

Many ways of being human: challenging the medical view of mental disorders and the implications for psychiatry

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Thank AAPP

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Read Szasz at medical school- liked his polemical style and the fact that he was not afraid to take a firm position. Time to come off the fence!

A few remarks about concept of mental illness (MI), with Szasz in mind, and then look at the implications of rejecting the term and conceptualising psychiatry or what it does outside a medical framework.

Critical psychiatry means different things to different people as we have heard at this conference. For me the most fundamental problem with psychiatry is that it is a medical speciality dealing with what are essentially non-medical problems. We psychiatrists may sometimes look like doctors- i.e. prescribing a lot of drugs (this is why drugs emblem of psychiatry), but this is a superficial similarity that obscures what psychiatry is really about.

Caveat

Now, the idea that “mental disorders” can be thought of as medical conditions is deeply embedded in our society and has profoundly important social consequences. But before I come to this in more detail, we need to be clear about what a medical condition consists of.

What are the key features of situations we refer to as illnesses or diseases that distinguish them from other situations and give them the power to provide the grounds for the socially sanctioned processes that surround them?

Szasz argues that the concepts of disease and illness are concepts that belong specifically to the context of the body, that is, they derive their particular meaning from their association with the body as a biological system. The meaning of the two terms is closely related, but broadly we can say that ‘illness’ refers to the experiences that arise in an individual as a result of a disease. Since illness derives from disease in this sense, I will concentrate on the concept of disease, although most of what I say will also apply to the concept of illness.

According to this view, diseases are properties of biological systems and can be understood according to general biological principles that are independent of the individuals or groups they affect. Diseases unfold in more or less predictable ways according to the principles that govern their biological nature. People may be able to influence the course of some diseases by modifying their body and its environment (such as stopping smoking, changing their diet), but someone cannot

simply wish a disease away (or so it is generally believed). Biological systems, like chemical and subatomic reactions, are governed by predictable regularities that have nothing to do with the desires and purposes of human beings.

Now, some thinkers suggest concepts of disease and especially illness can be extended outside the body to apply to patterns of thought and behaviour such as those we call mental disorders. This has been one of the main challenges to Szasz from within philosophy e.g. Wakefield's harmful dysfunction hypothesis, Fulford; Sedgewick. In contrast, I want to argue that Szasz was right in maintaining that the distinction between a condition arising from the body and one that consists of behaviours that have no obvious bodily cause is important. Firstly it is one we all make, and it helps us know how to respond to situations. Secondly, the concept of illness makes little sense if it is extended in this way.

Take the example of a seizure or of someone who develops paralysis. In both situations it is important to distinguish between a situation that has been produced by an abnormal bodily event, like an epileptic fit or a stroke, and one that has been instigated by the individual- whether they do this consciously or subconsciously. And to distinguish between these two scenarios, we look for evidence that the event arose from the body- we look for physical signs and bodily risk factors (like hypertension). We also look for the meaning of the event- whether it makes sense in terms of the aims and goals of the individual. In other words are there reasons why someone might 'fake' a fit at this time (e.g. to get access to drug) or want to appear paralysed (the need to gain care and attention- what we sometimes refer to as 'secondary gain')?

In other words, as Szasz suggested, we find it important to distinguish situations that arise as a consequence of a bodily state or event, and those that are manifestations of what we recognise as human behaviour, that is goal directed activity initiated by an autonomous, self-directing individual. Making the distinction is sometimes challenging, but it matters, and we go to some lengths to make it.

Now, those thinkers that want to divorce disease or illness concepts from the body, or at least de-emphasise the connection, stress the normative or evaluative component of the concept. They stress that nature does not distinguish normal and abnormal biological states (like it does not distinguish weeds from other plants). It is human beings that make this distinction, based on what biological states we value and prefer.

Because they claim this is the principal component of the idea of an illness, they claim that mental illness (or concepts elided with these such as mental disorder) do not need to consist of a biological or bodily state, and that they can be defined in purely normative terms. But this comes down to saying that they are simply an undesirable state of affairs.

Now Szasz never denied that disease and illness are normative terms (as some suggest he did, e.g. Sedgewick). He just argued that they were also essentially biological concepts. In terms of formal logic, being a condition of the body is a *necessary* condition of a disease, but not a *sufficient* one. For the term disease to be clear and useful, it must be able to distinguish a certain set of unwanted situations from others.

