

BACK

**Adjustment or change?
Radical issues in psychiatry**

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Author's post-scripted foreword (March 2014)

'Adjustment or change?' was written in 1977 and is republished here, nearly four decades later, in its original form.

It is writing very much of its period: political debate was more sanguine and polarised, old fashioned socialism looked set for longevity (and the USSR for eternity). Vietnam was a fresh, sharp memory. Feminism was young, raw and accelerating. There was more righteous anger, optimism and political diversity.

Although this period-piece may now, in places, sound callow and strident, it still has important messages. Although theorists, politicians and planners are often now very mindful of the importance of social and environmental factors in the generation of illness, this is often not evident on the hospital ward-round, or in the doctor's consulting room. The contemporary practitioner is likely to confine his view to looking into two 'boxes': the patient (the locus of biomechanical breakdown) and the computer (for the abstracted data). Doctors now are likely to be less personally acquainted with a particular patient, their story, their social milieu and their physical environment. Doctor-patient interactions are now likely to be even more myopically confined to the biomechanical, and devoid of the kind of personal influences that create a broader view of growth and healing.

This article, for all its gauche rhetoric, is probably more relevant now than in 1977. Equally arresting are these considerations: *where* in the NHS could Mrs E (Patient 2) get such undesignated therapy?, and: *what* mainstream medical journal would now risk publishing such feral dissent from the frontline?

I can well remember my surprise and confusion when, as a medical student, I discovered the irrelevance of medical technology in the epidemiological patterns of tuberculosis. Until that time I had assumed that technical advances in diagnosis and management had been central to its decline. Like many aspiring professionals, I had imagined and wished my power to be far greater than it was.

The medical model and social perspectives

To find that the overwhelming bulk of tuberculosis was more dependent on our arrangements for living together than on mass radiography, Mantoux testing or streptomycin, brought me acute awareness of how distorting the hospital and individual centred models of medicine can be. I learned far more about diagnosis and management of individual pathology than about the social framework that led to overcrowding, cold, damp and malnutrition. Poverty was parcelled, with an apology of scientific correctness, into 'social classes V and VI'. True, I was training to be a doctor, not a political radical, but I wonder how many doctors continue to be similarly oblivious, or indifferent, to the fundamental social forces operative in patterns of 'illness'.

Illness as a scapegoat

The concept of illness may very often be seen as a way of 'scapegoating' a part of a problem so that the presenting patient is labelled, treated and despatched, leaving the forces acting on him unexamined or unchallenged. Tuberculosis sanatoria may have contained some individual cases of consumption, but were no substitute for proper working or living conditions. In this respect, treating the designated patient alone, while ignoring the pathogenic influences acting on him, can be seen as a kind of sop, or parrying manoeuvre. It is similar to the unhappy or ill family, whose discord is clearly related to alienating and depressing housing, who are told: "The council can't find you a decent home, but they'll send a social worker to see you instead". The social worker's implicit brief here is to act as a decoy and tranquillizer, so that the immediate symptoms of disturbance can be averted, if not suppressed. Perhaps she will have the skill to transmute a housing problem into 'casework' or 'family therapy'; the important point is, however, that she cannot provide a new house, only social work skills.

In formulating and dealing with symptomatology within the conceptual framework of individual pathology, it is easy to make the assumption that the only fault lies within the patient, not in the world in which he lives. Studies in social medicine and statistics may provide a theoretical antidote to such projection, but the actual practice of medicine and other caring agencies continues to enact this conservative principle. So long as we describe certain people as being 'ill', rather than oppressed or injured, the rest of us can feel blameless and unquestioning of the status quo.

Illness and psychiatry

Nowhere is this concept more relevant but concealed than in psychiatry. At the present time this is exhibited most floridly and distastefully in the USSR, but the West has its insidious counterpart, which is probably equally extensive. Such a view has been elaborated from different aspects by Reich, Szasz, Laing and Illich. For the general practitioner, the extrapolation of variety and quantity of psychotropic drug consumption, while 'psychiatric morbidity' continues to rise is perhaps a more vivid and understandable illustration of these principles. In my earliest experiences of general practice I felt like the bewildered King Canute, trying to turn back waves of symptomatized discontent, armed only with my knowledge of psychiatric labels, and my power to prescribe tricyclics and benzodiazepines.

Doctors and patients

Likewise, when I first became a hospital psychiatrist I felt like a casualty officer in Northern Ireland; I had no idea what all the fighting was about but nevertheless I patched people up, hoped that was sufficient, and sent them on their way.

The following case probably has an all too familiar ring to most psychiatrists and general practitioners, and serves to illustrate some radical questions in contemporary psychiatry.

