Putting the soul back into psychiatry

MindThink report 1
Introduction

How does psychiatry relate to users of psychiatric services? What does it have to say about their direct experiences of mental distress? How do psychiatrists relate to alternative modes of treatment and to other professions and services? Is psychiatry capable of operating across the cultural, religious and spiritual boundaries characteristic of a diverse society?

On 21 March 2007, Mind held a MindThink seminar at Church House in London to grapple with these questions. The seminar was held in association with the Centre for Ethnicity and Health at the University of Central Lancashire and the Critical Psychiatry Network. It brought together a range of people with experience of mental distress and the mental health system, along with psychiatrists, academics and others with an interest in psychiatry, culture and spirituality.

Participants

This report is based on a roundtable discussion held in March 2007. The views of participants varied. This report captures some key issues discussed at the seminar, and what Mind believes were some of the most interesting proposals for change. It should not be assumed that all individual participants would agree with all of its recommendations.

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Discussion points and conclusions from the seminar are summarised in this report, which also makes some practical recommendations for reform of psychiatry. Participants had different views on key issues. These disagreements are not always captured in detail by this report, which highlights some key issues and draws out some conclusions on which there was wide (if not complete) consensus. The report is not exhaustive in its coverage of the issues and does not discuss the available literature and evidence base. Its purpose is to provoke discussion, not pre-empt it; to inform and reconfigure debates on key issues, not to provide the final word.

Unless attributed to another source, all quotes are from the transcripts of the seminar. Mind would like to thank all participants for their involvement and contributions.
‘Psychiatry needs to recognise the limitations in the ways it currently approaches mental distress and open itself up to the experiences and expertise of those with direct experience of distress, receiving mental health services and living with a mental illness diagnosis in contemporary society. If psychiatry is to avoid driving itself and those it deals with further up an increasingly barren cul-de-sac, it must have the courage and insight to give up its heavy dependence on the medical model and the quick-fix technology of psychiatric medication. Above all, psychiatry must step down into the street alongside service users and be guided first by what they want from their lives, not by the knowledge it has been perfecting in spotless laboratories and ivory tower institutions. In this way we might end up with some outcomes we can all live with…’

Peter Campbell, survivor

‘I fear that university and paid work will become the most revered ‘recovery outcomes’ which will leave some of us feeling that our ‘recovery’ is somewhat substandard by comparison. Psychiatry really needs to consider changing to becoming a ‘gateway’ for people to enter to access anything which may help. Some people might want traditional psychiatry or psychology, whereas the next person might want a clairvoyant ghost specialist or Maori drumming. It would be the job of the psychiatrist to bring in whatever the person wanted according to their frame of reference on the NHS. Labels wouldn’t be required to access social supports, we would be able to use ordinary language such as ‘voice hearer’ which a psychiatrist could legitimately back.’

Louise Pembroke, survivor

‘Psychiatry should be a service, subservient to people’s needs; it can work for some people but should not have a privileged position. Choice, control and service user empowerment is the fundamental thing.’

David Crepaz-Keay, Mental Health Foundation

**Background and context**

Currently, there is widespread concern that psychiatry is being co-opted by a wider political agenda that may be corrosive of the therapeutic basis of psychiatric practice. Psychiatrists are blamed in the extremely rare cases where people with mental health problems commit violent crimes. The wider political agenda on mental health is driven by exaggerated public safety fears that are often fed by myth and misinformation. This shapes the perceptions and expectations of psychiatry of the general public, policy makers and opinion formers. It is against this background, that the psychiatrist’s role is shifting.

The Mental Health Act 2007 gives psychiatrists new powers to control the behaviour of people who are discharged from hospital and living in the community – powers which many psychiatrists did not want. There are concerns that psychiatric hospitals will be used to warehouse ‘difficult’ people for whom they can offer little or no treatment with therapeutic benefit.

Another serious cause for concern is over-representation of BME groups in the mental health system. While the exact causes of this over-representation are disputed, the approach that psychiatry takes to social justice and cultural identity will surely be of critical importance in addressing these imbalances. The ‘Count Me In’ census in 2007 found that black people were 44 per cent more likely to be sectioned under the Mental Health Act, and black men in the mental health system were 29 per cent more likely to be subject to control and restraint. Psychiatrists do not need to have racist intent to perpetuate a situation in which black people are over-represented – this may appear to amount to a form of institutional racism within the psychiatric system.

The debate about the nature of psychiatry has profound and far-reaching social implications for everyone. It raises basic human rights and civil liberties issues. It invites fundamental questions about the vocation and limits of psychiatry in multicultural societies.
‘What follows is essentially giving people permission to change.’

