



An anxious profession in an age of fear

R. LAKEMAN DipCpNsg BN BA Hons PGDip (psychotherapy) FANZCMHN MHN (credentialed)

Team Leader, Townsville Homelessness Outreach Programme, Australia

Correspondence:

R. Lakeman

% Townsville Integrated Mental

Health Services

100 Angus Smith Drive

Townsville Q4814

Australia

E-mail:

rlakeman@iqconnect.net.au

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This paper proposes that some practices and trends in mental health care may be considered as defensive responses to collective anxiety and fear. On a larger scale similar dynamics occur around fear of terrorism. Collectively and individually we are pulled by the defensive forces and dynamics associated with anxiety. This can in part explain the polarization that occurs around issues of definition and response to mental illness. Fear and anxiety push services towards simplistic viewpoints and futile practices. The capacity to view things from the perspective of others, embracing explanatory and therapeutic pluralism and adopting a humble attitude, may be helpful in enabling anxiety to be channelled productively.

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Introduction

September the 11th 2001 marked the end of a long run of complacency for many people and ushered in what has been described as a global culture of fear (Wikipedia 2005). Opinions are polarized about the nature, causes and responses to the threat of terrorism but many people harbour lingering anxiety about their security. Fear demands a response whether the threat posed is based on fantasy, fact or fabrication. In Australia, as in other countries public anxiety has been manipulated to justify extreme responses such as going to war and incarcerating refugees. The Australian Prime Minister was quick to accuse asylum-seeking parents of throwing their children overboard in shark infested waters and thus perpetuating a myth for political advantage that asylum seekers are callous, inhuman and a threat to our safety (Manne 2003). Far from being damaged by 'poor intelligence' our political masters have been rewarded generously at the last federal elections with the greatest majority in Australian history. The public appears largely forgiving of an over-response or ineffectual response in the face of collective anxiety and arguably people feel no safer now than they did prior to 9-11.

As people who work closely with those identified as mentally ill and as daily witnesses to human suffering we ought to know something about responses to fear and anxiety. Indeed, similar dynamics around mental illness and deviant behaviour have long held sway at personal, institutional and societal levels. This discussion will focus on the tendency towards polarization and reductionism in confronting mental illness and distress but such exploration must first proceed with some shared understanding of the nature of anxiety.

An anxious society an anxious profession

Fear and anxiety provoke similar physiological responses. Fear is provoked when an individual perceives a threat to be real, immediate and demanding an active response. The anxious individual however, is focused on potential threats that may or may not come to pass in the near or distant future. The anxious individual can often do little to solve the problem and remains anxious or must attend to the anxiety itself (Catherall 2003).

When the needs, wishes, desires or expectations of people are frustrated then anxiety arises (often manifested as

anger). Felt discomfort is almost immediately followed by acts or defences that are geared towards providing relief or preventing more anxiety, and ‘... that subsequently are justified or rationalized’ (Peplau 1989, p. 282). Main (1957) famously and articulately described the largely unconscious dynamic that arise in groups and individuals who work with people who fail to progress as expected:

... if human needs are not satisfied, they tend to become more passionate, to be reinforced by aggression and then to deteriorate in maturity, with sadism invading the situation, together with its concomitants of anxiety, guilt, depression and compulsive reparative wishes, until ultimately despair can ensue. We need not be surprised if hopeless human suffering tends to create in ardent therapists something of the same gamut of feeling. . . . The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment. (p. 9)

It is not hard to find contemporary examples of this dynamic occurring at the ward or individual level. Main’s examples of practices that palliate staff anxiety continue to have resonance. For example, he observed that no matter what the rationale, ‘... a nurse would only give a sedative at the moment when she had reached the limit of her human resources and was no longer able to stand the patient’s problems without anxiety, impatience, guilt, anger or despair’ (p. 130). He noted that it was always the patient and never the nurse who took the sedative.

Another way of viewing anxiety is as a consequence of incongruity between the ideal self and the actual self. We do not however, construct a view of ourselves in isolation from others or the multiple discourses that shape our lives. A great many people, including ourselves have ideas and expectations about how psychiatric/mental health nurses ought to be and the kind of service that we ought to provide. Far from being consistent, stable and congruent these expectations are often inconsistent, unstable, incongruent and polarized. For example, it is hard to reconcile the notion of enabling personal recovery, with the coercive practices of psychiatry such as compulsory assessment, forced treatment, seclusion and the like.

