Correspondence

EDITED BY TOM FAHY

Psychiatry and the politics of the underclass

Sir: Thomas *et al* (1996) ascribe "the death of community care" to the failure of psychiatry to meet the needs of service users. Although I share their concern about our adherence to the medical model, I believe historical and social factors have not only exposed its inadequacies but have also contributed to its persistence.

In the UK, our adherence to the medical model is the direct result of decisions taken by the Macmillan Committee in 1924 in the belief that a disease model would destigmatise patients by removing the charge that they were responsible for their plight, allow access to the "sick role" and a means of securing resources for mental health care. More recently, there has been an undue emphasis on the right of the individual to succeed or fail without collective responsibility for social adversity. In this context it does not seem surprising that psychiatrists have attempted to protect their patients from stigma and blame by an adherence to the medical model.

Psychiatry has found itself caught in a double bind as de-institutionalisation has inexorably proceeded. A redefinition of community mental health services should be possible in the future but only through a political and economic climate that encourages society to consider mental health as a public health issue and assume collective responsibility for disadvantaged members, allowing us to move on from the medical model.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

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Sir: Thomas *et al* (1996) reiterate well-established arguments on political influence in psychiatry, and the devaluing of social factors and causation of illness through the pursuit of biological psychiatry. By providing us with few recommendations on how to alter our culture in their conclusions, they have unwittingly illustrated a core issue: that physicians have little sway with the forces of society and culture that may shape an illness' aetiology, diagnosis, treatment, course and prognosis. From the helplessness produced by this conflict, biological psychiatry can be seen as a secure base, and there is no shame in this approach.

In their conclusion, the argument becomes less clear when Thomas *et al* advocate clearer communication and understanding (i.e. treatment), at the expense of the diagnostic interview. The latter is of prime importance in establishing some order in the chaotic life of the patient. After this, ventilation, understanding, help with jobs and housing can begin, namely through the well-established disciplines of psychotherapy and social work.

It is correct that the argument about "our blind devotion to biology at the expense of all else" needs dusting off and reframing for the present political climate. However, their recommendation for social definitions of illness would lead us constantly to rework our models of illness, depending on the prevailing wind of politics and culture.

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Sir: I wonder whether I am the only psychiatrist who was disappointed with your October editorial by Thomas *et al* (1996). The authors draw conclusions that people who use mental health services are disillusioned. Do they mean everyone? This is not my overall experience but if it were true, even of some, could it be related to the kind of disillusion among mental health services staff that such negative articles risk engendering?

The authors also conclude that, "There is no sharing of languages, no common tongue with which to forge a genuine understanding". Concentrating on psychiatric rehabilitation, I take issue with this. Individuals affected by long-term mental illnesses may suffer a range of impairments, handicaps and disabilities. These are useful concepts, particularly the latter which can further be understood as primary, secondary and tertiary (Wing & Morris, 1981).

It seems to me to be the mental attitude to achieve positively for those disadvantaged by long-term mental illness in the community, rather than the language, which is lacking. Much can be done and is being done, for example by a wide range of intelligent, energetic, caring and committed staff such as those working in psychiatric hostels and day centres who have taught me a great deal about attitude.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

Wing, J. K. & Morris, B. (1981) Clinical basis of rehabilitation. In *Handbook of Psychiatric Rehabilitation*. Oxford: Oxford University Press.

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Sir: We were pleased to read Thomas *et al*'s (1996) editorial. As child and adolescent psychiatrists, we have been forced to see the micro and macro social context of virtually all the problems presented to us. The trouble is that once general psychiatrists open their eyes to the social damage with which they have to deal, they will become politicised and possibly unable to continue working in the way in which we were all trained.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

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Sir: Thomas *et al* (1996) have highlighted an issue which is fundamental to the practice of clinical psychiatry. I agree with them that

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our patients are becoming alienated from us, because they feel we do not speak the same language. I also agree that the increasing concentration on biological explanations emphasises individualism, as opposed to a broader perspective encompassing social and personal dimensions, and that as a result of the positive developments in neuropsychiatry and psychopharmacology we may focus increasingly on narrow medical interventions. However, I suspect the majority of psychiatrists would acknowledge that the social framework within which they are working is also changing the focus of their practice, and thereby the educational environment for postgraduate trainees.

