RCPE Casenotes: Past & Present Podcast - Psychiatry Transcript

Narrated and curated by Dr Daisy Cunynghame, heritage manager and librarian at the Royal College of Physicians of Edinburgh.

[introductory music]

Welcome to the Royal College of Physicians of Edinburgh's Casenotes podcast. Over the next few months we're going to delve into the different physician branches or specialties.

Just to start off with, what is a physician? Most people know what a GP is, and what a surgeon is, but not everyone knows exactly what a physician does. Well the formal description is specialists in internal medicine, so diseases and complaints that happen inside your body. And even if that sounds unfamiliar, you have almost certainly heard of a lot of the areas that this covers, like cardiology, diabetes, allergies, palliative care, infectious disease and neurology. These are all branches of medicine, or specialties, that physicians are responsible for.

In each coming episode of Casenotes we will pick one of these specialties and delve into its history, looking at its development over hundreds of years, and some of the interesting stories and cases from the past. We'll also talk to a current physician working in that area, to find out what it is like to be working as a specialist physician in the twenty-first century.

[musical interlude]

In this episode of Casenotes we're looking at the past and present of psychiatry. We'll be talking in a bit to Professor Soraya Seedat, but we're going to start by delving into the history of psychiatry.

Mental illness has been documented throughout human history. While the symptoms have varied, it has often been identified by behaviours seen as abnormal or somehow socially unacceptable. In ancient Greece insanity was often considered to be either a punishment by the gods or the sign of a divine message.

In the Middle Ages, after the Black Death swept across Europe killing nearly fifty percent of the population, ideas around mental illness began to take a more sinister form. Such conditions were increasingly believed to be the result of supernatural forces and malicious demons. Later, during the Renaissance, the focus was placed on diabolical possession, particularly witchcraft. Given this attitude, how else could these diseases be explained if not by witches under the power of the devil? Women were condemned as witches far more than men. Whether they were providing medicine for the sick or acting in a manner considered hysterical, women's behaviour could be seen as abnormal, or threatening social norms.

Early medical treatments were often more dangerous than the conditions they were supposed to treat. In the case of mental health, many sufferers were dealt with more like prisoners than patients – the goal being containment, not cure. With a lack of specialist institutions, the mentally ill were often housed in workhouses, religious establishments and even actual prisons.

As physicians became more involved in the treatment of those deemed insane, the responsibility for their care began to be taken away from communities, folk-healers and religious figures. This, however, did not always mean an improvement in standards of care. In some asylums beating and intimidation of the mentally ill was common, fear and pain being viewed as effective methods of treatment.

Even more invasive were some of the recommended surgical procedures. Trepanation, the drilling of holes through the skull, was used as a treatment for mental illness for thousands of years. Patients were also encouraged to eat tobacco and rhubarb to induce vomiting. When such drastic measures failed, opium, laudanum and other drugs were always available to sedate and 'calm' the patient.

In the 1800s urbanisation removed people from traditional support networks, making it harder for them to care for the sick or the aged. As a result, asylums were increasingly used to house the mentally ill, rather than treatment being provided in their own community.

The ineffective nature of the treatments which were attempted meant longer stays for the chronically mentally ill. Extending the length of time patients were housed in asylums contributed to overcrowding and lowering standards of care. Attempts to solve these problems led to legislation such as the County Asylums Act (1808) in England and Wales and the Lunacy Act (1857) in Scotland.

While earlier asylums had often been run by non-medical staff, the asylums which were founded in the 1800s attempted to establish their authority by employing medical practitioners. This started a move from containment to treatment, which led to the emergence of novel therapies, greater understanding of patient needs and the new field of psychiatry.

One such asylum, established in the 1800s, was the Royal Edinburgh Hospital. In Edinburgh in the 1700s people with mental illnesses were often cared for at home. While wealthy individuals could afford private asylums, the only option for the poor and middle classes were the cells within the city's charity workhouse. These housed people in notoriously poor conditions.

