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# Users and Abusers of Psychiatry

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A critical look at psychiatric  
practice

Second edition

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London and Philadelphia

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# The story of a depressed housewife

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This is the story of Elaine Jones, who is typical of very many women who break down and are taken into psychiatric hospitals.

## **ELAINE'S STORY**

Elaine is 46, married with four children. Her husband is a van driver for a local firm, where she worked as a cleaner before her marriage. She is warm, outgoing and intelligent, and cares very deeply for her family. Generally she seems to cope well with her life, which since her marriage has consisted mainly of looking after her husband and children.

However, six months after the birth of her last child fifteen years ago, she suffered the first of many recurring episodes of depression, which have often been so severe that she has tried to kill herself. She has had over twenty admissions to psychiatric hospitals, varying in length from a few days to several months. Her treatment has consisted mainly of medication; she has been prescribed twenty different drugs, and has been taking at least one of them ever since her first breakdown. She has also had ECT (electro-convulsive therapy). While in the occupational therapy department, she has followed programmes of cooking and sewing, pottery and art. None of this has prevented her from breaking down again, sometimes only weeks or months after being discharged.

On Elaine's twenty-second admission, a new member of the psychiatric team, hearing that she had had a very unhappy childhood, suggested that she might benefit from a different treatment approach.

This new team member was prepared to offer Elaine psychotherapy sessions to try and understand the background to and reasons for her depression. The consultant, who had had a lot of contact with Elaine over the past ten years, was not keen on this idea. He was inclined to believe that Elaine was not so much depressed as seeking an escape from chores at home, and pointed out that a few weeks after admission she usually appeared looking perfectly cheerful and asking to be discharged. However, he eventually agreed to the new plan.

Elaine, too, had mixed feelings about starting psychotherapy. She knew very little about it, and in any case she and her family had been told by her doctors that her depression was due to a recurrent illness. She found the idea of looking too closely at her feelings rather frightening. Nevertheless, she wanted to try anything that might help.

In the first session, Elaine started to reveal the depression behind the brave face that she felt compelled to put on for the world. Ever since childhood she had been known as the 'strong one', and she felt tremendously guilty about not being able to be strong for her family all the time. Although the battle had often been horrific, she had forced herself to carry on through many bouts of depression without coming into hospital. Sometimes she had vomited because of the strain of preparing herself for family gatherings; but not wanting to let people down, she somehow got through them without her social façade cracking. At other times, however, she reached the point where even washing a plate seemed like climbing a mountain, and she collapsed and retreated to bed in an extremity of exhaustion, guilt and despair.

Elaine also described how hurt she was that others did not understand how she felt. Her brother slammed down the telephone one night when for once she rang for help. Tears came to her eyes as she recalled the incident. But she expressed nothing but gratitude to the hospital for taking her in so often. The consultant insisted on discharging her once after a three-month stay when she had not improved at all, and although she had thought she would not be able to stand it, she had struggled through in the end. At the time she had thought him harsh, but looking back she was grateful for his firmness.

In that initial session, Elaine also revealed for the first time the incident that precipitated her first breakdown. She had been feeling

very low after the birth of her third child, when some homeless relatives and their children arrived on the doorstep. She and her husband had felt obliged to take them in, and most of the burden of looking after two families in a medium-sized council house had fallen on Elaine's shoulders. The visiting husband started drinking heavily, and the whole family departed after six months without a word of thanks. Elaine broke down shortly afterwards.

In twice-weekly meetings over the next four months, Elaine and her therapist continued to trace the roots of her depression. A theme that emerged very strongly was the resentment and anger behind Elaine's guilt and depression. She had helped to set up a situation in which it was somehow always she who did the giving while getting no acknowledgement from anyone else. For example, in the build-up to the present admission, her stepmother had invited an extra six relatives for Christmas lunch at Elaine's house. Since it had always been Elaine's task to cook the meal, she had felt unable to refuse or ask for extra help. Her Christmas had been a nightmare of shopping, cooking and organising. Elaine's life was filled with similar incidents. Her sons expected dinner to be ready as soon as they came in, although sometimes they arrived hours late and offered no apologies. Her father and stepmother were offended if she did not visit them, and yet often they neglected to visit her when she was in hospital. Even on her weekend leaves from hospital she rushed around doing household chores while the rest of the family had a lie-in. She described tearfully how it was always she who went forward to kiss her children and parents at visiting time and ask them how they were. 'Why can't it be the other way round for once?' she cried.

The irony was that Elaine's 'brave face' was too effective. Patients mistook her for a nurse and implied that she didn't need to be in hospital, while her sister said openly that she was just looking for an escape from her responsibilities. Elaine feared that the hospital staff thought the same, though they denied it to her face. Elaine had set a trap for herself; she felt she had no right to protest or be dissatisfied. So she struggled on, putting on a façade which others were deceived by, and then felt angry and hurt about being so badly misunderstood, as well as guilty at not being able to cope. She tried to suppress these feelings too, and so the vicious circle continued.

Elaine and her therapist started looking into her childhood for the origins of this pattern. The accumulation of hurts, resentments and losses went back many years. Elaine was nine when her mother died. Shortly afterwards, Elaine's father remarried and two further children were born. Elaine and the two boys from the first marriage were shunned; but although still a child herself, Elaine had to bring up her younger brothers. She was kept back from school to do the housework and despatched to relatives to help out, while her half-sisters had every attention and comfort. Elaine, known as the 'strong one', was expected to cope with all this without acknowledgement, support or affection: and as a young child she had little option but to comply. It was very painful for Elaine to recall these events from her past. At one point she cried out in anguish, 'Why did they do it to me? I needed love too! Why did they have everything and I had nothing?' and she wept bitterly. But as the hurts were gradually released, she experienced the sensation of a hard lump in her chest slowly dissolving.

Elaine and her therapist discussed the ways in which she was continuing her childhood role of serving others, bottling up her feelings, having to be 'strong' and not having anything for herself. On the one hand, she seemed to spend her life apologising and fighting for the right to exist. On the other, a part of her was starting to say more strongly, as she put it, 'I'm me, I'm an individual – I'm not just a cook and wife and mother! I've got to have some life of my own!'

Slowly, Elaine started to make changes in her life. She resolved that this time she would not discharge herself from hospital long before she was fully recovered, telling the doctors untruthfully that she was fine because she felt so guilty at taking up their time and neglecting her home. She allowed herself to let down the brave front a little, and asked the staff for help and support when she was at her worst. She was firmer with people who questioned her need to be in hospital, whether they were staff, patients or family. Her therapist arranged a different occupational therapy programme that included some enjoyable and relaxing activities.

The major changes had to take place within her family. There were some successes. On weekend leave, instead of cleaning out the kitchen cupboards, she started to go on outings with her husband. She summoned up the courage to tell her brother how much his actions had hurt her. Although he was not very receptive, she found

an unexpected ally in her sister-in-law. In fact, they discovered that they were both fed up with various aspects of Elaine's parents' behaviour, and decided to visit them less often, even if there were complaints and 'bad atmospheres'.

However, Elaine was still very fragile, and often despaired of the possibility of changing entrenched patterns of behaviour in her own home. Her two daughters, who uncomplainingly took on the role of cleaning and caring for the men of the family during Elaine's admissions, had never given much trouble, but they, like Elaine, found it hard to break the habit of running around after everyone else. Her two sons resisted change very fiercely. Elaine asked for her husband's support in challenging the long-standing tradition that they contributed none of their earnings for food, keep or laundry, and a furious row broke out. For once Elaine held her ground, only to be told by her sons that she was 'hysterical', 'crazy', and needed 'another spell in the loony bin'. Most hurtfully of all, her husband changed sides and accused her of stirring up trouble and being too hard on young lads who deserved a bit of fun. Still fragile and unsure of herself, Elaine was driven close to despair by such incidents. She felt it was desperately unfair that, while everyone else was allowed to get angry and have their say, she was labelled as 'crazy' when she spoke up for once instead of trying to soothe everyone else, and the whole family ranged themselves against her. Yet she now realised very clearly that her only hope of staying out of hospital was to bring about changes at home. Both options seemed so bleak that she sometimes contemplated running away and leaving the family, but they were her whole life and she felt she could never do it.

Elaine tried to explain some of this to her husband. He had coped valiantly with the children during her many admissions and had refused to put them into care, and she deeply appreciated how much he had had to bear over the years. At the same time the changes in her were beginning to highlight severe difficulties in their relationship. She knew him well enough to sense that he was feeling very low himself, yet he refused to confide in her, his GP or anyone else. Nor would he come up to the hospital for a joint session, saying, 'The next thing, they'll put me in there too!' When they made time to sit down quietly and talk, he would try to understand what she was going through; but in family crises he was as likely to shout at her as to support her. He frequently exploded in violent rages.

Elaine told her therapist, ‘Sometimes I think he should be here talking to you, instead of me.’

