to think of spirit as

not only separable but already separate from body. For centuries the insane were imprisoned or put away with no thought of insanity as a condition directly comparable with other diseases. And when the confinement became kinder – a relief crystallised in the word asylum – the insane were still segregated from the rest of society, still feared. No other specialty of medicine has had to rescue its patients from persecution, live with them in social ostracism, restore their capacities and then return them to an environment both exigent and suspicious. Man is always superstitious and irrationally conservative when beset by fear and crisis. It is a wonder that scientific medicine has ever emerged from witchcraft’.

A fear of dangerous behaviour is an element in this fear of mental illness. Another dread is that this might cause changes in behaviour, leading to unbridled or abnormal sexuality or violence. Alzheimer’s disease can make a shell or caricature of previous personality with loss of dignity and inability to retain normal autonomy. Mental illness remains feared. Suicide is commoner among psychiatric patients than any other group of patients.

Psychiatrists differ from other doctors as they must treat unwilling patients and at times curtail their liberty. Mental Act Commissions may be large, cumbersome and unduly legalistic and some of its members deeply suspicious of the motives of doctors, but it is necessary to have such bodies. Psychiatrists should always behave with visible rectitude. They should learn from these stereotypes of their profession when recommending hospitalisation or assertive treatments they should remember with what fear and distrust they are typically depicted in films. They should remember the cruelties and neglect of vulnerable patients that has been

perpetrated or condoned by their professional colleagues. They should be aware that patients seek healers. Doctors may be losing the ability to talk to patients. With high technology, diagnostic machinery and the need for haste they place less value on history taking and spend less time talking to patients. Finally, psychiatrists should be clear about their limitations. They do not possess a store of specialised expertise which equips them to engage in all-purpose human engineering. Better training of psychiatrists might improve their image and evade some of the stereotypes.

CONCLUSIONS

Views of psychiatrists as Mad, Bad or Saintly have a long history. These stereotypes are regularly reinforced by books, films and jokes. There is a basis for the stereotypes as psychiatrists have been under trained, behaved badly and have unwisely expanded the boundaries of the subject. Despite this the probable reason for the stereotypes is the nature of mental illnesses, the most frightening and fearful of all illnesses. Properly trained psychiatrists need to be aware of the stereotypes and the reasons for them.

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