The first appeal to raise public funds for a specific mental health facility in the city was launched in 1792 by Andrew Duncan, President of the Royal College of Physicians of Edinburgh. The foundation stone was laid in 1809 and the Edinburgh Asylum opened to fee-paying patients four years later. During the 1840s it was granted a Royal Charter and poor patients began to be admitted and transferred from the city's workhouse.

The treatment approach was the relatively new concept of "moral therapy". Patients followed regular routines with substantial meals and early bedtimes. Physical and mental stimulation were encouraged through work, recreation and physical exercise. The asylum was renamed the Royal Edinburgh Hospital for Mental and Nervous Disorders in 1922 and continues to provide acute psychiatric and mental health services to this day.

[musical interlude]

Daisy: So we're focusing now on psychiatry in the modern day, and we have here with us Professor Seedat. So could we just start off with you introducing yourself, just saying who you are and a little bit about where you work?

Soraya: Thank you very much. I'm a psychiatrist by training, I've been a clinical researcher for just over twenty-four years, and I chair a Department of Psychiatry at Stellenbosch University in Cape Town, South Africa.

Daisy: Thank you. So just to start from the beginning with the absolute basics – how would you define what psychiatry is?

Soraya: Psychiatry as a medical discipline is primarily concerned with the diagnosis, treatment, rehabilitation and prevention of mental illness or mental disorders and psychiatrists work holistically in understanding the contributory factors that give rise to mental illness in individuals. I'm trying to get individual patients who present for treatment to a state of better wellbeing, and I think it is important to think about psychiatry as being that discipline that is really concerned with a holistic health, because mental health has both intrinsic as well as instrumental value. So when we think about mental health, it is not just about individual wellbeing, it's about collective and societal wellbeing.

Daisy: So I have a bit of a horrible question now, which is: you've already touched on, you know, the breadth of what your work entails, so can you, you know, in a very simple nutshell, talk us through a 'day in the life' of your work and what you do? Or is that actually an impossible question because your work is just so varied?

Soraya: My work is varied, but I can highlight some of the activities that may consume some of my work week. So I have, as I indicated right at the outset, been a clinical researcher and so my focus is on clinical research, primarily on patient populations, but [?] patient populations who are recruited for various research projects. And within my research I have postgraduate students and staff that I oversee and mentor and provide support to. I also train and teach our postgraduate as well as undergraduate students. More specifically I train registrars in psychiatry

and because I've had a longstanding interest in anxiety disorders, I run an anxiety disorders clinic for registrars or residents and their doctors who specialising in psychiatry. But I also, I do more didactic teaching to undergraduate students, particularly medical students in their third and fourth years.

Daisy: Thank you very much. I was very interested to see that you've done quite a bit of work on post-traumatic stress disorder and I was just wondering, you know, if you could just tell us a little bit more about that? You know, what interested you in that aspect in the first place and have you had any interesting findings that you could share with us?

Soraya: I've had a longstanding interest in post-traumatic stress disorder, and my interest came about during my registrar training. During my registrar training, I was expected to undertake a research project. I became particularly interested in obsessive compulsive disorder over that time because my supervisor-mentor at the time was a world-renowned expert in anxiety disorders. I soon realised that obsessive compulsive disorder and hoarding – hoarding is one of the features of obsessive compulsive disorder, but it's also now characterised as a stand-alone mental condition – that this disorder overlaps with other anxiety disorders like panic disorder and social anxiety disorder and generalised anxiety disorder. And what I saw in patients that I was involved in recruiting for my research projects at the time, was that they had very high rates of exposure to trauma and I became particularly interested in assessing the impact of trauma on those research participants, but also in patients that I was seeing in the clinical setting.

And I then decided at the time, together with my supervisor, that because I was interested in trauma and I was interested in the impact of trauma on youth in my geographic region – South Africa as you may know has very high rates of exposure to interpersonal violence, in particular physical and sexual violence – and so, together with my supervisor, I discussed the possibility of setting up a research clinic for youth. So a few decades back in 1999, I established a small research clinic and it was called the Bathuthuzele Youth Stress Clinic. Bathuthuzele is a Xhosa word, so Xhosa is one of the African languages in this part of South Africa, in the Western Cape province, and it means ‘comfort them’. So this was a clinic to recruit and assess youth exposed

to violent trauma in particular and to assess them for emotional, behavioural or academic difficulties and then refer them for appropriate care.