If you properly divorce concept of Mental illness or mental disorder from the body in this way, they cease to do the work that it currently does- it can no longer fulfil its current social function. You can't fudge the issue. Either mental conditions are brain diseases and we carry on as normal, or they are not in which case the social basis of our current system has to completely change.

What is the social function of the idea that mental disorder is a brain disease?

If someone's behaviour is regarded as simply the result of an underlying brain disease, and something that is quite separate from the personality (or personal self) of the individual who is manifesting it, then that behaviour can be forcibly changed in the name of helping the patient, without the need for justification or scrutiny (or much of it). So the implicit assumption that mental disorders are brain diseases provides the justification for forced hospitalisation of people who are exhibiting socially problematic behaviour, and the use of mind altering drugs to change their behaviour.

Example: Outpatient commitment: forced life-long drug treatment vs sex offenders. Chemically altering someone's body and mind against their wishes. This would simply not be acceptable unless there is an implicit assumption that the person suffers from a disease, and the medication is a treatment being administered in their own interests, which they are unable to express due to the biological process taking place in their brain.

As Frank on the Mad in America website out it: "mental illness is brain disease approach...cancelled me out as a human being" (Frank Blankenship, March 28th 2017, <https://www.madinamerica.com/2017/03/mental-disorder-disease/>).

If someone's behaviour is the result of a disease, there is no reason to respect their wishes in any way. Frank continued "I was no longer seen as a person but as a collection of symptoms spelling out disease, disease to be completely suppressed"

The idea that mental disorder is a disease is also the basis of modern welfare systems and crucially important for enforcing the modern work ethic. The idea that a person's condition is the result of a disease means they can occupy the sick role, whereby they are entitled to care, exemption from normal duties (e.g. work) and financial assistance, and they are given these privileges by virtue of not being responsible for their condition and being deemed unable to change it. We have almost no system that can give people a break from work or financial assistance if they are not considered medically sick. Most employers in UK make allowance for a close bereavement, but If someone is going through a divorce, for example, and is experiencing a particularly difficult time, they have to have authorisation from their doctor to have time off work, for which they need to be deemed to have a medical condition of some sort.

The idea that is also appealing to billions of people worldwide who are encouraged by the idea that unwanted emotions and behaviour are an illness to think that their problems are in their brain, they are powerless to help themselves and the solution lies in a pill or some other technical intervention on their brain.

NB Distinguishing disease and behaviour

Now Szasz recognised that in some circumstances, bodily disease could give rise to abnormal “behaviour,” as in the case of dementia or neurosyphilis (symptoms included cognitive impairment but sufferers would also frequently become paranoid, aggressive, confused and hallucinate). Szasz always maintained that if a pattern of abnormal behaviour was found to be caused by a specific irregularity of the body or brain, then it would be revealed to be a legitimate medical condition. If that irregularity is located in the brain, it becomes a neurological condition, if it was an endocrine abnormality, it becomes an endocrine disease. In this case, the behaviour is no longer really behaviour as we think of it, but a manifestation of a disease [*This is what was commonly believed to have occurred with neurosyphilis, although the reality is likely to be more complex as we will discuss later.*]

[There is a sense in which many biological psychiatrists agree with Szasz, incidentally. They believe that modern psychiatry has over-reached itself and that many of the problems it addresses are not brain diseases but, as Szasz would also argue, variants of normal (that is non-disease induced) behaviour (Craddock et al). The difference is that Szasz did not believe there is sufficient evidence to assume that any of the situations we currently refer to as mental disorder are brain diseases.]

If there are some situations where ‘behaviour’ (or what is apparently behaviour) is determined by brain disease, how do we work out when behaviour is driven by a brain disease and when it is not?

Szasz assumed that the criteria for considering a situation to be a bodily disease consist of the detection of specific bodily signs such as cellular, biochemical or physiological abnormalities or irregularities.

But this is not always the case. There are situations that we consider to be the manifestation of bodily diseases where the disease process is not detectable, or is not specific. The pathology underlying multiple sclerosis, for example, has only become visible since the advent of Magnetic Resonance Imaging (MRI). The brain changes that produce what we call ‘dementia’ are not qualitatively different from the changes that occur in normal ageing, and do not enable you to distinguish the brain of a person with dementia from the brain of one without.