Over the following weeks, Elaine needed a great deal of support, which she gained both from her therapist and from a small therapy group of other patients. Slowly, she increased in strength and confidence. Indeed, she said, ‘If I’d had this sort of help fifteen years ago, I might not have needed to be on pills all this time.’ But she couldn’t afford to look back with regrets because she knew the struggle to bring about changes in her family would continue for many months and need all her courage and determination. After a longer stay than most, she reached the point of being genuinely ready for discharge. She intended this admission to be her last one. Time will tell whether she succeeds.

Elaine’s story is a clear illustration of many of the themes with which this book will be concerned. It can be understood and examined on various levels.

## **THE PSYCHOTHERAPEUTIC ANGLE**

Let us look at Elaine’s episodes of depression from a psychological point of view. Her psychotherapy gives us a way of understanding her depression as part of her whole person, of all of her past and present experiences and relationships, rather than just as an unpleasant recurring illness.

Clearly, Elaine was severely emotionally (and to some extent materially) deprived from a very young age. Not only did she miss out on the love, care and attention that all children need, she was also expected to provide it for others – her younger brothers and relatives. She was bearing adult responsibilities without getting the emotional nourishment that she needed for herself. Her parents seem to have justified this treatment by designating her as the ‘strong one’ who could cope with anything. Elaine learned to accept this view, which effectively stopped her from complaining or questioning the set-up. She too believed that she should be able to cope. In any case, she had very little choice in the matter.

Since the capacity to meet other people’s needs depends on having your own needs met in the first place, someone in Elaine’s position is in constant danger of becoming emotionally overdrawn, as it were, and



of not having the resources to cope with others' demands. Moreover, someone like Elaine is particularly likely to get into the situation where others are making a lot of demands, since the role of looking after others is one they have been trained in from childhood. As Elaine herself came to realise through her therapy, she had contributed to setting up a repetition of her childhood circumstances, and still felt she had no right to protest about it.

Obviously a lifestyle based on such fragile foundations cannot continue indefinitely. There comes a point where so much more is being given out than taken in that the whole system breaks down. Sometimes the event that is the 'last straw' seems fairly trivial. Since the family, psychiatric staff, and indeed the woman herself have usually subscribed to the myth of her as strong and capable, the sort of person who helps *others* with their problems, they are often at a loss to understand why a relatively minor incident precipitates such a severe reaction. They are unlikely to appreciate that, from a psychological point of view, the breakdown can be understood as a cry for rest, care and the replenishment of depleted resources, and as a desperate protest against an intolerable lifestyle.

The significance of the precipitating event for Elaine's first breakdown now becomes clearer. After the birth of her last child, she was fragile and vulnerable. At the same time, she was required to meet the needs of others – her baby and her existing family – and to push her own needs into the background. It was a repetition of her childhood predicament. For many women, made vulnerable by similar backgrounds, childbirth on its own is enough to trigger what is usually described as 'post-natal depression', but often has its roots much further back. For Elaine, however, the problem was compounded by a whole extra set of demands from the relatives who came to stay. There was just too much weight on the wrong side of the fragile balancing act, and Elaine tipped over from 'strong one' to 'sick one'.

Real recovery from depression, as opposed to merely managing and containing it with medication, involved change on a whole-person level. Elaine had to find a way of completing the many unfinished events from her past that still haunted her. Much of this work was done in the therapy sessions, where she was able to release the hurt and anger she had been carrying around for so many years. By shouting, weeping and grieving, Elaine was able to work through and come to an acceptance of her past, and to liberate the energy that had been bound up in keeping all this pain inside. At the same time, she needed to fill her emptiness with support, understanding

and care from her individual and group sessions. Her feelings had to be recognised and validated, not labelled and dismissed. Finally she could turn to the task of redefining herself and her life.

Elaine's therapy also showed that her depression had to be understood, not just as part of a whole person, but as part of a whole system. She was involved in a network of relationships which included her husband, parents, children, brothers and sisters, friends, patients and hospital staff, and many of the interactions between these people were actually helping to maintain her depression. For most of her fifteen-year career as a psychiatric patient, this system was stable, if uncomfortable: various people continued to hurt and use her; Elaine continued to allow herself to be hurt and used; and the psychiatrists continued to admit her to hospital at regular intervals to administer the same treatment as before. Through her therapy, Elaine was made aware of this pattern and the way in which she had, in her own words, 'made a rod for my own back'. As she started to change her contribution to the pattern – for example, refusing to do her sons' laundry – other members of the system found that their roles were being challenged too. If, in certain instances, she was not willing to be the servant, they were no longer so clearly the masters. Change was forced upon them too.

When someone like Elaine starts off this process of change, two things characteristically occur. First, it becomes less clear who really is the 'patient'. Elaine and her family had long accepted the doctors' definition of her as the 'sick one' in the family. However, as she began to make sense of her depression and climb out of the passive, suffering 'sick role' to become more active and assertive, the problems in the rest of the family started to come into focus. Her husband, in particular, seemed to be or to become quite depressed himself. It began to look as if it had been part of Elaine's function to 'carry' the depression for both partners in the relationship. While she was the 'sick one', he could continue the familiar but limited role of strong, silent head of the family. As she changed and demanded more understanding and emotional support from him, it became apparent that he was completely unable to deal with his own or other people's feelings other than by blocking them off. Other members of the family had their difficulties too – the daughters tending to follow their mother's lead, and the sons to follow their father. In fact, it could be said that in some ways Elaine's depression had served the function of camouflaging the problems of the whole family.

The second characteristic occurrence is that there is strong resistance to change from other members of the system, who find themselves being challenged in very uncomfortable ways. Elaine's sons didn't

want to do their own laundry; her husband was scared of acknowledging his own feelings; her brother was reluctant to admit he had been hurtful. Although they would doubtless all have said they would do anything to cure the 'illness' which had brought the whole family such unhappiness, a view of her difficulties which included a critical look at their own contributions was not so welcome. In fact, their reaction was to try and push Elaine back into the 'sick role' by labelling her new and assertive behaviour as 'hysterical' and 'crazy'. Thus their own investment in keeping her sick was revealed.

For Elaine, too, it was tempting to fall back into this familiar role, to keep quiet and struggle on as before, paying the price of needing future hospital admissions. Some people who become psychiatric patients actually prefer to stay in the sick role, with the compensating benefit of avoiding painful conflict. Many others stay in the role that psychiatrists and other staff assign to them because they do not get the help they need to break out of it. Either way, a false solution, a kind of unhappy compromise, is reached. No one is especially happy but, on the other hand, everyone can avoid facing certain painful issues. In such cases, the unresolved problem tends to be passed on, to reappear in future generations. This can be seen in Elaine's case. Elaine's daughters had learned to take over her role, stepping in to do the cooking, shopping and cleaning for the whole family, including their grown-up brothers. Possibly they too had unfulfilled emotional needs because of their mother's depression and absences during their upbringing. Their compliant behaviour allowed the men of the family to act selfishly and ignore other people's rights and feelings. All the children were thus set up to repeat the pattern in their own families: the men prepared to exploit, and the women to allow themselves to be exploited. In this way, the sins of the fathers (and mothers) are visited upon the sons (and daughters).

## **THE MEDICAL ANGLE**

Let us now look at the part played by the hospital and its staff in Elaine's story.

In fifteen years and twenty-two admissions to two different hospitals, Elaine had come into contact with more than twenty psychiatrists, including three consultants, and a large number of nurses, occupational therapists and other staff. Some of the psychiatrists saw her simply as an unfortunate victim of a recurrent illness which caused her to become depressed. Most of the others would have agreed, if asked, that childhood

experiences and family relationships play a part in depression; but with little or no training in psychotherapy, they did not have the skills to work out how this might apply to Elaine. In this they were no wiser than Elaine herself, who hadn't realised how her upbringing was still affecting her and blamed herself for everything, and who initially presented a picture of a happy family where only she was at fault. With a long list of other patients to be seen, it was easier for the psychiatrists to fall back on something they did know about: medical-style treatment consisting of diagnosis, hospitalisation and medication, all of which carried the implication that Elaine was suffering from some kind of mental illness. In Elaine's notes, the words 'depressive neurosis' or 'endogenous depression' appeared in the space left for diagnosis. Although details of Elaine's childhood were dutifully recorded by each of the many doctors who admitted her, no one was able to make sense of it in relation to her breakdowns; nor were the interactions between Elaine and her extended family investigated or discussed. In other words, Elaine's depression was treated, whether deliberately or in default of any alternative, not as part of a *whole person* and a *whole system*, but as an isolated phenomenon. Elaine and her family accepted the professional view that frequent admissions and permanent medication were the best hope of keeping it under control.

In fifteen years of pill-taking, Elaine had been prescribed the following drugs:

|               |             |
|---------------|-------------|
| Stelazine     | Tofranil    |
| Largactil     | Nardil      |
| Melleril      | Nomifensine |
| Procyclidine  | Tranxene    |
| Amitriptyline | Valium      |
| Prothiaden    | Mogadon     |
| Tryptizol     | Priadel     |
| Tryptophan    | Dothiepin   |

She also had ECT (electro-convulsive therapy or electric shock treatment) during which an electric current is passed through the brain, simulating an epileptic fit.