As part of that research we conducted very careful diagnostic assessments, cognitive assessments, because we know that trauma and post-traumatic stress disorder have an impact on the cognitive abilities of youth as well as adults. We also conducted brain imaging studies of those adolescents to try and delineate the impact of trauma on the brain. That clinic has continued and it is one of the activities that I am most proud of. It's a clinic that continues to this day and in fact since we recommenced the clinic after a hiatus during COVID and during lockdown in South Africa, we've seen the uptick increase quite, and it's been quite incremental growth of youth that have sought to access our clinic, and [unintelligible] particularly encouraged about that, and you know that clinic has also allowed us to nest many other research projects within it.

Daisy: Thank you, it's fascinating to hear about something that's obviously been so, and continues to be, so impactful. So I have another question which is probably a bit trickier for the field of psychiatry than for other branches of medicine. So in my dream scenario I am given the money to set up a museum of medicine, and I will collect one object that represents each specialty to put in this imaginary museum. What would be the one object for psychiatry, would you say?

Soraya: I think it would be a brain specimen, but I think a brain specimen together with a human form, perhaps a human form with kind of hands that encompass the brain, and I think that would represent kind of both the science and the art that is required in managing mental illness, as well as represent the importance of the doctor-patient interaction, and the qualities of empathy and listening that are integral, they're at the core, they're in fact the cornerstone of treating a person with mental illness.

Daisy: Yeah, I did, and that's fantastic, thank you, but yes, I did think before I asked it that it's a lot easier of a question for a cardiologist, for example, to answer, but your's wasn't the most disgusting because I won't get into what the gastroenterologist wanted a jar of in this exhibition, so yeah, no, it's easier for some than for others, certainly. So

you've talked about the past and the changes that you've seen. I'm interested to know what you think the changes will be in the future. So where do you see psychiatry growing and changing in ten, twenty or thirty years' time?

Soraya: Well, I think that there is going to be far more integration of treatment, I think we're going to be in a better place in terms of understanding how to integrate different treatment modalities. And I am specifically referring to integrating treatments, particularly novel treatments, with psychotherapeutic approaches, because even though we do implement integration in our practice, we do it in a somewhat haphazard way, and it is not yet on the back of very robust evidence. So I think that we will be in a place where we will have the tools to integrate those treatments in a more effective way, so that, you know, it has more substantial benefits for the patients that we manage.

What I also see is there being far more integration of the management of mental health within general health services, because we need to do that for many reasons – we need to move a long way towards decreasing stigma and discrimination of the mentally ill, and we also need to ensure that we can consolidate the scarce resources that we have available. It is also well better to have the integration within the whole system of mental health and other medical services, because I think it allows for greater interdisciplinary collaboration and more of a team approach to managing the mentally ill and, you know, collaborative care is at the heart of what medicine is about.

I also see from a technology perspective being in a place where machine learning will be used more routinely to predict the course of individuals who may be presenting with early mental illness; to assist with diagnosis; to assist with prognostication. But at the same time I see that there will always be a place for a psychiatrist, even with the, you know, development of kind of robotics and bioinformatics and machine learning and computational thinking. There will always be a need for a psychiatrist because it is about humanely treating individuals and I've, as I've said, empathic listening is at the core and, you know, we may have diagnostic systems, but it is not a cookie cutter evaluation that one does as a psychiatrist. It does require clinical judgment, it does require more holistic understanding of the person who is sitting in front of you.

Daisy: No, absolutely, I completely agree there's some things that a robot can't do and it can't be a human, essentially, and have those kind of human qualities. So we're coming towards the end now, but we're talking in July 2022, so before we finish up we should probably touch on the thing that's dominated all of our lives for the last couple of years, which is the coronavirus pandemic. So I'm just curious – how did the pandemic impact on your work and on the profession of psychiatry more generally?