The context of psychiatric services today is vastly different to that experienced by Main in the 1950s when long-term psychotherapy and containment were the *raison d’être* of psychiatric hospitals. Today different imperatives drive psychiatric service delivery and are both a response to, and concomitant source of, anxiety. Concepts such as asylum and continuing care are decidedly unfashionable, if not relics of a bygone era but are nevertheless sought or needed by some people. Acute or crisis services are more akin to ‘drive by’ psychiatry (Ryan &

Just 2001) in which only the most dangerous are provided beds and then for the shortest periods possible. ‘Managing risk’ has usurped notions of providing care and practitioners increasingly operate under a critical and litigious public gaze. Our expectations for ‘improvement’ or at least progression out of our public services are perhaps higher now than ever before. However our capacity to facilitate improvement has not kept pace with expectations of rapid resolution of problems of living as evidenced by numerous reports scathing of the state of mental health services (see for example Mental Health Council of Australia 2005).

While considerable progress has been made in reducing the stigma associated with conditions such as depression, those labelled with schizophrenia continue to be perceived as dangerous and unpredictable by large numbers in the community (Byrne 2000, Angermeyer & Matschinger 2003). The public generally has a heightened level of anxiety or fear about mental illness or at least the less explicable or dramatic forms. Those with diagnosed mental illness are more than twice as likely to be victims of violent crime as the general population (Hobart & Thompson 2001). However, those with schizophrenia are significantly more likely to behave violently than others, although the numbers are small and the overall contribution to violent crime by people with mental illness is negligible (Walsh *et al.* 2002) and people’s perceptions exaggerated (Munro & Rungay 2000). The public fear associated with perceptions of the mentally ill as dangerous is a driving force behind policy and practice.

Polarization

A social consequence of collective anxiety tends to be polarization. That is extremes of opinion relative to others arise which serve to define members as belonging or not to particular groups. Johnson (2005) argues that ideological polarization borne of anxiety continues to prevent us from rationally assessing and dealing with real threats such as terrorism. Polarization assists to defend against existential anxiety by seeing oneself as a secure member of a meaning-conveying cultural group (Baldwin & Wesley 1996). This is illustrated by President Bush (2001) who proclaimed, ‘You are either with us or against us in the war against terror’. In relation to mental health and illness there is a tendency to view mental illness as dichotomous with mental health, one is either sane or insane. The dynamic of ‘othering’ has been described as an ethically problematic stance whereby groups such as the mentally ill are objectified, depersonalized and defined as other (MacCallum 2002, Peternej-Taylor 2004). In subtle ways this dynamic occurs in workplaces and between groups. If people do not see things

in the same way they are not part of the group they are 'other', or even bad.

Few fields of human interest and endeavour have generated such polarized views about the nature of the phenomena of concern and the right approach as mental illness, distress and psychiatry. The orthodox psychiatric view of mental distress may be summed up as the 'brain-in-need-of-a-chemical' (Lego 1999). That is, some kind of biological disease underpins aberrant or 'disordered' behaviour. This fundamental assumption dominates public policy, the practice of public mental health services and the minds of most clinicians. The belief in the biological aetiology of mental illness has provided a rationale for almost every kind of psychiatric treatment in the past century (Barker 2003). A recent survey of Finish nurses found that only a minority thought coercive practices at all ethically problematic (Lind *et al.* 2004). While some urge justification for coercive practice in every individual case (O'Brien & Golding 2003), from the point of view of the orthodox view of distress it is not difficult to rationalize or justify coercive practice.

The orthodox psychiatric view that dominates psychiatric discourse serves to legitimize psychiatric power and authority and conveniently locates the source of aberration within the individual. This in turn absolves society of any responsibility for the conditions that might contribute to the development of distress (Smail 2001, p. 23). The problem with the orthodox psychiatric view is not that it is wrong but that it is assumed to be the only right way. This view may also be a helpful one for psychiatry but is a poor platform for nursing and allied health from which to offer any meaningful help to people.

There may be nothing at all wrong with polarized opinion and views. Strongly articulated views contrary to dominant contemporary policy or opinion may ultimately shift the opinion or practice of others closer to the truth, justice or some other ideal. The view of the majority may at times be wrong. However, in practical endeavours and ethical pursuits such as health care dogmatism can be profoundly destructive. This applies to almost any viewpoint which is arrogantly asserted, applied or imposed. A case in point is 'deinstitutionalization'. In Australia the process of deinstitutionalization, that is, closure of large tertiary psychiatric hospitals is almost complete. While undoubtedly good for most people this process has led to some widely acknowledged negative consequences, for example, large numbers of people incarcerated in prison have an identified mental illness and some of the most seriously ill people (from an orthodox psychiatric point of view) are either homeless or living in squalid boarding houses (Mental Health Council Of Australia 2005). Nevertheless influential elements in health, disability and professional

advocacy industries appear most influenced by an 'anti-institutional' stance, that is, any practice, process or service configuration that bears any resemblance to institutional practice is bad. Therefore, providing 24 hour care by qualified staff, notions of continuing care, or any kind of purposeful clustering of accommodation to provide efficient service is seen as bad. Those that advocate for such solutions are cast as outsiders who are construed as wanting the return of some kind of total institution akin to that described by Ken Kesey. Dogmatism is rife in politics and health care and combined with polarization constrains constructive dialogue and the potential to find creative solutions.