Patient 1

Mrs B is 30 years of age. She has three children under the age of five years and lives on the 13th floor of a council high-rise block with her husband, who works in a semi-skilled capacity

at a car factory. Although the block of flats is only 10 years old, it has the usual stigmata of anonymous public contempt, desecration and fatigued indifference; peeling paintwork, ubiquitous grime, litter and dogs' faeces on the worn floor covering. Aerosoled on the concrete wall outside is an impotent, misspelt, rebellious slogan overtly advertising the National Front, but in reality attempting to purge an uncomfortable burden of blind anger. Mrs B's flat is crowded and has only a small balcony looking out onto a grim, grey, industrial landscape. She spends her day controlling or nurturing her children and either seeing her husband off to work or awaiting his return. The architecture of the flats makes no provision for children to play or mothers to meet, so she sees few other adults during the day. Even shopping is a major expedition because of the demands of her children. Consequently she rarely goes out, and her husband shops at weekends. She welcomes the regular visits by her health visitor if only because it gives her some adult conversation and the opportunity to be looked after for a while when, at almost every other point in her waking life (and sometimes in her dreams as well), she is looking after others.

The health visitor. The health visitor was first allocated to her after the birth of her second child, when she was hospitalized with a 'puerperal depressive illness' and, almost as a matter of routine, was then considered as being 'at risk' with the mothering of her child. In spite of the pleasant and friendly manner of the health visitor, Mrs B feels ambivalent about her. Although she feels she ought to be grateful for the trouble she takes, she perceives dimly that she is being patronised, and that somehow this is irrelevant to her underlying problems, which continue unformulated and unresolved.

Marriage. When Mrs B married at the age of 23 she was impelled largely by romantic fantasies of uncompromised closeness and sharing. Her own parents' relationship had been ground down to a state of indifferent semi-tolerance by their banal and repetitious life, but she did not yet anticipate this for herself. She envisaged her own marriage as plucking her out of this situation, so that her life could become the kind of existence featured in popular women's journals – a state of serene and gratified selflessness earned by courting her family with the whiteness of her wash and lightness of her pastry. The reality has been predictably and bitterly disappointing. Early in their marriage Mr and Mrs B were aware of a sense of emptiness and malaise that they could not articulate, communicate or understand. Mrs B felt emotionally unnourished and discounted, while Mr B felt trapped and nagged at. She needed

Valium for her 'anxiety state', and he needed alcohol for his night out with 'the boys'. The birth of their children has driven them even further apart emotionally but, paradoxically, the bonds of guilt between them have grown, so that they both feel doomed to endure their marriage as it is, come what may.

Mr B. *Mr B is not an unkind man but is unable to understand what is wrong in his life. Due to his wife's unaccountable (to him) unhappiness, he escapes the endless circular rows at home by saying he has to work late, and finding solace in pubs, male friends and the occasional furtive sexual encounter. Perversely, however, these make things worse rather than better. They both feel increasingly resentful, guilty, inadequate and paranoid, so that their contact together always culminates in a stalemate of alienated conflict. Mr B "just cannot understand it". After all, he works extremely hard and feels he shares the money he earns as fairly as he can. He finds his work as a body-welder monotonous, exhausting and unrewarding. The works milieu is enormous, noisy and anonymous. He repeats the same task about 60 times daily and, in spite of the increased bargaining power of his union, he continues to feel disposable, unimportant and depersonalized. He has never seen the people who make important policy decisions at his place of work, and his ultimate employers reside in distant boardrooms reified for him only by mediators, memoranda and rumour.*

He is an intelligent man but the deprived background in which he grew up furnished him with neither the norms nor the educational facilities, ever to aspire to further education or professional training. Like so many others in his situation he feels alienated, frustrated and cheated, but is unable to understand the basis of this sensation. His private and stored resentments are sometimes discharged publicly in bargaining disputes, but even when these are resolved with apparent success his underlying sense of oppression remains. He continues to feel trapped and used, but his bills have to be paid and so he works for the money. To counter the industrial wilderness he endures every day, he hopes this year to buy a colour television and spend a couple of weeks in Majorca. Not surprisingly, when he returns home to find a harassed, unhappy and demanding wife, he fails to understand his part in all this. "What more can I do? I work hard and then I get this every evening ...", he ruminates with glum rhetoric.