Elaine also received treatment on what might be called a behavioural level, that is, focusing quite simply on the activities, or behaviours, that she was unable to carry out. Here the equation seemed to be:

*Problem:* She says she can't cope with the household chores.

*Solution:* Make her do the household chores.

Hence she was assigned to cooking and household management programmes in occupational therapy, as well as art, pottery and discussion groups.

Clearly, Elaine's physical treatment was not particularly successful. Her doctors might have argued that she would have been even worse off without medication, which at least kept her going for a time, although Elaine herself said she was nearly always aware of depression lurking in the background. But there seems to have been general resignation to the fact that she would need to come into hospital regularly, and to be supported with medication – supervised in fortnightly or monthly outpatient appointments – in between. Since 1991 patients have had the right, except in some limited circumstances, to read their medical notes. However, since no one may quote from them without the permission of the health authority, some fictional examples based on typical real-life extracts will serve to illustrate how the 'medical model' approach works in practice.

In cases such as Elaine's, the accumulation of notes and letters tends to follow a predictable sequence. There will be a pile of memos from psychiatrist to GP monitoring progress and making minor adjustments to medication following the fifteen-minute appointment, along the lines of:

Dear Michael, re: Mrs Elaine Jones, I saw this patient of yours today in my outpatient clinic. Her depression is improved and she is doing rather well on Dothiepin 150 mgs nocte. I have suggested she reduces the Tranxene to 15 mgs daily. I will see her again in two weeks' time.

After some months or years of ringing the changes in this way, with no substantial alteration in the patient's condition, a slight note of desperation may creep in, although the remedy is still to prescribe more of the same treatment rather than to revise the treatment approach itself. One might then see:

Dear Michael, I saw Mrs Elaine Jones who is still complaining of severe depression, with associated early morning wakening, lethargy, and loss of appetite. Although I appreciate she has not done very well on tricyclics, I thought it might be worth starting her on Tofranil,

possibly combined with ECT and/or admission at a later date if her condition seems to warrant it.

Or there may be a bald statement about recent stresses, without any suggestion that it might be useful or relevant to discuss the meaning and implications of these with the patient: 'Her son has recently left home to start a college course, and her elderly mother is ill. I will be seeing her again on . . .' At this stage, there may be some grasping of straws, at the possibility that another physical cause will be found so that she can be put right, perhaps: 'She seems to be worse pre-menstrually, and I wonder if it would be worth referring her to Dr Smith for possible hormonal therapy.' Even a psychological hypothesis may be put forward, usually to be dismissed: 'One suspects that her marriage plays some part in her depression, but I am doubtful about the likelihood of change in that area.' A male psychiatrist's identification with the husband who also has to deal with this awkward woman may be revealed by such phrases as: 'Mr Jones has put up with his wife's outbursts with remarkably good humour over the years.'

Finally, a note of persecution creeps in. The patient has obstinately refused to get better, and someone who started off five years ago as 'this pleasant lady' may end up as 'this difficult woman' or worse.

If we look at the effect of the medical model approach on Elaine's depression, we can see that one result of ignoring the whole-person, whole-system approach is to deny that her feelings and reactions have any validity. It is not that she has reason to be depressed, or exhausted, or tearful—these are merely 'symptoms' of her 'illness'. This effectively traps her in her situation. She does not strive for change, because important professionals who know about these matters have defined her problem in such a way that she is prevented from realising that change is necessary. Her part is to comply obediently with the treatment that they prescribe. Indeed, the underlying message of giving pills to a patient is: 'Let *me* diagnose and treat this problem for you. Follow my instructions and you will be better.' This may be very appropriate for earache or 'flu, but for someone like Elaine it is not only not helpful, it is actually harmful. The final irony is that she even thanks the hospital for their treatment, and feels especially grateful to the consultant who discharged her, protesting, despairing, and unhelped, back to the very situation that was contributing to her problems in the first place.

As we have seen, the illness model also reinforces the family's natural tendency to exempt themselves from playing any part in Elaine's depression. Their need to see the entire problem as located in Elaine and her 'illness' is legitimised.

To summarise, Elaine's treatment not only failed to address the wider issues at stake, but actually ensured that they would not be addressed. It not only failed to help Elaine, it actually perpetuated her difficulties. Indeed, one could go further and say that the medical model approach not only perpetuates, but actually creates the difficulties it purports to solve because, as we have seen, Elaine's children are set up to carry the problem down the generations.

Elaine's story is all too common among people having psychiatric treatment. This is not to say that Elaine would have suffered the same fate everywhere. The standards of psychiatric practice vary, and there are some excellent wards, community centres and teams which offer a very good service to those in need. Nevertheless, the fact that the combined efforts of more than twenty psychiatrists and many other staff over fifteen years failed even to start to help Elaine make sense of her depression indicates that she was not just the victim of an unfortunate oversight. Nor is such treatment found only in the more backward asylums; most of Elaine's admissions were to a modern psychiatric unit in a district general hospital. She had in fact received fairly standard psychiatric care as practised in the majority of hospitals in this country. If this is so, how and why does it happen?

Part of the answer lies in the training that doctors, nurses and other psychiatric staff receive. Contrary to popular belief, most of these professionals are *not* primarily trained to understand people and their problems. Doctors are mainly trained to diagnose and prescribe, nurses to manage wards, occupational therapists to run activity and discussion groups, and so on. If they do have additional skills in counselling or psychotherapy, these will probably have been gained on courses taken voluntarily after training or picked up on the job.

Another factor is that even the best efforts are compromised by working within the psychiatric system. Some of Elaine's nurses spent hours talking with her and some of her doctors would doubtless have learned to understand her much better had they not been obliged to move on every six months to fulfil their training requirements, or had they had more time and supervision. However, the overall policy towards a patient tends to sabotage whatever more constructive work may be carried out, unofficially, by staff lower down the hierarchy. By the time someone gets to be a 'known depressive', usually about their second or third admission, the chances of them getting treatment different from before become fairly remote – partly because success would challenge the correctness of the original decisions. As we saw, Elaine's consultant was reluctant for her to have psychotherapy, even though his efforts

had not met with notable success. So, while individual members of staff may be trying their best to understand the patient as a person in a difficult position, their efforts will be undermined by the overall message that she or he is 'ill'.

Finally, the 'illness' model enables the psychiatric staff themselves, like Elaine's family, to avoid facing and sharing the enormous amount of pain that Elaine and others like her are carrying around inside them. They can distance themselves from their own hurts, fears and frustrations which might otherwise be stirred up. They do not have to confront the difficult questions that Elaine's anguish might raise about their own attitudes, families, beliefs, roles, and the society in which these things take place.

## **THE 'SEX ROLE' ANGLE**

Let us look at Elaine's depression from yet another perspective, that of sex role expectations.

Elaine, like most people who are diagnosed as suffering from depression, is a woman.<sup>1</sup> One way of viewing her problems, and those of many of her fellow-patients, is that she was caught in the contradictions of the traditional female role.

Part of Elaine's dilemma was that she was expected to give without receiving enough in return, leading to a build-up of need and resentment. Believing that she ought to be able to cope with this, she blamed all her failures on herself, without questioning the role that had been thrust upon her. This was not just Elaine's particular misfortune, although she had had an especially rigorous training in it. Despite changing roles in recent years, women in general, especially older women and those from workingclass backgrounds, are expected to spend their lives giving to others – their husbands, children and extended families. They are often defined not as individuals, but in relation to others – wife, mother. Even outside the family, the jobs that involve most in terms of giving, and return least in salary and status, are still held mainly by women – nurses, cleaners, primary school teachers, secretaries, childminders. When Elaine cried out, 'I'm not just a wife and mother, I'm me! I'm an individual! I've got to have some life of my own!' she was speaking not just for herself, but for her whole sex. The women who break down and come into psychiatric hospitals tend to be those who have adopted the traditional woman's role most completely.<sup>2</sup>

Behind every woman trapped in her sex role, there is a man trapped in his. The partner who presents to the psychiatric hospital is often the



woman, since women in trouble characteristically become unable to *act* but are overwhelmed by their *feelings*. Men, on the other hand, who are generally less in touch with their *feelings*, but are freer to *act* in the world, are more likely to deal with distress by such means as drinking, violence and delinquency, and ultimately to end up in prisons rather than psychiatric hospitals. They may also manifest distress in physical illnesses. While Elaine followed the woman's pattern, her husband was prone to violent outbursts. As Elaine progressed, his inability to deal with his feelings in any other way became very apparent. His male conditioning did not equip him to deal with years of strain or to meet his wife on an emotional level. He was trapped too.

Again, the hospital served to reinforce rather than to challenge these complementary roles. As far as Elaine's husband was concerned, no attempt was made to allow for his feelings over fifteen difficult years, to encourage him to express them or to see his wife's desperation as anything more than the symptom of an illness. His part in the treatment was limited to meeting the doctors from time to time to discuss what was going to be done to his wife next.