Now unlike MS, where there are usually physical signs like weakness or sensory loss, in dementia, cognitive dysfunction or impairment and associated behavioural changes are often the only feature, but we still have little difficulty in understanding its manifestations as symptoms of a brain disease. So I think it is useful to think about what it is about cognitive impairment that links it so tightly with brain dysfunction, and how it is different from other ‘symptoms’ of mental disorders.

[progression and intellectual disability]

I came across a quote by Jaspers recently that helps put our intuition about this into words. Jaspers classed neurosyphilis and cases of what he called ‘schizophrenia’ all under the umbrella term of ‘the psychoses’. However, he also noted the differences between these conditions. Thus he observed

that 'in the one case it is as if an axe had destroyed a piece of clockwork, and crude destructions are of little interest. In the other it is as if the clockwork keeps going wrong, stops and then runs again' [SLIDE]. This appears to suggest simply that schizophrenia involves a more superficial and temporary brain dysfunction, but he went on to say: 'but there is more than that. The schizophrenic life is peculiarly productive. In certain cases, the very manner of it, its contents and all that it represents can in itself create another kind of interest. We find ourselves astounded and shaken in the presence of alien secrets, which in this sense cannot possibly happen when we are faced with the crude destructions, irritations and excitements of General Paralysis' [SLIDE] (Jaspers, 1968) (P 576) cited in (Jenner, Monteiro, Zagalo-Cardoso, & Cunha-Oliveira, 1993) (P 32).

Thus although Jaspers believed that one day the brain pathology of schizophrenia would be revealed, he also suggested that 'there will always persist a profound contrast between the various different psychoses [ie between 'organic conditions' and schizophrenia], and probably too an interest of quite a different order in their psychic aspects' [SLIDE](Jaspers, 1968) (P 576) cited in (Jenner et al., 1993) (P 32).

Therefore it seems that it is not just the empirical association with specific brain pathologies that suggests to us that cognitive impairment is indicative of a biological condition, nor its progressive course when it occurs in later life. It seems to be something about its depleting nature: something about the fact that there is loss or lack without gain; a narrowing and restriction of human capacities, a lowering of the qualities that we associate with full human mental functioning, with no compensation in terms of the creation of alternative ways of seeing or responding to the world.

In contrast, the individual in the grip of a paranoid psychosis can be extraordinarily creative in constructing a delusional system or interpreting their own thoughts as alien occurrences. Even the fragmented and elusive speech of people with thought-disorder can be made to make some sense, usually of a tangential kind that suggests a creative process of sorts. And depression too can involve a productive state of self-blaming, catastrophizing and pessimistic interpretations of the world. [This is not meant to suggest that psychosis or depression are productive or useful states as we usually understand the term. Here I am simply making the point that states of madness or emotional extremis are not simply states of deficiency, as the state of cognitive decline and other features of chronic organic brain disorders can be understood to be. Unlike someone with dementia, people with psychosis or severe depression have not lost the tools of mental activity. They are employing those tools in unusual ways.]

Sometimes severe mental illness can mimic the loss or lack associated with brain disorders, such as someone who has severe negative symptoms of schizophrenia or a depressive stupor. It may be that some such situations are produced by faulty brain processes, as Szasz would probably have thought. Often, however, inklings of productive and creative thought provide evidence that mental abilities remain intact. I recall a young man with severe negative state schizophrenia, for example, who barely spoke, and spent almost all of his time slumped in a chair with his hood drawn down, apparently doing nothing. He could, however, rouse himself to levels of extraordinary ingenuity from time to time in order to obtain supplies of marijuana!

So to summarise, outward behaviour can sometimes be disturbed by a brain disease or process, but when it is there is a loss or depletion of mental capacities which is not characteristic of mental

disorders (or other mental disorders) where mental and particularly creative abilities remain intact, even if they are used in unusual ways.

If mental disorder is not a disease, what is it, and how should we try to understand it?

Szasz simply said that the situations we call mental disorders should be viewed as ordinary behaviour and judged according to the same criteria but this doesn't seem to be quite adequate.

Now most ordinary, everyday behaviour is what we would call meaningful. In other words other people can make sense of it, and understand why someone might do it. But the behaviour of people diagnosed with mental disorders often does not make much obvious sense.