Soraya: So in South Africa we had to pivot very quickly, as did many clinicians and psychiatrists in particular around the world, to managing patients in a different way using telemedicine to reach out to patients to conduct therapy sessions. We had to downscale our inpatient units in order to admit patients with COVID rather than patients with mental illness. It's been a very challenging time because of limited bed capacity in our hospitals to manage the mentally ill who also have COVID. It's very difficult in many instances to isolate patients, because they are so behaviourally disturbed, to contain them and to nurse them in isolation.

On the research front, many of our research projects were put on hold as I think was the status quo for many universities around the world, but when we were able to resume our research activities, we had planned very carefully with protocols in place, safety protocols to protect both our staff as well as our research participants and, you know, I'm pleased to say that here in July 2022 we are pretty much back on track with our research projects.

From the perspective of teaching and training, well we had to pivot to online teaching and training. What I did realise quite early on was the negative impact that it had, particularly on our new trainees, our new psychiatry registrars, who felt very isolated, who in fact had not met their fellow registrars in person, had only spoken to them on a Zoom call, on a Teams call or via WhatsApp. They were feeling very isolated and in fact not coping very well. And so we decided quite early on, as soon as it was safe to do so, that we would initiate small group teaching to allow for that social contact and social interaction and, you know, the feedback that we've had from our trainings has been very positive.

Daisy: Thank you so much for joining us, this has been really fascinating.

Soraya: Thank you.

[musical interlude]

Our case study today explores the little known Henry Newcome, author of a book titled *The Private Asylum: How I Got In and Out. An Autobiography*, which was published in 1889.

Fear of false imprisonment was a growing concern in eighteenth-century Britain. Private madhouses, where the inmates were paying customers, were particularly susceptible because there was little oversight of their practices. Although legislation to regulate asylums was introduced in 1774, its powers were limited and flagrant abuses of the system continued.

As the number of asylums increased dramatically over the course of the nineteenth century they were increasingly used to house individuals who were not necessarily a threat to themselves or others, but rather viewed as a social inconvenience. This was of particular concern to wealthy individuals, where any actions which didn't comply with social norms could be seen as damaging to the reputation of entire families. Public fear that incarceration could be used by families to obtain the patient's estate or to free up a spouse to remarry was also widespread and was a subject depicted in popular culture, including in the work of Daniel Defoe.

Growing concerns about this misuse of asylums led to the establishment of a select committee to investigate the issue in 1815. While subsequent legislation expanded the responsibilities of magistrates, an effective nation-wide system of regulation was not introduced until 1845. In large part this new legislation was the result of extensive public campaigns. Particularly prominent in this was a group, which included ex-inmates, who had formed a body called the "Alleged Lunatics Society" in the 1840s. But the problem didn't entirely end there.

The Reverend Henry Newcome was on holiday in Scotland in 1859 when his wife and sister became concerned that he seemed unwell. Newcome decided to visit a doctor to relieve their doubts. He was then detained in a private asylum in Edinburgh for nine months. This

detention cost Newcome approximately £500. Written thirty years later, Newcome's autobiography details his initial medical assessments and treatment.

One physician believed Newcome's invention of a "stove which will heat the room by the consumption of a newspaper in it" was proof that he had "lapsed into an *imbecile* state". This invention was no fantasy, however, and Newcome had already patented it six weeks before being detained. He also later received an honourable mention for his invention at the Smoke Exhibition in South Kensington in 1882.

The Royal College of Physicians of Edinburgh's edition of Newcome's work includes a letter he wrote, which is addressed to the President of our College. In it Newcome states that "with many of your profession, their hearts are better than their heads". He asks for the President's assistance, hoping to get a formal review of his case and certification of his sanity to demonstrate to his family, friends and parishioners his fitness to remain outside the walls of the asylum and continue his work. Newcome notes he remains unsure as to why he was detained but hopes "if anyone should find himself, through the fears of an affectionate wife, inside a private asylum, he will at least learn from my experiences what *not* to do".

[musical interlude]

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