As for Elaine, the hospital's message was quite clear. She was supposed to be able to cope with all her domestic duties without protesting. Indeed, successful treatment was defined in terms of her being able to return home and uncomplainingly continue the same activities. Obediently following this regime on the advice of experts, Elaine felt she had no one but herself to blame when she did not get better, and yet more guilt was added to her despair. In this too she was following the pattern of the rest of her sex, who characteristically blame themselves, their inadequacy, their weakness, their stupidity, their weight and their appearance, rather than question the obligation to meet these standards in the first place.

Hospital staff, like Elaine's family, often resist healthy assertiveness in a person who is taking steps towards real recovery. Someone who sits miserably but quietly in a corner, taking their medication regularly, is easier to deal with than someone who is prepared to disagree, protest and complain. Staff may show their resistance in the same way as Elaine's family did – by pushing her back into the 'sick role'. Patients are likely to acquire labels like 'aggressive' and 'paranoid' if their behaviour becomes too challenging.

What might be called the 'depressed housewife' syndrome, with variations, makes up the everyday bread-and-butter work of psychiatry. The unlucky ones will be getting exactly the same treatment as Elaine.

If traditional psychiatry fails these women so badly, as I believe it does, then it does little better with other categories of patient – people

who have acquired the labels of schizophrenia, obsessional-compulsive disorder, manic-depression, anorexia, and so on. A recent survey found that 40 per cent of psychiatric in-patients had previously been admitted within the same year; 13 per cent had had another admission within the previous six weeks.<sup>3</sup> For a substantial proportion, this will be the start of a pattern lasting twenty or thirty years. Such a situation would be unacceptable in any other branch of medicine. Yet a psychiatric admission costs £50,000 per person per year, and overall treatment costs of psychiatric disorders run at an estimated £4.2 billion a year.<sup>4</sup> Why are such enormous sums expended on methods that are not only ineffective, but damaging? I have indicated some of the reasons why this state of affairs continues. A fuller answer takes us on to the rest of the book.

## The Rescue Game

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There are many misconceptions about people who receive a psychiatric diagnosis. Surveys show that although people believe that they deserve sympathy and the best possible treatment, a significant and apparently growing minority also believe that they are potentially violent and dangerous, and may pose a risk to others in the community.<sup>1</sup> An international study found that ‘schizophrenia’ was ranked fourth of forty diseases in terms of stigma, after rabies, alcoholism and drug addiction.<sup>2</sup> This damaging and inaccurate picture is reinforced by the media, where even quality newspapers frequently run headlines such as ‘Schizophrenic raped three’ and ‘Schizophrenic killer given probation’,<sup>3</sup> which would rightly be condemned as racist if they contained the phrase ‘black man’ instead. In fact, black people, and particularly black men, may be doubly demonised: articles on homicides by psychiatric patients are often illustrated by pictures of black men, although four out of five perpetrators of these crimes are white.<sup>4</sup> Such reports are never balanced by less dramatic, but much more representative, announcements such as ‘Psychiatric patient settles peacefully into the community’.

The Glasgow Media Group analysed media items dealing with mental health issues and found that the theme of violence to others accounted for 66 per cent of all coverage in the sample month. Sympathetic stories, in contrast, made up only 18 per cent of the items. In exploring the impact of these messages, they found that two-thirds of their audience sample believed that mental illness was associated with violence, and most gave the media as the source of this belief. Worryingly, such beliefs sometimes prevailed even when contradicted by personal experience of those diagnosed as mentally ill. The researchers concluded that ‘the media can play a significant role . . . in fuelling beliefs which contribute to the stigmatisation of mental illness’.<sup>5</sup>

Campaigning groups such as the Schizophrenia Media Agency<sup>6</sup> have been formed to counteract this kind of press coverage. But what is the real risk of being murdered in a ‘frenzied attack’ by a ‘mad axeman’ released from the local asylum? There were 699 homicides in 1995, of which 32, or 4.6 per cent, were carried out by mentally disturbed suspects.<sup>7</sup> The risk per year of being murdered (by anyone) is one in 100,000.<sup>8</sup> Given that only a very small percentage of murders are carried out by those with a psychiatric diagnosis, the risk of being killed by someone with a mental health problem has been estimated at only one in 2,000,000 (compared, for example, to a risk of one in 25,000 of dying in an accident at home<sup>9</sup>). Nearly all these homicides are of family members;<sup>10</sup> although horrific for all those involved, this is not consistent with the picture of widespread random attacks on total strangers. Contrary to alarmist reports, there is no evidence of an increase in such incidents since the introduction of community care, despite the fact that the rate of homicides in general has risen; in fact there has been a small decline.<sup>11</sup> While tragic events do occasionally happen, and are rightly investigated so that lessons can be learned from them, there is no justification for stigmatising a whole group of people, or for condemning the policy of community care on these grounds.

Far less attention is paid to two important ways in which a diagnosis of mental illness clearly does have links with violence. One is the risk of suicide, which has been estimated to be up to sixteen times the rate in the general population.<sup>12</sup> The other is that the very people most often seen as *perpetrators* of violence are in fact more likely to be *victims* – previously in their lives, they are disproportionately likely to have suffered physical and sexual abuse.<sup>13</sup> And in their present daily lives, nearly half can expect to be publicly harassed, attacked or abused (for example, having local gangs spit at them and call them ‘nutter’, or finding dog faeces pushed through their letterboxes) simply because they have a diagnosis of mental illness.<sup>14</sup>

The vast majority of people using psychiatric services, then, are ordinary men and women who are temporarily overwhelmed by a complex mixture of emotional and social problems. On making contact with the psychiatric services, they are given a diagnosis in accordance with standard medical practice. The main division is into psychotics (people who are out of touch with reality, or in a layperson’s terms ‘mad’) versus neurotics. Under the first heading come diagnoses such as schizophrenia, manic depression and paranoia. Under the second heading would come agoraphobia, obsessive-compulsive disorder, most cases of depression and anxiety, and many others. In order to get a clearer picture of what actually goes on in psychiatry, I propose to look at groups

of patients, not according to their diagnosis, but according to how they use the services and how the services characteristically respond:

1. There is a group of people who are asking for help with problems that are really relationship and family issues. Elaine Jones is an obvious example.
2. There are people who ask for help with problems which, while still involving those around them, are not primarily to do with current partners or family relationships. An example might be someone who has been bereaved, or who is a victim of rape or sexual abuse, or who has had an accumulation of stressful life events.
3. There are other people who, usually for lack of alternative options or more appropriate forms of help, opt for the career of psychiatric patient as the only escape from painful situations in their lives.
4. There are those who use the hospital or out-patient services mainly to meet social or economic needs, perhaps because they are lonely and isolated or have no suitable place to live. Hospitals may also be used for what is often called 'time out', or respite. For example, an exhausted mother might come in for a break, or a disturbed adolescent might be admitted for a week mainly to relieve his parents. However, pressure on beds means that such admissions are far less frequent than they used to be.
5. There is a group of people who are suffering from conditions of definite physical origin, such as senile dementia, Huntington's Chorea and severe head injury.
6. Finally, there are more extreme examples of the first category, where family relationships are so intense and entangled that one person in the system breaks down very severely.

Obviously these divisions are very rough, and many people will cut across several of them. There are typical diagnoses for some of the categories – 'schizophrenia' is often the choice for the sixth group – but by using these categories rather than medical diagnoses as a guide, I hope to show what the psychiatric services actually do in response to people's overt or covert requests. The people who fall into categories 3–6 will be discussed in subsequent chapters. Meanwhile, we shall look at the first group.

## **PEOPLE WHO ARE ASKING FOR HELP WITH PROBLEMS THAT ARE REALLY RELATIONSHIP OR FAMILY ISSUES**

The ‘depressed housewife’ is the classic example of this type. She may be middle or working class, and may be treated as an in- or out-patient, producing many variations on the same theme. Let us look briefly at another depressed housewife fifteen years after her first breakdown.

### **Susan’s story**

Susan Smith is 58, a frail, timid, anxious-looking woman. She has been in and out of hospital for many years. Her admissions have usually been precipitated by complaints from her husband, Bill, that she is not keeping up with the household chores. He makes an out-patient appointment for her and brings her along, complaining forcefully about this and various other ‘symptoms’, such as her irrational fear that he is about to have an affair. She looks nervous and tearful, agrees she is depressed, and is admitted and medicated.

After many years of this treatment, a discussion in the team meeting led to a different attempt to help. In accordance with current practice, the team had been trying to avoid admission by assigning Susan a community psychiatric nurse to visit her and offer her support at home. This had not worked. At the most recent out-patient appointment, Bill angrily insisted that his wife needed to be kept in hospital for the rest of her life. However, the nurses commented that as soon as she arrived on the ward, Susan brightened up, settled in extremely happily, and showed no signs of depression. The clear indication was that the problems lay in the marital situation rather than simply in an ‘illness’ suffered by Susan. A member of the team agreed to see the couple, not, this time, to pass a medical judgement on the wife, but to find out more about the marital relationship.