But understanding the meaning of ordinary, more everyday behaviour is not as straightforward as we sometimes believe either. Firstly, what is considered understandable depends upon the norms of the society we live in, and what we are accustomed to. We live in an era and culture, for example, that values (indeed demands) independence, hard work and social integration. People who demonstrate behaviour that clashes with these values for whatever reason are more difficult to understand using the framework for meaning we inherit from our culture and history.

Secondly, as people like Bill Fulford have pointed out, it is only rarely the case that ordinary behaviour is the product of a process of rational deliberation with clear and unconflicted purposes. All human beings have varied desires and inclinations, and these may conflict with each other. Thus people often behave in ways that are inconsistent with their stated or conscious goals and purposes but may be fulfilling other desires. Many of us acquire 'bad habits' from time to time, whether that is smoking, drinking too much or biting our nails. We get some gratification from these actions, but recognise their damaging effects, and often try and resist them more or less successfully. We all act 'impulsively' in some situations and then look back on it and regret that we did not consider the consequences of our choices more fully. We sometimes have difficulty controlling our emotions as much as we would like- especially when faced with a challenging situation. We all feel at some points that we lack the stamina to persist in tedious or demanding tasks that we know will be useful in the long-run.

This line of reasoning suggests that although the meaning of mentally disordered behaviour and discourse is more difficult to grasp, it does not need to be seen as fundamentally different from the meaning of many forms of ordinary behaviour. So this is why I called my talk 'many ways of being human' which I got from a book by Alec Jenner and colleagues. Madness may be an unusual way of being human, but it is a way of being human nonetheless!

There have been many attempts to illuminate the meaning of behaviour we call mental disorder over the last few decades eg psychoanalysis, RD Laing's theory of psychosis as a form of withdrawal in the face of over-whelming anxiety induced by the nature and responsibilities of modern life, social constructivist thinkers such as Rom Harre who highlight the meaningful nature of emotions,

I also think cognitive models of addiction can be usefully extended to many situations labelled as 'mental disorder'. These models suggest that addiction is what occurs when a coping mechanism for dealing with unpleasant and unwanted emotions "gets stuck in the on position" (Richard Lewis, sept 12th, 2012, <https://www.madinamerica.com/2012/09/addiction-biological-psychiatry-and-the-disease-model-part-1/>). Drugs bring relief from negative emotions, but can become a destructive habit, that close down opportunities for learning other coping mechanisms.

What we currently call 'depression' can be seen in this way too. When confronted with an overwhelmingly difficult situation, or something that makes us feel bad about ourselves, a natural and protective response is to retreat and withdraw. Most of the time we then gather the strength to face the difficulties that caused the problem, but sometimes we get stuck in that self-protective mode. And the longer we get stuck like this, the harder it is to come back from, as we don't have the opportunity to build up our confidence of being effective in the world.

Laing's theory of psychosis as another form of withdrawal from the world is also compatible with this view.

At the heart of the question about the nature of mental disorder is the question of agency, or intentionality. The behaviour of someone who is deeply depressed or psychotic does not seem to be straight-forwardly purposive or 'motivated', but neither is much more familiar behaviour. But we can recognise in our own, everyday 'ordinary doing' (as Bill Fulford refers to it) that our motivations are often complex, conflicting and opaque. Agency in mental disorder is complex and compromised in the same ways. Moreover, we may need to step out of our usual framework of cultural expectations to understand the motivations behind behaviour we designate as mental illness or disorder.

The very sad story of **Linda Bishop** illustrates this well. Linda Bishop was a woman from New Hampshire, whose story was written up in the New Yorker and is now the subject of a documentary. At the age of 44, Linda walked out on her 13-year old daughter and drifted between hostels, hospital and relatives houses for the next few years. In 2005 she was imprisoned for a motoring offence, after refusing to pay the bail, and she was eventually (after a year and a half) transferred to New Hampshire Hospital from prison. She spent 11 months in the hospital but refused treatment throughout. A court hearing convened to designate her sister as her legal guardian and give the sister the right to force Linda to take medication deemed that there was insufficient proof of Linda's incapacity. She was released from hospital with nowhere to stay and no realistic plans to support herself. She broke into a derelict house in New Hampshire where she lived for several months eating only apples and water. Her dead body was found 6 months later. Throughout her time in the house Linda kept a diary which recorded her 'delusional ideas' alongside her real concerns about her health and safety. She thought she would be rescued by a man she had had a longstanding delusional infatuation with and thought she was married to. She read the bible, and thought that god had a plan for her.