Department of Health, *New Ways of Working for Psychiatrists*

‘Psychiatrists have a long medical training which focuses too much on scientific knowledge and diagnosis and not enough on understanding the social issues that cause emotional distress. Nor does the training equip psychiatrists with the skills to empower people to recover. Until these issues are addressed through initial training and also through continuing training, changes within the mental health system will be difficult to achieve.’

Kathleen Aitken, Swindon Mind

‘It is important never to lose sight of the big, foundational questions – not least, the need for evolution in our understanding of what the psyche is and what “madness” is. A reductionist model currently dominates psychiatric practice, and is why you get the corresponding focus on neuropsychiatric models and biological solutions. Addressing the limits of psychiatric practice means addressing fundamental questions about human experience and the nature of distress.’

Dr Nicki Crowley

‘Demonising psychiatry does not help – it alienates people. There is a lot of disquiet within psychiatry at the moment – psychiatrists want to be medical practitioners, they do not want to be police.’

MindThink participant

‘The German philosopher Karl Jaspers distinguished between science and scientism. Scientism is rigid and dogmatic – it makes a sort of cult or belief system out of scientific forms and scientific language. Real science is about challenge, criticism, evolution and progress through evidence. A narrow medical model is not science; it is scientism. Scientific method is a powerful tool in challenging the claims made for psychiatry as a form of scientism.’

Prof. Bill Fulford

**Positive moves towards a value-based approach**

In October 2005, the Department of Health published *New Ways of Working for Psychiatrists* (NWW), which argues for a new values-based approach to psychiatry. This was the final report of a National Steering Group chaired by the Royal College of Psychiatrists and NIMHE. In part, it was a response to dissatisfaction and burn-out within the profession and to difficulties in recruiting and retaining staff to work in mental health services.

The NWW review calls for ‘big culture change’. Psychiatry must adapt to a ‘person-centred’ ethos in mental health services. This requires a better understanding of ‘cultural identity’, and of ‘how this might impact on … behaviour and beliefs’. The NWW concludes that psychiatrists need to work with a social model of mental distress, and to work in multidisciplinary and multi-agency teams.

Professor Bill Fulford explained that value-based practice is all about a psychiatry that recognises the importance of interpersonal relations and is rooted in respect for individual and cultural diversity. It places a particular emphasis on the processes and forms through which psychiatrists engage with people, rather than understanding the psychiatrist’s role in terms of a set of fixed and determined outcomes. NWW is a major step forward in the development of a new psychiatric practice. It seeks to combine evidence-based and value-based approaches. It recognises the essentially multidisciplinary nature of effective mental health work, and champions a multi-agency approach to service delivery.

Psychiatry has derived much of its status and sense of importance from its identification as a bona fide medical discipline. It is still necessary to qualify as a medical doctor if you want to become a psychiatrist. Key functions of psychiatrists include diagnosis of ‘illness’ and the authority to wield a prescription pad. Can this kind of psychiatry respond to the values, cultures and beliefs of service users? Can it give appropriate weight to social inclusion? Professor Phil Thomas asks ‘what point is there in respecting the patient’s view if you believe the main objective is to rectify a neurochemical imbalance in someone’s brain?’
Crucially, a values-based psychiatry must fully involve users of psychiatric services in the review and reform of the profession. A 2003 review of the mental health service user movement in England concluded, ‘it can at times appear that the movement is divided between those who seek to reform services and those who want to challenge the scientific basis of them. However, the movement remains united on the importance of putting the views of service users centre stage’. A step-change in service user involvement in psychiatry is required if we are to make a reality of the ‘person-centred ethos’ called for in NWW.

**Soulless psychiatry? Concerns and issues**

Experiences and perceptions of psychiatry varied. Dr Christine Vize was sad to hear the word ‘psychiatry’ used as shorthand for soulless, disrespectful or bad practice. She said that the challenge for psychiatrists is to correct the balance by promoting the good practice that exists and developing and spreading it further. Some service users highlighted positive experiences. Marion Janner said her experience of psychiatry was ‘not disempowering or narrowly focused on diagnostic categories’. She had that day come from a ‘wide-ranging discussion’ with her psychiatrist, covering ‘suicide, housework, application for Disability Living Allowance, friends, work, nutrition, reducing medication, niche therapy and the internet’.

**Becoming a diagnosis**

Service user contributors to the MindThink seminar argued that psychiatric practice based on a narrowly medical model of mental distress reduced human beings to diagnostic categories and a range of human experience to symptoms of ‘illness’.

People’s expressions of life and creativity – be it their art, what they wear, hobbies and interests or religious convictions – may be pathologised. For example, Louise Pembroke had been asked why she wore Indian clothes in a way that pathologised her choice of clothing, and had been told that she was wearing ‘too much eye make-up’ and that this was symptomatic of a borderline personality disorder. At its worst, psychiatry reduces people to embodiments of diagnoses. Subjective experiences, individual choices, cultural identities and religious beliefs are reduced without remainder to the dimensions of a ‘disease’.