There were two sessions, both dominated by Bill. This large, well-built man loudly accused his thin, timorous wife of underfeeding him, of neglecting the housework and of having an irrational fear of his being unfaithful. He talked down to the therapist and demanded to know what she was going to do to improve the situation. The therapist, feeling rather overpowered, tried to point out that change would have to come from them both, and that Susan might have her point of view too. But Susan, who sat in tremulous silence throughout

these outbursts, could not take advantage of this invitation to voice her opinions. She seemed to have been completely cowed by years of submission and the therapist found out that she was fighting Susan's battle for her rather than helping her fight it for herself. Meanwhile Bill frustrated all attempts to get him to listen to his wife by interrupting and loudly insisting that he had always tried every possible way to help. The therapist was only able to claim the limited success of blocking his demand that Susan should once again be admitted to hospital. The opportunity to work on the relationship problems seemed to have passed many years ago.

Here again we see how medicalising a relationship problem heavily reinforced the unhealthy aspects of the marriage – the husband's bullying dominance, which was the counterpart to his wife's cowering submission. If the problem had been seen in a whole-person, whole-system way right back when it started, it might have been possible to do some constructive work with the couple. Alternatively, if the hospital had refused to get involved at all, the resulting crisis might have forced change to occur. But by taking an unhappy middle line, defusing each periodic crisis by admitting Susan without actually taking any steps to deal with the underlying problems, the hospital played a crucial role in helping to maintain this destructive relationship exactly as it was. It was the necessary third player in this unhappy game.

Again, the values of the traditional woman's role were accepted without question. The husband's complaints were accepted at face value, although it emerged in the sessions that one reason for Susan's so-called irrational fear of his being unfaithful was his continual threat to be exactly that if she did not pull herself together. Indeed, the therapist strongly suspected that he was already having affairs, and that his demands for his wife's hospitalisation coincided with times when it would be convenient to have her out of the way. However, by the time a more community-based, psychotherapeutic approach was available, the situation was too entrenched for change.

Not very long ago, Susan might have become one of the long-stay patients whose world is bounded by the grounds of a large Victorian asylum, where years of case notes slowly accumulate in the files. In today's world, community teams who inherit such cases are likely to be involved in a long, demoralising struggle with the legacy of the earlier medical approach. And because community teams still incorporate many elements of the medical model – for example, the use of diagnoses and medication – the overriding messages are still likely to be the 'illness' ones that are

keeping the situation so stuck. From a nursing point of view, this can be extremely frustrating, as one researcher observed:

In contrast to the ward, where the nurses had collective responsibility for dealing with a group of patients within a ward environment dominated by the ethos of organic psychiatry . . . the community nurses were heavily committed to the idea of establishing a personal relationship with their patients and helping to resolve their problems through individual psychological counselling . . . [However], the social role of the mental health system in modern society ensured that the contradictions and stresses which often led the ward nurses to withdraw from patient contact were recreated within the community setting . . . The community nurses' failure to perceive the underlying continuities within the structure of the mental health system could cause them to respond to changes in their work with initial enthusiasm followed by growing disillusionment.<sup>15</sup>

## **THE RESCUE GAME**

There are two predominant models or ways of viewing mental distress in psychiatry, one official and one unofficial. The first is the medical model, and second might be called the 'pull-yourself-together' approach. They combine very destructively to take away responsibility from the identified patient, and then to blame them for their helplessness. We saw with Elaine and Susan how the medical view initially encouraged them and their relatives to see them as helpless victims of an illness unconnected to the rest of their lives, which meant that the psychiatric services had to step in and take responsibility for them. Logically, when this fails to help, as it inevitably does, the conclusion should be either that the illness is more severe or complex than had at first appeared, or that something else is going on. In general hospitals, patients do not get blamed for suffering from incurable illnesses or being misdiagnosed. In psychiatric hospitals, however, the suspicion that psychological and/or social problems are involved tends to manifest itself in a gradual switch from pitying to blaming the patient. The same process can happen outside the hospital as well, with clients who are seen by the community mental health team. They turn from 'mad' to 'bad' and come to acquire one of the many diagnostic labels reserved for people whom the staff do not know how to help: hysterical, attention-seeking, manipulative, immature, inadequate, aggressive, histrionic. At this point, the person may be abruptly discharged. They are then in a



much worse state than before: they have been encouraged to hand over control and responsibility to the psychiatric services and to look to them for a solution, and have then been blamed for the service's failure to provide one. What they *are* left with is the original problem plus confusion, a sense of failure, possible dependence on medication, and a psychiatric label.

The process can be illustrated by a concept from the school of therapy called Transactional Analysis. Transactional Analysis analyses many of the interactions between people as games with predictable outcomes, in which set roles are adopted by the participants. One common example is the Rescue Game, in which the two players take turns to adopt the three main roles of Rescuer, Persecutor and Victim (see Figure 2.1).

'Rescuing' occurs when one person needs help and another person tries to help them. The Rescuer, however, fundamentally believes that people cannot really be helped, and cannot help themselves either. The corresponding position of the Victim (or patient) is: 'I'm helpless and hopeless – try and help me.' The Rescuer responds to this challenge by stepping in and taking over the responsibility for the Victim. Rescuing does not work and the Rescuer soon begins to feel angry with the Victim for being so helpless and hopeless and switches to Persecuting or punishing ('This manipulative patient . . .'). Or the Rescuer may end up being Persecuted by the Victim, who gets angry at being treated as less than equal, and may get his or her own back by making awkward demands, taking up staff time, and so on. Or, like Elaine, the patient may Rescue the staff by pretending to be better. (Rescuing was, of course,

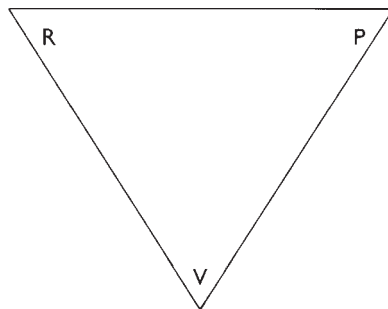


Figure 2.1 The drama triangle

Source: Adapted from S.B. Karpman, 'Script drama analysis', *Transactional Analysis Bulletin* 7 (26) (1968), 39–43

a lifelong pattern for Elaine.) The theory says that each player will occupy every position in the game at some time.

What the three positions have in common is that none of them can be a basis for relating to others as equals. You are either all-powerful or helpless. Some careers – nursing, medicine, the helping professions in general – are particularly suited to those who wish to play a lifelong game of Rescue. The medical profession, with its emphasis on power, status and specialised knowledge, provides an excellent basis for Rescuing if that is what a person wants to do.

In her research on stress in mental health nursing, Jocelyn Handy describes very clearly how nurses can get caught up in the contradictions of the system and, lacking a wider analysis of the situation, end up blaming the patients:

The patient . . . was an ex-school teacher in her early thirties who had been diagnosed as manic-depressive and was being treated within an organic model involving the long-term administration of lithium salts. The patient definitely exhibited quite severe mood swings . . . Whilst these symptoms may have had an organic basis, the nurse's comments indicate that the patient's behaviour also seemed to be influenced by a number of social factors which were not being dealt with because her problem was officially conceptualised in biological terms. In this instance, the main precipitant of a severe mood swing seemed to be a serious row with her boyfriend which had involved him threatening to leave her. The patient's hospitalisation had always reconciled the couple and provided them with a needed respite in which to re-negotiate their relationship. However . . . the long-term effect of this was that the hospital had become involved in their relationship as a third party which simultaneously bound the couple together and made their relationship more unstable by ensuring that both partners could relinquish responsibility for their acts and blame the patient's illness for the problems in their relationship . . . The nurse's description of this patient indicates that she experienced some confusion and frustration about this case. While she was obviously aware of the effect of the patient's personal relationship on her behaviour, she did not seem to consider the effects of the more general mental health context beyond claiming that the patient always 'played the sick role' to manipulate an admission. This statement then seemed to strike the nurse as too extreme and she immediately qualified it by affirming in another part of her diary that the patient had 'genuine mood swings' which were stabilised through lithium. The nurse's attempts to explain the patient's

behaviour thus oscillated rapidly between an individually-oriented psychological model in which the patient took full responsibility for her actions and a medical model in which the patient had no responsibility . . . She later commented to me, rather bitterly, that the patient ‘was never satisfied until she’s proved she’s ill by making you give her an injection’ . . . The nurse’s descriptions of her interactions with other patients illustrated the same problems and indicated that the paradoxes of the mental health system coloured most of her relationships with them.<sup>16</sup>

In psychiatry, the switch from Rescuer to Persecutor, from ‘this patient is mad’ to ‘this patient is bad’ is seen all the time. Some people present themselves as Victims at first assessment. Some are pushed into the Victim role by the process of medicalising their problems and gradually become more helpless and dependent on the psychiatric system, which in turn gradually becomes more Persecutory as harsher remedies are tried out.

This is not to say that Rescuing is always inappropriate. In emergencies – after an overdose, perhaps, or in the relatively rare instances where someone’s mental state puts their own or other people’s safety at risk – it may be necessary for someone else to take total responsibility for a short while. But in the long term any successful attempt to help people to change needs to be based on a treatment contract drawn up by both parties as equal and responsible agents. This flies in the face of all the usual assumptions about the capabilities of those who are called mentally ill. There will be further discussion of this issue later (pp. 59–61). Meanwhile, we can illustrate many of the themes we have been discussing by looking at how the psychiatric system characteristically intervenes in particular situations.

