

# Boekbesprekingen

## Pills, pushers and psychotherapy: learning to treat unquiet spirits\*

T.M. Luhrmann, *Of 2 Minds: The Growing Disorder in American Psychiatry*, New York: Knopf, 2000, 337 p., ISBN 0-679-42191-2

Does mental illness exist? Since the sixties – and Goffman, Laing, Scheff, Szasz and Foucault – there has been a lively and recurring debate on this issue within both psychiatry and the social sciences. After reading this well-researched and thoughtful book the reader will have little doubt that mental illness is real: and that it is often a deadly serious affliction.

I am particularly interested in this area and Luhrmann's anthropological approach to it for number of reasons. First, I have engaged in field work and have pursued issues related to qualitative methodology (Punch 1986, 1998). Second, there has been a significant shift in qualitative research to researchers taking a standpoint (largely under the influence of the feminist movement). Becker (1967) said researchers should take sides but now there are advocates of total immersion in the field and of an 'epistemology of insider-ness'. This means it is common for social scientists to take normative positions which contrasts with an earlier scholarly tradition of relative distance, and reserve, on social issues. Luhrmann does not take this radical position but she does take sides. Where does Luhrmann stand and what position does she adopt on psychiatry and the mentally ill? Third, I have been involved for a number of years in a Foundation set up in 1994 to help young people with psychiatric problems 'reintegrate' into society (Stichting Een op de Honderd; the One in a Hundred Foundation). My views and insights on mental illness and my reflections on Luhrmann's work, particularly in the concluding section of this paper starting with 'Consumers', have been influenced by my experiences in that Foundation.

Before Luhrmann brings us to that judgement on mental illness she takes us through the development of psychiatry, the training of doctors and psy-

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chiatrists, the way in which mentally-ill patients are dealt with in various medical and treatment settings, and current influences on the style and quality of treatment for such patients in America. Let me come clean immediately: my opinion is that this excellent book represents a paradigm for anthropological research not only in methods and insights but also in conveying a strong, humane concern for how society and the medical profession view and treat people suffering from mental illness – or ‘madness’.

Luhrmann is an experienced anthropologist and field-worker, appointed in 1989 to a department with a tradition of ‘psychological anthropology’ (at the University of California, San Diego). She informs us that her father is a psychiatrist, and that she perceives herself as something of a ‘halfie’ – someone who already has some background in the area that they end up studying. Out of personal interest, and encouraged by her colleagues, she started to sit in on lectures given to young psychiatrists which graduate students in her department were required to attend. Then one of the psychiatrists turned to her – people are always turning to Luhrmann, in coffee-lines and in aircraft, so she must have something that invites strangers to confide in her – and said ‘why don’t you write about us?’ This casual remark embarked this halfie on a major project into psychiatry. Initially it was focussed on professional socialisation, based on the research and literature of people like Becker et al. in *Boys (sic) in White* (1961), but it grew into something more substantial: namely, a portrait of American psychiatry in a significant and even dramatic period of change. Her coincidental entry into the field at that particular moment gives her book a significance that transcends what might otherwise have been an interesting but conventional study of how young doctors ‘become’ psychiatrists.

A halfie reacts, then, to a casual remark and starts an off-the-cuff project without presumably realising that the serendipitous timing would turn it into a major study of a peculiar profession and of contemporary societal attitudes to mental illness. But it was not just the right time and right place but also the right person. For Luhrmann is a gifted field-worker with immense energy, an intense curiosity, a rapport with the doctors she studies and an affinity with the afflicted she encounters, and an expressive style. She was over four years in the field; spent considerable time in several institutional settings; attended some fifteen conferences (her insights on conferences are sharp and telling); interviewed many people leading to hundreds of hours of recordings; read just about everything of significance on psychiatry; entered therapy herself, and took patients in therapy as an unqualified analyst. This sort of dedicated industry, based on prolonged participant

observation, is surely unusual in an era of publish or perish, university league tables and fast articles in instant journals.