Psychiatrists are increasingly questioning the validity and usefulness of mental health diagnoses, a view that was well represented at the MindThink seminar. The diagnosis of schizophrenia is a prime example. Its impact on users of psychiatric services was described by one participant as a ‘psychiatric death sentence’. It was argued that the label ‘schizophrenia’ focused on deficit and deterioration and carried a fatal payload of stigma, discrimination and exclusion. A 1998 Health Education Authority (HEA) report, *Healthy living with Schizophrenia*, concluded that a frequent concern among people who were newly diagnosed as schizophrenic was that they – wrongly – feared that they would become violent. This label comes with a lot of negative baggage, while, some frontline psychiatrists now argue, providing little real guidance for psychiatrists and other treatment providers, beyond encouraging the heavy use of medications. Similar points can be made about the increasing use of ‘personality disorder’ diagnoses.

‘People are reduced to walking embodiments of a diagnosis.’
Louise Pembroke, survivor

‘It is important the professionals stand up and draw attention to the harmful consequences of diagnostic labels … Psychiatric diagnosis is unscientific and thus a barrier to progress in research, conceptually and empirically.’
Prof. Phil Thomas

‘The key thing is that diagnoses have to be fit for purpose – and many people do not feel that existing diagnoses are fit for purpose any longer. Categories need to change and evolve.’
Prof. Bill Fulford
Blaming the customer
There is a growing public, media and political perception that drugs are the magic bullet for mental distress and that the main barrier to recovery is service users who don’t take medication. Discontinuing medication does often result in relapse (and, for some, to a return to hospital). But it was argued that the trend is to blame the service user for the limits and failures of available treatments. Service users are routinely condemned for stopping taking drugs that are having limited benefit and negative side-effects. Service users are criticised for failing to engage with psychiatric therapies that they do not feel are appropriate or helpful for them – or for failing to engage in ‘the right way’. It is important to get the message across that when people stop taking ‘their’ medication, this is often linked to problems with the drugs or the combinations of drugs or the dosages.

‘Medication makes a lot of people feel soulless. People are given medication on the understanding that it will enable them to respond to other forms of treatment – but too often that promise is empty and there is only medication.’

Peter Campbell, survivor

Meaning, culture and spirituality
The psychiatrist’s relationship with service users is often didactic and directive, not discursive and engaged. Psychiatrists appeared to avoid discussion of the meaning and significance of service users’ experiences, for example, to engage in any exploration of the textures and meanings of a particular experience of ‘hearing voices’. It was noted that medical students risk ridicule if they raise issues about the cultural or spiritual dimensions of mental health. It is difficult to see how psychiatry can operate effectively and appropriately in a multi-ethnic, multicultural and multifaith society while service user experiences that are lived in cultural, religious and spiritual terms are regarded as ‘pathological’ or ‘delusional’ – and therefore devoid of any meaningful or significant content.

DSM IV identifies ‘religious or spiritual problem’ as a mental health diagnosis. It states that ‘this category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values which may not necessarily be related to an organised church or religious institutions.’ Dr Nicki Crowley asked whether some experiences should be classified as symptoms of psychosis or crises within spiritual life. US transpersonal psychiatrists John Nelson and Stanislav Grof were of the opinion that to pathologise these experiences is necessarily to override the way they are understood in some cultural and religious traditions.

The comment was made that it is vital for psychiatrists to recognise that their knowledge and expertise is of limited application and value in engaging with human experience of mental distress. Responding appropriately to mental distress is not only about taking service user experience seriously, it is also about recognising the limits of psychiatric knowledge itself, and knowing who to turn to when the limits of that knowledge are reached.

Experience of discrimination and the mental health system
There was discussion of the social dimensions of mental health. Lack of housing, an impoverished physical environment, experience of abusive relationships, workplace discrimination and debt can all be causes of mental distress and obstacles to recovery. Psychiatrists must therefore work in close partnership with a range of stakeholders and agencies to address mental distress in its wider economic and social context. This may require radical shifts in the practice of psychiatry and its relation to other professions and stakeholders.

It was argued that psychiatrists need to be aware of the systems and procedures which form the context for encounters with mental health service users – the impact these have, and the damage they do. What does it mean to live with a mental health diagnosis in contemporary society? What is it like to be sectioned? What is it like to find yourself in handcuffs and solitary confinement at a time of acute stress and vulnerability? What is it like to find yourself on an acute ward that is unclean or unsafe? Such circumstances frame many interactions between service users and psychiatrists – and yet they are invisible in the consulting room.
‘S/he will respect diversity and recognise that issues of age, social background, spirituality, race and culture require particular attention on account of the nature and consequences of stigma, discrimination and exclusion. S/he will recognise that social inequality and exclusion have a potentially devastating effect on the recovery process.’