### **PEOPLE WHO ASK FOR HELP WITH PROBLEMS WHICH, WHILE STILL INVOLVING THOSE AROUND THEM, ARE NOT PRIMARILY TO DO WITH CURRENT RELATIONSHIP OR FAMILY ISSUES**

Linda Hart’s moving and compelling account of nine months in a psychiatric hospital, originally written as a diary, won the MIND book of the year award in 1995.<sup>17</sup> I quote extracts from it below.

Linda’s early life was extremely difficult. Her biological father was married to her mother’s mother, who looked after her while her mother went out to work. Linda was the youngest of six children and brought up in poverty. Her father was violent and a heavy drinker, but he did show Linda special affection, which made her siblings angry and envious.

She received little attention or warmth from anyone else. When she was three, Linda found her father dead in the lavatory.

As an adult, married with two sons, Linda became, in her words: 'some kind of Wonderwoman', working full-time, running and renovating a large house, and taking an active part in her local community. Perhaps inevitably, she broke down and was diagnosed as 'schizophrenic' although she believed that she was actually suffering from severe depression. After many years of admissions, her marriage ended. She was working part-time for Social Services in a mental health project when familiar feelings began to recur:

Gradually, high spirits and extravagant behaviour tipped over the line. I started getting up at 4 a.m. and couldn't relax during the evenings . . . That Wednesday evening . . . things began to turn. I was sitting in the kitchen and smelled the maggots in the rotting flesh in my stomach. I could hear my father's voice abusing me, saying I was nothing but a heap of shit and I deserved to die.

Her consultant psychiatrist visited:

I didn't want to go into hospital but Graham [the consultant] said he was going to call for an ambulance and if I didn't go voluntarily then he would get my G.P. and I would be sectioned [that is, admitted against her will] . . . Walking the short distance from my gate to the ambulance made me feel very humiliated and I dared not look around to see if I was being watched by anyone.

On the ward, Linda battled with overwhelming feelings of despair and anguish. Some of the staff were very caring; others were less so:

Last night was very difficult. I could see holograms on the chairs and floor. I spoke to Peter the nurse who tried to help me in my distress. I told him I felt very unsafe. It's as if I have a black stone inside me which continues to cause me despair and torture and has not really shifted an inch.

In her distress, relationships with the staff assumed enormous importance, and stirred up very powerful feelings:

Yesterday . . . I became extremely distraught. It centred around the way Laura was treating me. She didn't actually do anything but her manner was very distant, curt and abrupt. At lunchtime I became overwhelmed by the feeling that everyone on the ward, staff and patients, thoroughly hated me . . . My father jumped on

the bandwagon and told me everyone hated the sight of me and they were all fed up because I wasn't better. I feel very much in need of love and care but find it difficult to accept because I also feel unworthy. I have a degree of charm which people fall for but what they don't know is that I'm full of shit and maggots and putrid flesh. Someone take care of me, I'm very young . . .

Although she needed the ward, many aspects of institutional life were hard to bear:

Here on the ward the room for smoking in is really grotty. It's yellow from nicotine; the chairs all collapse under us; the TV changes channels by itself and has to be hit on frequent occasions; the carpet and coffee table are dirty and there's an extractor fan which makes a terrible droning noise . . . Things are always running out, like Flora and marmalade, butter, jam and toilet paper and tea bags and sugar and tissues.

The petty restrictions added to her feeling of powerlessness as a psychiatric patient:

They employ catering staff to stand by the bowls of cereal to make sure you don't take two Weetabix . . . I asked [a nurse] if I could have my medication early so I could go to bed. He tried to argue that I had to wait till ten because it's better not to do it in dribs and drabs. I said it has taken longer for him to argue than it would have been to hand out the pills. Then I got really angry and said it was humiliating for me at the age of 47 years to have to beg to go for a walk and to ask if I can go to bed.

She was also on very large doses of medication, which produced severe side-effects:

If I sit in a car seat or in an armchair my back muscles go into spasm and I arch my back. This is very uncomfortable and means I can't relax in an easy chair and sitting in a car for long periods is most uncomfortable. Then my stomach is very distended. It sticks right out and starts from under my breasts and goes right down so that I look eight months pregnant. I'm lactating [another effect of the drugs], so my breasts are enlarged. I have electrical sensations in my limbs, which make me jerk and twitch. My nasal passages are blocked so I breathe through my mouth, which gawps and makes me look like an idiot. My head feels fuzzy and I'm distanced from people and find sustained conversation a strain. My toes spread

and in sandals this looks weird. I'm constipated, tired and very unhappy with my lot. [Her consultant decided to increase her medication yet again.] Afterwards I slumped into a deep depression. I saw Laura and couldn't make much sense of what she was saying because I was emotionally overlaid. I felt a terrible fear about the medication but when I saw her later I realised that the fear was a projection. I felt unsafe myself and converted that into being afraid of the staff and to thinking they were trying to kill me with drugs.

In deep despair at her inability to escape her father's voice, Linda made a very serious suicide attempt and was found only just in time. Afterwards various nurses came to see her:

Christine came to special me [that is, to keep her under close observation]. She looked hostile. She said I was selfish, had betrayed her and when I cried she said she had no compassion whatsoever for me . . . Chris, the ward manager, kept away for several days and when he did come in he looked serious and said he had felt angry with me. Laura was also serious and said she felt very upset. I was kept in isolation in the room, only using the loo and the shower en suite. The nurses had each other in their teams, I had nothing. Only my nightie. Jack, who had more to lose than anyone, did not accuse me. He was forgiving and kind and gentle . . . I felt beaten, hated, abused . . . I did try to argue that because I was on a Section 3 [that is, detained on hospital against her will], legally I was not responsible for my actions. They told me over and over again that I couldn't go home and leave the ward because I wasn't considered responsible; but when it came to the hanging, suddenly I was considered responsible . . . I was taking instructions from my father. I had no resources left in my battle against him.

Linda was temporarily transferred to a locked ward, supposedly a safer environment for her. Here, there was little attempt to provide anything more than physical security. Linda felt rejected, terrified and punished:

I started wandering around the ward crying and terribly distressed. The nurse, Bridget, said I had to sit down and talk. I thought to myself I would never talk to a single soul again. How could I trust anyone? Eventually they made me take extra medication, but that didn't have any effect. Then Margaret came and held my hand. That was what I needed.

Very gradually, over a period of months, Linda started to emerge from her despair. She started to make sense of some of her experiences:

The emotions I've experienced [over some incidents on the ward], which are to do with doing something wrong and not being forgiven, have a deeper origin, I think . . . On reflection, I think it has to do with rejection, because when you are rejected by significant people you do feel you have done something wrong, or at least, you are unlovable and to blame. I can remember two occasions of significant rejection. One was my father dying and two was when Gordon [her ex-husband] told me he was leaving me to set up home with Ann. I think the first occasion was very traumatic and I've never really faced it. To find my father dead; to never get him back again; the finality; the panic and fear; to feel responsible for it; to feel guilty and to blame; and he never forgave me for finding him dead on the toilet with his dentures falling on the floor . . . I have never mourned his death, which is why he's still alive. I need to lay him to rest, but can I let him go? Isn't a tormentor better than a void? I wish there was somebody here to hold my hand.

Linda was eventually discharged and was successful in arguing for community-based help; she would be supported at home, and would have weekly visits from Laura, her nurse from the ward, for counselling sessions to explore the meaning of her 'symptoms' and experiences, and in particular the unresolved relationship with her dead father. Although there is a long way to go, she feels she is finally getting the kind of help she needs.

Linda's story is a further illustration of the themes we have been discussing so far. Although it might seem intuitively obvious that Linda had good *reasons* for breaking down, the medical approach on which her treatment was based saw her distress as an *illness*, which turns her experiences of feeling maggots in her stomach, hearing her father's voice and so on into *symptoms*. On this model, discussing the *meaning* of these experiences is as irrelevant as analysing the speech of someone who is delirious. Indeed, the traditional teaching has been that to do so is actually harmful to the patient; Linda's consultant advised her at one point not to look too deeply into herself. The main aim of her treatment, then, is to *suppress* rather than *understand* her 'symptoms'.

The commonest way to try and eliminate symptoms is by prescribing drugs. In more extreme cases, more extreme steps are taken. On a previous admission, Linda had been given ECT (electro-convulsive therapy); contrary to popular belief, ECT is still used throughout Britain on about 11,000 people a year. The flaw in all these interventions is the assumption that removing or relieving the ‘symptom’ is the same as solving the problem. Since this is not the case, repeated rounds of medication and/or ECT are usually necessary. Moreover, because real healing has not taken place, people may be unable to break their dependence on whatever is keeping them going – drugs, hospital admissions or ECT – and may become increasingly reliant on props that are steadily undermining their power to direct and control their own lives.