Admission to the local psychiatric unit. *Their sense of mystified powerlessness is further endorsed by the local psychiatric unit, where Mrs B has been admitted on three occasions in the last five years: twice with a diagnosis of 'puerperal depressive illness', and once with an 'agitated depressive illness'. Both Mr and Mrs B now believe that she has a 'disease of her nerves', which is what her psychiatrist conveyed to them. In any case they both see her unhappy and 'awkward' behaviour at home as being due to her 'depression'. They conceive, vaguely, that Mrs B has a 'fault' inside her and that this, rather than her marital arrangements or the environment in which she must survive, is the root of her difficulties.*

Medical assessment. *Their general practitioner has also been sucked into this collusion. Like most of us, his training taught him to look at people's problems from a basis of 'illness', from which they could escape only by reliance on medical personnel and their techniques. His view is confirmed by the vast bulk of literature and secondary medical consultations. Consider this letter written to him about Mrs B by the consultant psychiatrist.*

"... As you know, Mrs B was admitted here at your request following her increasing depression and agitation, which she had consulted you about in recent weeks. The pattern of this episode was similar to her previous bouts of depression, and was accompanied by early morning wakening and a loss of interest in almost everything, including her appetite. On admission here we found her to be markedly agitated and tearful, with a lot of self-demeaning ideas typical of depression ...

"She is a cooperative patient and she made an uneventful recovery on Imipramine 75 mg t.d.s., and a short course of ECT, as she has done previously ...

"There is, of course, the question of her children and, in view of her relapsing condition, you will remember that you kindly arranged for a health visitor to visit regularly, and we will try to arrange for one of our nurses to visit. Mr and Mrs B both understand the necessity for this. Mr B seems very supportive, though I understand he works very long hours...

"If she has another relapse it may be worthwhile trying her on Lithium, though I note she had kidney disease as a child. In the meantime she should continue her present dose of Imipramine, and I will see her as an outpatient in three weeks ... "

From the phenomenological viewpoint this is a competent medical assessment (except that there is evidence that she recovered from hospitalisation, not medication), but such a style of assessment and care is loaded with politically important assumptions. It conveys authoritatively to Mrs B, and all who are involved with her, that she is the victim of something wrong inside her, that only doctors can understand and alleviate. It conspires with the whole fabric and style of her life in duping her into the belief that she is powerless, and that her world is something she must adjust to, not question or change. There are probably hundreds of thousands of women like Mrs B in the UK today. Theoretically, each one may be viewed as suffering from an affective disorder. From an anthropological view, however, the overall pattern appears more as a concealed form of impotent rebellion and social control, with doctors performing a task similar to, but more technical than, that of policemen.

A radical political view of psychiatry

Awareness of the kind of matrix I have described has led recently to many fundamental and articulate challenges to the present status and ethos of psychiatry. In the USA particularly Radical Psychiatry has a large following. Even those who dismiss their political tenets can still derive perspicacity from the Radical Psychiatrists' clear-headed analysis of the present confused impasse of psychiatry. It is worth noting, however, that not all radical critics of psychiatry are politically left wing. Thomas Szasz is an example.

Claude Steiner, a Radical Psychiatrist in California, started formulating his standpoint at the time of the Vietnam war. This was a time when overt psychiatric morbidity, together with drug abuse among the young, rose to a very high level. The potential abuses and paradoxes of psychiatry became clearly highlighted at this time. Steiner captured this dilemma with a vividness and resolve that arose painfully out of his involvement. He writes:

"Consider a seventeen-year-old American youngster during the Vietnam war. He is told that he must offer his life to destroy the enemy in Asia. He is told that this is good for him, for his brothers and sisters, for his country, and even for the enemy. He is taught that a man will defend his country without question, and that a man who hesitates or questions this principle is a coward who does not deserve to be called a human being. If he fails to understand that he is being oppressed and if he believes these lies, he will eventually come to think of himself as less than human for not wanting to defend his country. He will doubt his own opinions and experiences concerning the war. He will come to consider himself a coward; he will become disgusted with himself; he will cut himself off from his peers and will become depressed. He may lose interest in everyday activities; he may begin to speak about hopelessness and meaninglessness; he may start using drugs to give himself a temporary reprieve from his despair. If his shame and despair reach large enough proportions, he may attempt to destroy himself. He will see himself as no good and will believe himself in need of psychiatric attention.

"If he were to consult a 'neutral' therapist, he might be asked, 'What is wrong with you? Why are you depressed? Why do you hate your father? Why do you rebel against authority? Let's talk about it, and you'll feel better. Tell me about your childhood. Maybe the bad things that happened then make you sad now. Other boys your age aren't depressed about the war and killing. These are troubled times, but others are able to adjust to them. Why don't you? Tell me your dreams. Maybe we can find what is wrong with you. The army is bad, I know, but it has its good points. It might make a man out of you'.