‘Person Description for Doctors in Specialist Training in Psychiatry’

‘The over-representation of some BME groups within the mental health system is well documented. While there are a number of factors which together lead to this disparity, of critical importance are conceptions of normality/abnormality and risk which underpin psychiatry. These precepts are formed and understood within a racialised social context where BME peoples, African-Caribbean people in particular, represent ‘other’ – the ‘non-normal’, ‘the mystery’ and by extension ‘the threat’. Accordingly, conscious racist intent on the part of psychiatry is not required to generate the disparity. The normal operations of psychiatry include the appropriate dynamics for racial bias.’

Marcel Vige, Mind

‘This perspective should be underpinned by a positive attitude of hope and recovery that each person may continue to lead a self-defined life, thus reflecting their hopes and ambitions. The individual needs to be able to make their own choices, be the key person in interpreting what is happening to them and, therefore, in deciding on interventions they will engage with.’

‘There are many facets to people’s lives; seeing them too narrowly not only risks failure to meet their needs but can also cause them and their families damage.’

Department of Health, New Ways of Working for Psychiatrists

**Putting the soul back into psychiatry – things to think about**

What would putting the soul back into psychiatry look like? What needs to change if we are to develop a new values-based psychiatry that respects service user narratives and sees mental distress in its social and cultural contexts? These issues were discussed in the concluding session of this MindThink seminar. While opinion varied and there was not necessarily a consensus on the way forward, a number of proposals were made that had wide support at the event, and which Mind believes should be taken up and explored by the relevant policy bodies and practitioner communities. The following is a selection:

1. **More emphasis on ‘people skills’ in the recruitment and training of psychiatrists.**

   ‘Excellent people skills should be key for a career in psychiatry and fundamental in the training of psychiatrists – that includes more awareness from psychiatrists of what they are about and where they are coming from.’

   ‘Dehumanisation starts with basic training – for example, medical students being told they are weak for showing compassion to patients or being put down for doing so.’

2. **More meaningful service user, carer and community involvement in the syllabus, curriculum and training programme for psychiatrists and in the development of values-based psychiatry.**

   ‘Service user/survivors and other stakeholders need to get more inside the thinking of the Royal College of Psychiatry and to keep these issues alive. For example, there could be a service user reference group linked formally to the RCP to contribute to debate on the development of psychiatry as a profession – for example, by advising on training and curriculum development.’

3. **More service user, carer and community involvement in the education and training of psychiatrists.**

   ‘It can be really difficult for service users to get their articles published in the sorts of journals that psychiatrists read, even when they’ve got the support and backing of psychiatrists for their work.’
‘There is a lot of evidence out there that trainee psychiatrists do not get to see and that needs to be made more accessible to them. One existing project is to get survivor lectures filmed and sent around to medical and nursing schools that may not be able to get survivors in to speak to people.’

4. A review of the content of the MRCPsych Syllabus involving service users, carers and others in the mental health system.

‘There should be less emphasis on clinical neuroscience, and more emphasis on philosophy, the history of psychiatry, anthropology and the humanities.’

5. Change to improve understanding and communication between psychiatrists and other stakeholders in multidisciplinary contexts.

‘The way psychiatrists relate to other stakeholders could be improved by a deinstitutionalisation of psychiatric training, moving away from placements in hospital-based services, to community organisations and primary care.’

‘What about service user/survivor mentoring for psychiatrists and other mental health professionals? Or service users getting involved in overseeing research projects by psychiatrists?’

6. Developing psychiatric practice that is responsive to service user choice and enables service users to explore alternatives to medical and neuroleptic approaches.

‘Ninety per cent of service user life is not about psychiatry – the most effective way to empower service users is to provide greater choice of therapeutic and other interventions – so psychiatry becomes a gateway to services and one option among others.’

7. Service user involvement in identifying, negotiating and re-negotiating desired treatment outcomes and modalities with mental health service providers.

‘At the moment, clinicians typically decide what matters in treatment and what the desired outcome of treatment is – as well as what form it takes. Service users need to have much greater control and involvement in treatment processes.’

‘Choice, control and service user empowerment are the fundamental thing. People may choose psychiatry or not, they may choose drug treatments or talking therapies or something else.’

8. Clinical and other administrative processes should be reformed to enable frontline psychiatrists to avoid using labels such as schizophrenia in circumstances where their professional judgement says that they are unhelpful or inappropriate.

‘You have to use the labels. Service users currently require a diagnosis to access benefits and social care – for example, disability living allowance – and a range of clinical and other services may be denied to people who don’t get the “right” diagnostic label, even if they are in great distress. So psychiatrists end up using the labels even when they know they don’t really fit.’

‘It would be a big step away from a narrowly medical model if psychiatrists were able to use plain English descriptions on forms, instead of diagnostic labels.’