The Rescue Game is clearly at work in Linda’s account. She was initially Rescued, or taken into hospital under the threat of compulsory admission, a decision that may well have been necessary at the time. However, the staff were very reluctant to allow her to step out of the patient/Victim role and play an equal part in decisions about her care. This, and the numerous petty restrictions of life on the ward, reinforced her sense of fear and powerlessness. Ironically, as Linda herself tried to point out, it was at her time of greatest need and despair that she was finally seen as ‘responsible’ and in fact blameworthy, as the staff Persecuted her for being desperate enough to try to kill herself. Such reactions are not unusual; one authority on suicide noted that in the build-up towards such acts: ‘ward staff became critical of [the patients’] behaviour, which was construed as provocative, unreasonable, or over-dependent . . . Such alienation appears to have been malignant, in the sense that it gathered momentum inexorably and was associated with a fatal outcome.’<sup>18</sup>

Cruel and damaging as such responses are, they too have to be seen in context. In a setting based upon a medical rather than a psychotherapeutic model, little allowance is made for the feelings of the staff, who are left to struggle largely unsupported with the sometimes overwhelming impact of others’ distress. And, as we discussed earlier in the chapter, staff too tend to be caught in the paradoxes of the mental health system: ‘the dynamics of the psychiatric system are not those of “oppressors and oppressed” but of an institution manifestly failing to meet the human needs of both those it exists to help and those who labour within it’.<sup>19</sup> Damaging and Persecutory responses are the inevitable result.

Another inevitable consequence is that in ignoring the meaning of people’s experiences, and failing to see them as part of a whole person and a whole system, the psychiatric services end up recreating the



conflicts that lie behind their breakdowns. Coldness from the staff, who were caught up in their own reactions to Linda's distress, reinforced all her feelings of unworthiness and made her father's voice more abusive. Banished to a locked ward after her suicide attempt, Linda felt as lonely, rejected and punished as she had as a child. All aspects of someone's behaviour on the ward, or of their relationship to a community worker, can give vital clues to their difficulties, and can, if understood correctly, provide a unique opportunity for learning and growth. With insufficient training and support in psychotherapeutic approaches, staff all too often ignore or encourage compliant and passive behaviour, and Persecute anger or dissent.

What was also overlooked was the meaning that physical treatments had for Linda. Not only were the side-effects extremely unpleasant, adding considerably to her distress, but the fear of being persuaded or compelled to take larger and larger doses increased her distrust and fed into her beliefs about her father. Of course, medication can be very unpleasant in general medicine – chemotherapy for cancer, for example – and this isn't necessarily a reason not to prescribe it. Applying the same model in psychiatry, Linda's doctors presumably believed that the imposition of extremely powerful chemical compounds was justified by the urgent need to treat her underlying 'illness'. However, the analogy is false; Linda was looking for help, not with a physical state, but a mental one, and medication at these levels was actually making her mental state worse.

A psychotherapeutic understanding of Linda's difficulties would perhaps see the 'maggots' in her stomach as a vivid metaphor for her self-hatred, and her father's voice as expressing her guilt and confusion about his death. With the help of a counsellor, Linda has built on these insights. She believes that his loss, and the circumstances of his death, were simply too much for a three-year-old to bear. She also suspects that, abusive as he was, a bad father was better than no father at all in her hostile family, and that at some level she has been unable to let him go. Although she still hears his voice, she now feels more in control and less of a victim of these terrifying experiences.<sup>20</sup>

Unfortunately, although community-based teams can often offer talking treatments alongside other interventions, there tends to be little time or support for such work in hospital. This has been even more true in recent years, when the closure of beds has meant that only the most disturbed are admitted to hospital and there is constant pressure to discharge them as quickly as possible. In the words of a recent report, people who are admitted to psychiatric wards enter a 'care vacuum'

where, instead of an individualised approach, they are offered ‘the same service, facilities and environment, regardless of their circumstances or needs, with only minor differences in therapeutic interventions’. In summary, ‘hospital care is a non-therapeutic intervention’ which may actually increase distress in the long term.<sup>21</sup> Even if psychotherapy is offered, it may actually be necessary to undo the effects of medical treatment before the original problem can be tackled; for example, Elaine and her family’s view of her depression, and the way the family relationships were organised around these beliefs.

We can summarise the principles of two major models of understanding mental distress, the medical and the psychotherapeutic, as follows:

| <b>Medical</b>                                | <b>Psychotherapeutic</b>   |
|---|--|
| Deals with the ‘illness’                      | Deals with the person  |
| Problem is within the individual              | Problem seen in relationship/cultural context.                     |
| Looks at ‘symptoms’                           | Looks at meanings  |
| Need to categorise, relate findings to theory | Need to understand, form a relationship                            |
| Aims to return patient to previous state      | Sees opportunity for learning and growth                           |
| Staff feelings marginalised/ignored           | Staff feelings acknowledged and supported, as central to the work. |

Of course, in any enlightened medical setting there will be attempts to support the staff, form good relationships with the patients and see people in their wider context. However, this will be *in addition to* the real treatment – the operation, the medication regime and so on – and is perfectly appropriate for most physical illnesses. In a psychotherapeutic setting, where emotional distress is the focus, *the relationships are the treatment*. The healing comes not from medication (although it may help someone to cope), but from other human beings. Linda’s story illustrates the point. In her greatest distress, she wanted to be offered, not pills, but a hand to hold. She was searching, not for the correct diagnosis, but for a way to understand her experiences. She is working towards healing, not with the aid of drugs – in fact, she is weaning herself off them – but with the help of a trusting relationship within which she can come to terms with her past.

Most contemporary psychiatrists would see themselves as using an ‘eclectic’ approach – that is, they draw from a number of different models, including psychotherapeutic ones, as appropriate to the situation. However, the above summary, and the stories we have heard so far, make it clear that medical and psychotherapeutic models are fundamentally incompatible. They start from opposing assumptions, give contradictory messages to patients and staff, and have different aims. It would be more accurate to describe the so-called eclectic model as unintegrated, in terms of its poorly thought-out philosophy and inconsistent application. An American psychiatrist describes his observations during training:

I listened carefully to staff psychiatrists who made discontinuous switches back and forth between the two dominant paradigms [models] in discussion of a single case, within the same spoken paragraph, and I realised that psychiatry does not have a coherent, unified model or doctrine. In one instance, a psychiatrist was discussing a young man with schizophrenia from a biomedical . . . point of view. Suddenly, he lurched into a discussion of projection as the underlying mechanism for some of the man’s symptoms; then after a couple of sentences, he as suddenly returned to his biomedical mode and vocabulary.<sup>22</sup>

This kind of confusion can be observed on a daily basis in psychiatry. For example, a young man is referred to the psychiatric team after the death of his father, and counselling is recommended to help him through his grief. However, as soon as he becomes tearful and low – a necessary part of coming to terms with his loss, from a psychotherapeutic view – he is prescribed anti-depressants, which suppress his feelings again. Community mental health teams have moved away from the hospital site, but since the medical way of thinking still runs in parallel with psychotherapeutic models, the same kind of muddle still follows. Clients who have suffered major traumas may be assessed as having a ‘depressive illness’ rather than an understandable emotional response, and be offered medication in parallel with counselling. Survivors of sexual abuse may find that therapy is only offered at the cost of acquiring a psychiatric label.

In my experience, the switch from psychotherapeutic to medical language has very little to do with the patient and his/her problems. It tends to occur when mental health professionals, and psychiatrists in particular, reach the limits of their own ability to see someone’s distress in psychological terms and to bear the feelings that this stirs up. Since

most professionals only have a very basic training in counselling, if any at all (see Chapter 7), these limits are reached fairly rapidly. Medical and/or Persecutory interventions are the rule for patients who are more distressed than the staff can bear, as Linda discovered. As one woman put it, 'I feel that, essentially, when a doctor prescribes a pill for me, it's to put *him* out of *my* misery.'<sup>23</sup>

The split in the treatment approaches can come to reflect the split in the patient: 'Can I bear to get in touch with my feelings, or shall I try and push them away?' Unless this split in the treatment is resolved, there is no chance of resolving it within the patient. He or she will simply become trapped in the mixed messages from the staff, who are themselves trapped in the mixed messages of the system they work in.

We have now seen numerous examples of the ways in which the main model of mental distress, on which psychiatry as a branch of medicine is based, that is the medical/illness model, undermines and opposes the psychotherapeutic one, often with disastrous results for patients and staff. However, the split is not just between different models of intervention. There is also a fundamental split between the way service users generally see their problems and the way their difficulties are seen by psychiatrists. When asked what made them break down, service users typically give this kind of response:

I was depressed and upset following the death of my mother. We had a difficult relationship and I never felt wanted by her. While she was alive I felt she never loved me. After her death there was no chance to put that right. Also earlier abuse by a family member affected me and the relationship I had with my husband as a result.

Long periods of unemployment. Society in general saying that there was plenty of work to be had, so those out of work were seen as being lazy. Employers told you that you were no good by not employing you.