"This young man may eventually feel better because of the friendly and warm attitude of the therapist, thus mystifying his true feelings about the war. He may 'pull himself together', his personality-trait disturbance (passive-aggressive, aggressive type) may improve, and he may wind up in a flag-wrapped box. His therapist will feel and will contend that he was neutral throughout the therapeutic intervention and that he did not attempt to influence the young man. But in truth he

acted as a recruiting officer for the army, all the more effective for his disarming smile."

Driven by such experiences, the Radical Psychiatrists drew up their Manifesto, which was presented in 1969 at the Annual Conference of the American Psychiatric Association. Again I quote at length, as I cannot effectively paraphrase:

"1. The practice of psychiatry has been usurped by the medical establishment. Political control of its public aspects has been seized by medicine, and the language of soul healing ... has been infiltrated with irrelevant medical concepts and terms.

"Psychiatry must return to its non-medical origins since most psychiatric conditions are in no way the province of medicine. All persons competent in soul healing should be known as psychiatrists. Psychiatrists should repudiate the use of medically derived words such as 'patient', 'illness', 'diagnosis', 'treatment'. Medical psychiatrists' unique contribution to psychiatry is as experts on neurology and, with much needed additional work, on drugs.

"2. Extended individual psychotherapy is an elitist, outmoded, as well as non-productive, form of psychiatric help. It concentrates the talents of a few on a few. It silently colludes with the notion that people's difficulties have their sources within them while implying that everything is well with the world. It promotes oppression by shrouding its consequences with shame and secrecy. It further mystifies by attempting to pass as an ideal human relationship when it is, in fact, artificial in the extreme.

"People's troubles have their source not within them, but in their alienated relationships, in their exploitation, in polluted environments, in war, and in the profit motive. Psychiatrists should encourage bilateral, open discussion and discourage secrecy and shame in relation to deviant behaviour and thoughts.

"3. By remaining 'neutral' in an oppressive situation, psychiatry, especially in the public sector, has become an enforcer of establishment values and laws. Adjustment

to prevailing conditions is the avowed goal of most psychiatric treatment. Persons who deviate from the world's madness are given fraudulent diagnostic tests which generate diagnostic labels which lead to 'treatment' which is, in fact, a series of graded repressive procedures such as 'drug management', hospitalization, shock therapy, perhaps lobotomy. All these forms of 'treatment' are perversions of legitimate medical methods that have been put at the service of the establishment by the medical profession. Treatment is forced on persons who would, if let alone, not seek it.

"Psychological tests and the diagnostic labels they generate, especially schizophrenia, must be disavowed as meaningless mystifications, the real function of which is to distance psychiatrists from people and to insult people into conformity. Medicine must cease making available drugs, hospitals and other legitimate medical procedures for the purpose of overt or subtle law enforcement and must examine how drug companies are dictating treatment procedures through their advertising. Psychiatry must cease playing a part in the oppression of women by refusing to promote adjustment to their oppression. All psychiatric help should be by contract; that is, people should choose when, what, and with whom they want to change. Psychiatrists should become advocates of the people, should refuse to participate in the pacification of the oppressed, and should encourage people's struggles for liberation ..."

An example of radical psychiatric therapy

Patient 2

Mrs E was initially referred to a gynaecologist because of her secondary amenorrhoea. He did not feel that her amenorrhoea was of great significance, but he became alarmed by her behavioural symptomatology. An urgent psychiatric assessment revealed to me the distressed and bizarre pattern of her present life. Apart from her amenorrhoea, she had a marked appetite disturbance, so that she would either starve or gorge herself for periods of weeks, leading to a marked fluctuation in her weight. When gorging herself she would eat packs of butter and sometimes even scraps of food from the dustbin. Her comment about herself during these times was, "I'm fat and gross and disgusting, but I feel so empty; I've got to get something

inside me". Her sexual needs were similarly cyclical. When overeating she would be sexually compulsive, insatiable and demanding. When starving herself, her disinclination for sex was so great that she would spend the night in a sleeping bag within her marital bed. In the background was her misery and depression and the 'escape hatch' of recurrently contemplated suicide should things get too bad. Mrs E was not 'acutely ill' insofar as she had received miscellaneous kinds of psychiatric help since a severe marital disruption six years before. Her husband had left her for a few months, leaving behind a trail of lies, veiled threats and innuendoes. She said of that time, "I think I died then. She (the other woman) represented everything I could never be. But it was the lies that hurt me most. Somehow I still think he hates me, although I don't know...".