But she also read books she found in the house and wrote about them quite lucidly. She considered a plan to hitch-hike to some neighbours to get food, but then considered that this was abandoning her faith. She also worried that if she re-entered society people would classify her as disabled, which

she found humiliating. She clearly knew that she would die of starvation if she did not get food, but somehow she did not seem to be able to find the motivation to leave.

Linda's sister and daughter sued the hospital for failing to plan her discharge, and the hospital defended itself by that Linda was making a reasoned decision to pursue an alternative lifestyle. As Linda told an assistant at the hospital shortly before she left: 'you're putting your values on my life'.

The story illustrates why our understanding of the nature of mental disorder is so important. If you see Linda as a victim of a diseased brain, then the hospital authorities should have locked her up until she accepted medication, and continued to enforce it after she left. This is the way UK mental health services largely work nowadays. If you see mental disorder as a way of being human, you see her as an individual that made some unusual and tragic choices, but who lived her own life according to her own values.

Despite suing the hospital, Linda's daughter commented: 'my mom made a choice- she could have walked out of that house, but she wouldn't give up her freedom. She could never let go of that person she always wanted to be.'

Part II

What are the implications of rejecting the idea that mental disorder is a disease ?

I said earlier that the idea that mental disorder is a disease is deeply embedded in modern society, and in particular that it is the basis of most of our commitment laws and our welfare systems. But the importance of the disease concept is relatively new. As Michel Foucault suggests, it has been grafted onto much older systems of social organisation and control.

One of the first formal systems for looking after people who were in distress or unable to cope was the English Poor Law. This consisted of a bureaucratic system centring on the local church or parish, and a county-level system conducted by locally appointed Justices of the Peace- later called magistrates. Parish officials and magistrates administered the Poor Law, collecting local taxes (rates) and distributing the proceeds to local people who needed assistance. This included families of people who were unable to earn a living or fulfil other familial duties due to physical illness, old age or a mental disorder. The officials were also charged with maintaining social order. If a family was unable to cope with the behaviour of one of its members, and that person was causing disruption or threat to the community, the Poor Law officials could, for example, arrange for another member of the community to take that person in until such time as they had recovered. Sometimes this would involve placing the individual under lock and key. In extreme cases, magistrates also had the power to forcibly remove someone to a local prison or prison like (but the local rate payers had to pay for this, so it was very much a last resort, and people were brought back when they could be).

These systems involved difficult and contentious decisions about the rights and entitlements of individuals, balanced against other individuals. It was accepted while communities were still small, and people knew their neighbours and their needs. It started to break down with industrialisation and increasing urbanisation in the 19th century. This is when the idea that mental disorder as a disease started to take hold. It was useful to justify the removal of people whose behaviour was disorderly without too much fuss, in a society that placed an increasing emphasis on the rights and freedom of the individual. It was also necessary to explain to the tax payers why some poor people cost more to look after than others – the cost of keeping someone in an asylum was considerably higher than the cost of keeping them in the workhouse, where conditions were deliberately meagre in order to deter people from seeking help and force them quickly back out to work.

This is the core of what psychiatry is about- this system of social control and care that it inherited from the past. Psychiatry and the medical framework it brought with it, by implication if not explicitly, legitimated this system at a time when it was being increasingly questioned. The medical framework has then expanded the remit of psychiatry by pulling in lots of other social problems and personal distress that can now be reconceptualised as medical conditions with a quick medical fix. Its important to recognise though that this change was not brought about by some conspiracy of doctors or psychiatrists. In fact in the early 20th century at least, psychiatrists were much less keen to medicalise psychiatric services than politicians. It was governments that drove this process primarily because it provided a simple solution to what would otherwise be some tricky political problems.

Rejecting the idea of brain disease therefore has the immediate consequence of making these issues transparent again. *Should* some people be able to control and adjust the behaviour of other people, even if it inconveniences them or even threatens them? If so how and in what circumstances, and how do we regulate this? And who has the right to financial assistance and other forms of state aid and care, and who should make decisions about this?

I don't think there are easy answers to these questions, but I think they need to be debated transparently, and I don't think it is beyond the gift of a complex society like our own to design a system that is democratic, fair and accountable.