The direct issue was the loss of my baby. The indirect one was problems with my neighbours and my job.<sup>24</sup>

If I look back on what caused the depression and what caused me to try and take my life, it was quite normal, average things . . . a divorce, I had two children, I was three months pregnant when I left . . . holding three jobs down, mundane jobs, trying to keep it going really. I was worn out, absolutely worn out.<sup>25</sup>

In other words, despite the adoption of some medical terminology ('I'm diagnosed as manic-depressive', 'I was very psychotic at the time'<sup>26</sup>),

service users tend to attribute their breakdowns not to *illness*, but to a variety of psychological and social *reasons*. The shorthand for this is a *psychosocial* understanding of mental distress; that is, a model which sees psychiatric breakdown as resulting from a mixture of *psychological factors* (mainly past and present relationship difficulties, and sometimes a spiritual crisis of values and beliefs), often accompanied by *social and financial problems*.

An eclectic psychiatric view would certainly see such factors as being relevant too; perhaps they were triggers for an underlying illness in rather the same way that stressful life events may lower your immunity to cancer. This is sometimes known as a vulnerability-stress model of mental illness, and is subscribed to by many psychiatrists. However, a survey of 516 service users emphasises the difference in viewpoint: 'It was not these factors which *led* to their problem; these *were* the problem. . . . Respondents saw their difficulties as meaningful in the context of their life experiences in regard to past disappointments, current dilemmas and future concerns.'<sup>27</sup> Their difficulties were complex and individual, and could not be reduced to simple diagnostic categories such as 'manic-depression' or 'anxiety neurosis'.

As many readers will be aware, dissatisfaction with what the psychiatric services offer has led to the rise of an increasingly active and vocal service user movement in recent years. Their protests make sense if there is such a mismatch between how service users and professionals view mental distress and the ways it should be dealt with. The above survey put it like this:

Being treated in a medicalised way, as if they had physical illnesses, formed the basis of negative evaluations and complaints on the part of most users in every aspect of their management. This ranged from a dislike of the aloof and cool attitude of psychiatrists during interviews whilst in-patients, to the rejection of physical treatments as a response to personal distress. In summary, the professional discourse and the lay discourse about personal distress are incompatible . . . In this light it is not surprising that our respondents felt misunderstood and aggrieved so often.<sup>28</sup>

It is consistent with these findings that service users described warm, caring attitudes and being treated with respect as the most appreciated aspects of their treatment. Counselling or psychotherapy was described as helpful or very helpful by almost three-quarters of those who had been offered it. On the other hand, a narrow focus on medication and diagnosis was disliked: 'They have a set diagnosis which they work to

and treat [you] with ECT and drugs. They do not search out the reasons for your illness with you, so the illness just repeats again and again.’<sup>29</sup> Perhaps we should not be surprised that this survey found psychiatrists rated as the least helpful profession by one in five people, and the most helpful by only one in eight.

Other surveys of user views have produced similar results; for example, women who self-harm report that what they want above all is to be able to talk to someone who is sympathetic and supportive about their emotional and practical difficulties. What they are more likely to get from the psychiatric services is ‘no help other than a hurried prescription for drugs’ and dismissive or blaming attitudes; 96 per cent of them are dissatisfied with their hospital treatment.<sup>30</sup> Of those service users who spoke to the Mental Health Foundation, 401 said their main need when distressed was for ‘someone to talk to’, to be listened to and respected, to help them express and understand their feelings. This did not necessarily mean formal counselling sessions, although again these were rated very positively by those who had been offered them: ‘Because I feel my mental illness had its roots in emotional damage . . . examining these things was more profitable than merely using drugs to contain it.’ Although medication could also be helpful, people were clear about its limitations: ‘A recurring theme is the failure of these treatments to take account of the whole person.’ As one respondent put it, ‘Medical treatments can be applied in an impersonal way, as though you are an object that needs re-moulding rather than a person with feelings and human needs.’<sup>31</sup> And a detailed investigation into the lives of discharged psychiatric patients uncovered the same themes in those trying to survive in the community. One person put it particularly clearly:

A doctor treats a *patient* and he looks at it, he’s patient-orientated and my contention is that I get mentally ill because of social problems . . . Although they tackle me and give me these injections and so on, it will continue to happen because of the social problems involved . . . If you like, I am the symptom of something outside, the cause is outside, whereas they would see the cause as me and if they solved me, solved my problem, then everybody else is all right. And so it’s an eternal conflict!

As the interviewers noted:

What participants looked for from psychiatrists was an approach that took account of their needs and concerns as persons, an approach in which . . . the prescription of anti-psychotic drugs was an adjunct

to a psychosocial understanding of their predicaments rather than a substitute for such understanding . . . And it was here that their conflicts with the medical profession arose.<sup>32</sup>

If the above picture is accurate, and there is indeed an irreconcilable difference between what service users want and what the psychiatric system provides, between the *psychosocial* understandings and needs of those in distress and the *medical* assumptions and treatments of the professionals, then two results can be predicted:

1. recovery within the psychiatric system will be rare;
2. those who do recover will do so despite rather than because of their psychiatric treatment, and mainly with help from non-medical settings outside the psychiatric system.

There is evidence for both these predictions.

Anyone who has worked in psychiatry knows how unusual it is for people to recover completely and be discharged for ever. One psychiatrist who asked colleagues in a busy psychiatric unit to identify recovered patients for a research project collected only thirteen names in nine months, and even these people were still suffering from considerable problems.<sup>33</sup> Every ward has its complement of regular attenders who may have had up to twenty or thirty admissions over the years. The staff move on; the patients, on the whole, do not. Some of this can be attributed to the 'poor prognoses' of the 'illnesses' concerned, although there is intriguing evidence that 'schizophrenia', for example, has a much better outcome in non-Western, non-medical settings (see Chapter 10). The alarmingly high re-admission rate, as discussed in Chapter 1, confirms this depressing picture.

There has been remarkably little official interest in how service users do explain their recovery, if it occurs (although service users themselves have written on the subject<sup>34</sup>), but some patterns can be discerned. The people in the Mental Health Foundation survey had found alternative and complementary therapies very helpful, as well as a variety of coping strategies (exercise, keeping busy, having a regular routine, getting support from friends, and so on). Many of them found support from religious and spiritual beliefs. Others described how their lives were turned around by, for example, a stay in a therapeutic community. These are hospitals run entirely along the psychotherapeutic principles already described; a few of them exist in the NHS, usually under permanent threat of having their funds withdrawn:

It was the most helpful psychiatric ward I was ever in. What made it so helpful was the ethos that we were all there to help each other. We had to agree to a written contract before we went in. We could leave at any time. No one took any drugs. The contract said some unusual things, for example, 'Free expression and exchange of views is desired so that we can learn about these reactions between people.' Also, 'The staff do not have all the answers, and they have their problems too. The patient is just as likely as the staff members to find a solution to one of the problems under discussion' . . . I was in this residential place for over three months, and came home transformed. It was like being brought up again. It was a lesson in love from fellow group and staff members. I carry the things I learned with me still.<sup>35</sup>

As we have already noted, not everyone wants or needs formal counselling or psychotherapy, and the woman quoted above, like many others in the surveys we have discussed, also found invaluable support from other service users and self-help groups:

A friend's boyfriend had joined a self-help network . . . A few months later I hit a further low-spot of despair and went along to a meeting. I was greeted as an equal . . . No one was an expert; they'd all started where I was. Meetings were led in turn, all tasks were subject to election and time-limited, so all members quickly felt ownership of the group . . . I cannot describe the difference between a self-help group based on mutual respect, and the mental health system where one set of people are the healers and get status and money for it, and another are the 'mentally ill', at the bottom of the hierarchy with less than equal citizenship, stigmatised, no power, barely enough money, seldom respected work, and sometimes no housing.<sup>36</sup>

Others echo these sentiments:

I have the support of the tranquilliser project . . . and I work for them and we all help and encourage each other, support each other and it's brilliant. And you have to build back your self-esteem, your self-worth, it doesn't just happen . . . and I'm doing it now and it's fantastic.

I had so much inspiration from other people who were further on [at a support group], and I really just got involved and started helping out there and becoming a bit more empowered . . . I just knew that's what I wanted to do, try and help other people in the way that that helped me.<sup>37</sup>



The survey of 516 service users noted that they tended to speak far more positively about voluntary sector provision (drop-in centres, clubs and groups and so on) than about the official services, because of the less formal and more equal relationships, the support from others in similar situations, and the chance to make an active contribution to the service.

The overall themes are by now very clear. A substantial proportion of users of the psychiatric services find them not only unhelpful, but actually damaging. The good work that does go on is undermined by the basic principles on which the service is run, which derive from the medical model of mental distress. Service users on the whole see their difficulties in terms that are not just different from, but incompatible with, these assumptions; this can be referred to as a psychosocial understanding of distress. Those who recover often do so despite, rather than because of, their psychiatric treatment, and with non-medical help from outside the psychiatric system.

All of this raises important questions such as: Why does psychiatry continue to operate in this way, if it is so unhelpful? Is there any evidence in support of these models and approaches? How can the situation be changed? However, before discussing these issues, we need to look at some further consequences of traditional psychiatric practice.