I work in a psychiatric day hospital, where we have managed to protect a multidimensional approach to patient care. Even in this relatively protected setting, however, we have to defend ourselves against the increasing pressure to treat patients in as short a time as possible. We are expected, appropriately, to justify our interventions, and the easiest measure of improvement is a change in the patient's mental state. My colleagues in the acute service are faced with an ever-increasing demand with ever-decreasing resources, and they find it difficult, if not impossible, to pay attention to their patients' needs in a way that does justice to the complexity of their situations. In these circumstances the only way to survive with one's integrity intact is to focus on an increasingly narrow model of psychiatry, in which doctors deal with the medical problem, and leave everything else to their colleagues from other disciplines. For some psychiatrists this fits in with their personal view, but in my experience the majority find such a limited approach frustrating and unsatisfying. There is a serious danger that a new generation of psychiatrists who have been trained in this environment will lose sight of the intellectually more rewarding, and clinically more effective, broad perspective of mental illness.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

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Authors' reply: The responses to our editorial (Thomas *et al*, 1996) demonstrate the inherent problems of psychiatry. No one doubts the profession's commitment in wanting to do its best to help patients, but, as Greenberg points out, the practice of psychiatry is time-consuming. We work under pressures of time, which force us to practise in ways that do not provide us with the opportunity to listen carefully to what our patients really have to say to us. Under these circumstances the use of biological models and disease entities which have no established scientific validity (Boyle, 1990) becomes attractive. This means that we interpret our patients' experiences in terms of mental state phenomena, without really listening to what they have to say. This leads to dissatisfaction and disenchantment for the psychiatrist as well as the patient, because psychiatry is a speciality which attracts those who are fascinated by the necessity to juggle with the complex and unresolvable. This, ultimately, is a resource issue, one which needs to be located firmly within political discourse, because governments are elected on the basis of policies which determine economic priorities in the country as a whole. As a profession we must engage in political discourse if we are to change this situation.

Our starting point was the disaffection of service users with psychiatry, and this basic premise remains unchanged by resource issues. What point is there in increasing the availability of psychiatrists if they continue to practise in the same way? Our argument has major implications for the training of psychiatrists. Kraemer & Roberts observe that child psychiatrists have always recognised the importance of the interaction between biology, psychology and sociology in understanding individual development, and this suggests that all psychiatric trainees should be exposed to child psychiatry. But there is more to it than that. Collaboration between the profession and other organisations, including user groups such as the Manic Depression Fellowship, is important and valuable. This welcome development must be extended to other areas, particularly the involvement of service users in the training of psychiatrists. There is a growing number of service users who are involved in training, and some are starting to make contributions to the education of psychiatrists. We regard this as vital if we are to balance the 'technology' which increasingly dominates academic teaching.

There remains, however, an insoluble conflict between all specialist languages (whether neuroscientific, psychological or social) and that of our patients' experiences. The two are locked in a dialectic; oppositional discourses which express a tension with which psychiatrists must engage. If we fail to do this, and we lose our ability for self-reflection, our patients will become even more alienated, and the disillusionment of our profession will increase.

Boyle, M. (1990) *Schizophrenia: A Scientific Delusion*. London: Routledge.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

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Ethology and self-injury

Sir: The article by Jones & Daniels (1996) is a welcome addition to the ethological conceptualisation of suicidal behaviour. In the model proposed by Jones & Daniels there remains the need to link the "feelings of frustration, threat, abandonment or arousal" with the subsequent behaviour. The concept of "conservation withdrawal"; Engel (1962) appears to provide this link. Engel (1962) noted that conservation withdrawal "may lead to behaviour to h[elp] cling, ingratiate, reward, force or seduce external object so as to prevent or replace [the] loss and ensure continued supply. With the failure of such changes or mechanisms to provide the solution, the affect is felt with increasing intensity . . . the drive aspect is s[o] preservative, but in a primitive 'last ditch' sense. It is essentially a conserving and includes a heightening of the barriers to reduce incoming stimu[li] reduction of activity to save ene[rgy] 'holding action' until the arrival supplies, help in the form of a s[uit]able object".

While such a formulation c[an] criticised as lacking specificity t[o] behaviour, it is consistent with th[e] invariably reported wish to escape who take drug overdoses. Furthe[r] those who cut themselves it is c[om]mon reports of the cutting bringing reality (Simpson, 1976; see [also]

The application of this clinical and theoretical adva[nce] clinical point of view an[d] suicidal acts as examples o[f] withdrawal, as relatively un[re]sponses to stress with the wis[h] an intolerable situation, allows a no[n]

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