So what would a modern social system look like that is not based on a medical model, and should doctors or psychiatrists have a role to play in this?

If you break the link with disease and illness - then services to help people with mental disorders could take many shapes and forms. Since mental disorders often consist of ways of behaving that are socially problematic, or lead to people failing to cope with societal demands, it seems to me that social work would be the most logical home for these services, but an alternative would be an arm of the criminal justice system like probation. The social function of the service would be clearer, and it could more easily be held to account.

I don't see a particular need for doctors to be involved, but I propose that there needs to be a new form of generic training for people who work in this area, grounded in social work and criminal

justice, but with elements from many other disciplines and professions including medicine, but also law, probation, occupational therapy, psychology etc.

The academic background of such a profession would be the humanities and social sciences - the study of human beings, not of their biology. To understand the nature of mental disorder we need philosophy to think about the nature of being human, sociology to understand our relation to the social world and the humanities to give us insight into extreme and unusual ways of being human that cannot be addressed analytically. We need an understanding of law and politics to help us design a system that balances the rights of different parties and that ensures that social needs for peace and safety are addressed with minimum interference into individuals' lives and bodies. Elements of medicine and psychiatry are important too. As Sandy mentioned, training in identifying different patterns of experience and behaviour (psychopathology) is useful, and if we are going to continue to use drugs then these professionals need to have very thorough information about the effects of mind and behaviour-altering drugs – much better than psychiatrists currently have (and for that much more research needs to be done into their global effects, but that's another talk). Then professionals could help people to exploit the effects of drugs more wisely, recognise their limitations and avoid the pitfalls and be very clear about the harms that we inflict on people when we make them take these drugs against their will for the benefit of others.

What would a new profession- or for that matter our current profession do if mental disorder is not a disease? What are the implications of understanding mental disorder as many ways of being human for how we might help people.

There is a job of social control to do, and it needs to be done fairly and transparently. There is also the job of helping people to access their inner resources to find more socially acceptable habits and behaviours to replace dysfunctional ones. This might include the use of mind-altering drugs on occasion in a way that is properly informed by all the benefits and harms of doing so.

Psychiatry has had some great qualities- that is what attracted me and many others into the profession. Historically psychiatrists have been concerned with the meaning of people's responses e.g Adolf Meyer described 'the abnormal mental trend as a genuine but faulty attempt to meet situations, an attempt worthy of being analysed' 1948, p 136 [SLIDE]. There is a long tradition of social psychiatry, both in terms of looking at social correlates and precipitants of mental distress and disturbance, and in terms of finding social solutions through initiatives such as therapeutic communities. And there is a longstanding interest in philosophy and the humanities. At the beginning of the 20th century, among many articles on hereditary and infective agents, The British Journal of Psychiatry published essays on William Blake, Nietzsche, immortality and witchcraft.

All these worthy enterprises remain confused however if we don't give up on the disease model of mental conditions, and the attitude that goes with it that psychiatrists are engaged in some heroic battle against the dark forces of disease. Human beings come in many different shapes and sizes. Even in a perfect society, we will never eradicate mental suffering and challenging and inconvenient behaviour. The quest to eradicate this, as if it were some sort of fungus, is a concealed battle against some members of our society and their way of being themselves. It is also doomed to failure.

So I will leave you the words of Dr Seuss- do read Solla Sollew if you haven't read it [SLIDES]:

A small fury creature is beset by 'troubles,' nasty looking creatures that peck him and bite him and pull his tail. So he follows the advice of another creature to head for the:

"City of Sola Sollew, On the banks of the beautiful river Wah-Hoo, Where they *never* have troubles!
At least very few!"

So after a long and traumatic journey, he finally reaches the mythical Solla Sollew, only to find that the one little problem they have is that the key to the entrance gate is stuck and you can't get in!

At this point the hero of the story is tempted to head off to the

"City of Boola Boo Ball, On the banks of the beautiful river Woo-Wall, Where they never have troubles! *No troubles at all!*"

"So I started to go (he says)
But I didn't/ Instead...
I did some quick thinking/Inside of my head"

He turns round and goes home to face down his troubles:

"I've bought a big bat,
I'm all ready you see,
Now my troubles are going
To have trouble with me!"

'Troubles' are part of the human condition, and always will be. The art of living is to learn to manage them ourselves. The art of being a psychiatrist, or any other sort of professional in the area, is to help others to.