Seeking certainty in uncertainty

A coalition partner must do more than just express sympathy, a coalition partner must perform . . . That means different things for different nations. Some nations don't want to contribute troops and we understand that. Other nations can contribute intelligence-sharing. . . . But all nations, if they want to fight terror, must do something. (Bush 2001)

The field of psychiatry is fraught with uncertainty . . . uncertainty about the validity of psychiatric diagnosis, uncertainty about the aetiology of mental illness, uncertainty about the effectiveness of biomedical treatments, and uncertainty about how people will behave in future. Lawrence (1995) proposes that the psychotic anxieties suffuse institutional and societal life, that is, fear of death, disorder, chaos, of not making sense of reality, in short of madness. Furthermore, most group and individual arrangements are designed to avoid the conscious experiencing of these anxieties. Our natural inclination is to attempt to create situations of relative certainty even if such certainty is illusionary. As Keen (1999, p. 422) observes 'A simple coherent doctrine based upon familiar scientific principles like biological illness and behavioural control is much more politically attractive than continued uncertainty'.

When faced with uncertainty in psychiatry there is a drive to do something or at least be seen to do something. Smail (2001, p. 23) suggests that the credibility of the helping professions is maintained on the grounds of plausibility or impressiveness of its procedures rather than on the achievement of concrete results. If one intervention (usually drug) does not work then another is tried (or electroconvulsive therapy is considered). This experimental method when applied to mental illness might not be particularly problematic except the procedures are potentially dangerous. The capacity of the 'treatment team' to sit with, or contain the distress of others, to contain their own anxiety or to discover more creative solutions is easily eroded.

It has long been recognized in psychology that affective states influence people's motivation and decision-making processes. In a range of situations anxious people when faced with a decision are biased in favour of low-risk/low-reward options (Raghunathan & Tuan Pham 1999). This dynamic reflects a 'better safe than sorry' approach and promises a degree of certainty in otherwise uncertain situations. At the institutional level this also occurs. In the 1950s Menzies-Lyth (1988) described defensive practices that arose in a hospital setting to protect against otherwise anxiety provoking work. Such defences included attempting to eliminate decisions through ritualizing the work and providing guidelines, checks and balances, minimizing the significance of individual nurses and patients, and providing training which emphasized communication of facts and techniques. The anxious, defended hospital has much in common with highly bureaucratized organizations of all types which are characterized by a hierarchy of authority, rigid rules, and the inhibition of personal identity and initiative (Giddens 1989). The anxious institution encourages 'othering' practices, the inhibition of creativity and the denial of uncertainty.

The organization of mental health care and the 'clinic floor' has been infiltrated by what Evans (2005, p. 285) describes as a discourse of managerialism:

The idea of uncertainty, gaps, things remaining unknown and a limit sits uncomfortably with the dominant discourse of managerialism; one that demands no limits, complete data sets, and many satisfied customers.

Managerialism has become an ideology and dogma that has colonized the language and thought of clinicians and indeed society. Managerialism demands more and better information, quantification of risk, quantification of outcome, explicit treatment options and predictability. This positions the clinician as a data collector and relegates the patient to an un-suffering consumer (Evans 2005) or a case to be managed. Managerialism embraces an extreme reductionist orthodox psychiatric view which enables every case to be classified ('case mix') via diagnosis ('diagnostic related groups'), treatment standardized (into treatment 'pathways' or 'best practice') and outcomes compared ('benchmarked'). The standardization of care matched with standardized measurement may not be helpful in witnessing recovery but it allows one to avoid witnessing suffering or grappling with the complexity of people's experience (Lakeman 2004) and serves as another means to palliate anxiety. Nurses and others may now assume the valued role of gathering and sharing intelligence. Even if the activity or stance does not help the distressed individual, comfort can be obtained by following the protocol, policy or procedure. Those that object to the practices that arise from or are demanded by the ideology of managerialism

risk the sanctions of being identified as the 'other', not a team player or of even being a bad clinician (as a good clinician is defined as someone who follows procedures).