It was the custom in the department in which I was working for a committee of psychotherapists to discuss suitability and allocation of all referred cases requiring psychotherapy. They were fascinated but dismayed by what I brought them. Their prevailing view was that her symptomatology represented a severe disturbance, with regression back to an early oral stage of development, with its accompanying psychotic component. Nothing short of extensive individual psychoanalytic psychotherapy, they held, would have any chance of helping her. This would only be possible within the context of private psychoanalysis (which she could afford) or one of the few NHS inpatient psychotherapy units.

Marital problems and family background. *By the time the committee's assessment was made, I had a joint interview with Mr and Mrs E. From what I heard and observed, I felt that her overt pathology was quite as much a function of the dynamics of the marriage as Mrs E's intrapsychic difficulties per se. Mrs E had compromised herself for Mr E ever since the beginning of their relationship and, furthermore, her marriage closely resembled her parents'. Early on she supported her husband while he went to art college and, although he had become successful in his work, this pattern had largely continued, so that the bulk of the chores had been carried by Mrs E. She had been oppressed into believing that she was the lesser of the two partners and therefore must subjugate her needs to those of her husband and his work. Her own family had expected her to heed and tend to other people's needs before her own, and she had continued to relate to people in this way. Like many women, she received extremely little gratification for herself directly but was expected to compensate for this by such*

vicarious gratification as she could eke out of her nurturing role with Mr E and their small son. Ironically, she had come to see both of them in the same light: domineering, demanding and more important and powerful than herself. The resentment and anger that she felt thus came from a thwarted and one-down position. To compound her problems she felt mystified about her feelings, and thus assumed that her 'illness' was due to some fault in her alone.

Therapy. *Mr and Mrs E declined the individual psychoanalytic approach that had been suggested and by this time viewed her symptomatology as being a product of their marriage, and had come to a point of wanting to do something about this. I agreed to work with them with the following explicitly agreed formulations and strategies:*

- 1. That Mrs E's 'illness' had arisen because of her muted resentment, and represented her need to have her feelings understood, expressed and cared for. It also signalled her need to have as much space and autonomy as other members of her family.*
- 2. Much of her sense of passivity arose from the inequality of power in their relationship. Mrs E was either not doing what she wanted, or doing what she did not want, far more often than Mr E.*
- 3. Her bewilderment had many roots in her husband's mystifying and deceptive behaviour. (Due to his own family background, he had developed a great fear of closeness and a need to 'hide' what was going on in himself.)*
- 4 Mrs E's part in overcoming these problems was to:*
 - a) clarify for herself what she did and did not want*
 - b) learn to ask directly for what she wanted*
 - c) make it clear to Mr E when she was doing anything that she did not want to do*
 - d) spend a certain amount of time each day doing something that was not at all accountable to others in the family, but was personally gratifying to her.*
- 5. Mr E's part was to:*
 - a) really listen to his wife (which involved looking at her)*
 - b) accept her having her feelings, without trying to parry or rationalise them away*

- c) nurture her more, and share much of the domestic work*
- d) demystify himself by honestly owning and communicating his thoughts and feelings when she asked him to do so.*

6. *My part in this programme was to remain as impartial as possible, to clarify and interpret, to mediate, to make practical suggestions and to protect them at times of emotional stress. I also undertook to provide alternative medical care if this failed.*

Outcome and discussion. *Six months after we had embarked on this contractual therapy, Mrs E was symptomatically clear of her presenting complaints. She spoke with an assurance and warmth that was not evident before. There had been times in therapy where the marriage had looked extremely tenuous, but overall its foundations and communications had become firmer, surer and more equally acknowledged and shared. Most gratifyingly they seemed able to resolve their problems without me.*

Such a method of therapy lies outside the medical model and its conventional psychiatric derivatives. Paradoxically, conventional psychiatric therapy ran the risk of driving Mrs E further into the system of thoughts and feelings that was central to her distress. Even classical psychoanalytic psychotherapy would have attempted to label and treat her individually without much emphasis on the real forces that were acting on her in the 'here' and 'now'. The psychoanalytic model would probably formulate her problem as "a narcissistic woman of passive-aggressive type, with weak ego-defences who has regressed or become fixated to an early oral infantile stage, with the mobilization of much archaic and hysterical material. Such material might lead to a psychotic transference reaction in psychotherapy, which should thus be avoided". To Mrs E this would have been as mystifying and alienating as a prescription for Imipramine. More importantly, it would have confirmed for her yet again that there was something wrong with her (although she would never quite understand what 'it' was), that she was powerless, and must continue to be confused in the world in which she found herself.

Acknowledgement

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