Towards pluralism

Psychiatry itself is slowly whittling away from within at some fundamental assumptions. Diagnosis is recognized by some as having utility but limited validity (Kendell & Jablensky 2003). The prospect of finding simple explanations and cures for mental illness has become increasingly remote despite the initial excitement and heightened expectations with the discovery of the cause and treatment for general paresis (syphilis). Kendler (2005) argues that psychiatry cannot expect to discover any more 'spirochete-like' discoveries which will explain mental disorder and must strive towards embracing complexity and explanatory pluralism. Indeed almost by definition psychiatry is the business of complex and speculative causes and palliative treatments. For if simple causes and curative treatments are discovered the illness and treatment would be usurped by general medicine (as in the case of syphilis) or other specialties such as gerontology (in the case of Alzheimer's) or neurology (in the case of observable brain damage).

The biological sciences offer useful but limited means of understanding mental distress. This is true of most explanatory frameworks and ideologies. The danger is when any framework is applied or asserted dogmatically or arrogantly. Polarization can give way to extremism which has been described as the enemy of our times and fanaticism which Husserl is purported to have asserted is the defence mechanism of doubt (Road to Peace 2005). What is required of health professionals is a large dose of humility in the face of madness which remains an essentially mysterious phenomenon (Casey & Long 2003). Those that would aim to help others must also acknowledge therapeutic pluralism. That is, that there may be many pathways to recovery and many valid ways to think about care. This is strongly supported by the work around therapeutic alliance which suggests that the quality of the alliance between therapist and patient has more of an impact on treatment outcome than the carefully chosen and skilfully applied intervention or approach (Bambling & King 2001).

Gallop & Reynolds (2004) argue for an integration of the biological sciences, psychodynamic theory, and socio-cultural theory. In practical terms there are advantages to have at one's disposal more than one way to view a problem or issue. Indeed a great deal of animosity and conflict in all manner of circumstances quite aside from therapeutic endeavours might be avoided if people had a robust appreciation of different viewpoints. An appreciation of different models and theories would also better enable the adapta-

tion of help and care to the needs of the individual. Whereas, only a limited repertoire of helping methods requires the individual to fit with the programme on offer (this often is simply drug therapy or cognitive behavioural therapy). Seeing and experiencing things differently is at the heart of what therapy is all about (Gibney 2003).

Those who work in psychiatric settings must be cognizant of the many purposes of their work such as social control, protection, symptom management and assisting people to find meaning. Rarely is one called to assume one role or to serve one master. These multiple purposes need to be acknowledged rather than denied. In so doing this may lead to tolerable discomfort where roles and purposes conflict rather than the mobilization of dysfunctional defences. Bower's (2002) research on working with people diagnosed with 'dangerous and severe personality disorder' recognized that cognitive-emotional self-management was a necessary foundation of effective and sustained care. Additionally a broad philosophy of practice and strong moral commitment towards people was needed. Such a commitment or disposition will encompass a drive towards attaining the wisdom that will enable the practitioner to balance the competing demands of practice. Wisdom entails humility, strives for knowledge rather than information, and eschews extremism and fanaticism.

Conclusion

Russell (1950) wrote that 'Neither a man nor a crowd nor a nation can be trusted to act humanely or to think sanely under the influence of a great fear'. Various defensive measures can and are mobilized when faced with fear or anxiety. Unfortunately, many of these mechanisms are unconscious, cannot be directly observed and can readily be rationalized by the affected parties. Thus, the observations in this paper are speculative and are no more than my own thoughts and observations. Nevertheless, the 'war on terror' and the political/societal manipulation of, and response to, fear can provide some insights into the dynamics of how individuals, organizations and systems also respond to fear and anxiety in relation to psychiatry and the mentally ill. Fear can give rise to polarization and at its worst extremism and fanaticism. The uncertainty associated with psychiatric diagnosis and treatment causes anxiety which is palliated through viewing people as standardized cases and promoting the application of standardized care and treatments. Whether treating people in this way works or not (and I have posited that it generally doesn't), health professionals are at least soothed by the certainty of policies and procedures.

To counter this dynamic, an attitude of compassion and humility ought to be the predominant orientation of health

professionals. Furthermore, all health professionals should have the knowledge to view and understand human behaviour from several different lenses or viewpoints, and aspire to the wisdom to be able to choose the right way. Unfortunately this breadth of knowledge has been eroded from the training programmes of most health professions in which people have become increasingly qualified but in narrower fields. Fear and anxiety needs to be in the first instance acknowledged and talked about. If those that work with distressed people in psychiatric settings do not feel at all anxious then this ought to provide a prompt for self-examination.

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