The reward for her endeavour, however, is a deeply researched book on a serious subject that will attract considerable attention and foster serious debate. I shall endeavour to summarise her work under six aspects. How doctors are made; how psychiatrists are made; how the mentally ill are diagnosed and treated; the increasing dominance of the biological model; the rise of managed health care in the USA; and the predicament of psychiatry and the treatment of the mentally ill.

#### ON BECOMING A DOCTOR

Medicine is a demanding profession because it is based on a wealth of knowledge that no-one can properly master, on learning a craft that takes years to acquire, on coping with scathing public criticism from seniors (the abrasive surgeon Romano in the hospital series *E.R.* on television is really quite mild), and on the fear of a mistake – because it could cost someone's life. In conventional medicine danger runs, as Luhrmann puts it, from doctor to patient. The essence is to put knowledge and experience together to make a correct diagnosis that will cure an illness, reduce suffering and perhaps save a life. It is also important to behave like a doctor. From early on the medical student is seen as a doctor by others and learns to conduct himself/herself accordingly with an air of self-confidence and competence: and the white coat helps. (Indeed, academic researchers who have worn a white coat in a hospital setting have testified to the strength of its symbolism). Doctors can draw on a wealth of research-based knowledge, on sophisticated technology (depending, of course, on their specialisation and hospital funding), and on a high status. Initially they learn from being thrown in at the deep end – students learn what they know about medicine by *doing* it – and from not making the same mistake twice (which helps explain the brutal culture of public shame and humiliation – although the predominance of male doctors in the past may just have something to do with it). In essence, their occupational training programs them to treat the problem not the patient, to filter pain and the person out of illness (getting 'the person out of your face'), and to depersonalise the human body. What ultimately counts professionally is 'does the patient get better?' When a doctor is successful it shows: and it can be highly gratifying. When not, the patient may die.

## BECOMING A PSYCHIATRIST

After medical school and internship there follows three years of residency. Those choosing psychiatry are here again thrown in at the deep-end, being expected early on to handle intakes and to supervise patients, while much of the apprentice-style instruction is given by older, senior residents. Within weeks a young, inexperienced resident can be responsible for an entire unit when nearly everyone has left for home and he/she is also legally liable for mistakes. Even today, moreover, there 'is no medical test for a specific disease pathology for any major psychiatric illness'. From the measure of certainty and degree of competence built up in previous medical training, the resident is plunged back into a sense of insecurity and feeling incompetent. Luhrmann describes well the experiences of noviciates; they are petrified. They may be dealing with disturbed or even potentially violent people with little backup. Here they learn to see that the danger runs from patient to doctor. Yet within a year they can diagnose patients rapidly – almost at a glance – with an air of certainty and perhaps conduct 6-7 'intakes' in an evening. They have developed clinical intuition based on seeing many cases and have adopted a practical stance. There is an underlying disease, disorders are real, and are instantly recognisable. This is particularly the case with the 'biological model' of mental illness – but more of 'psychopharmacology' later.

Some aspiring psychiatrists go into therapy themselves; all of them are supervised on a one-to-one basis by people who rarely if ever see them perform. They are not 'expected to read much' (!) because they are essentially taught a practical skill – 'what to do in therapy'. There are also regular case-conferences with supervisors and residents discussing treatment for patients and sometimes open meetings with patients and staff where the novice may come under scrutiny or have to justify a clinical judgement. Luhrmann conveys graphically the intimate, small-town, somewhat paranoid culture of some units where residents are in therapy (a 'powerful, intimate experience') with people they see regularly, where rumour abounds, and where they feel under constant scrutiny. Supervision is really always *about them*, they feel, even when they are ostensibly discussing the patient. There are tears, rage and frustration in private while, writes Luhrmann 'they are, with respect to private matters, the singularly most talkative people I have ever met'.

Therapy (psychodynamic psychotherapy) involves an intense interaction between two people where the individual reveals a great deal about himself/herself by talking about feelings. It takes considerable time, is emotion-

ally demanding, and implies a particular type of relationship. Empathy is demanded from the therapist whose work depends to a large degree on his or her human capacity. This is a strongly contrasting model to that of standard medicine. In the mental health area no medical test can reveal an underlying disease; diagnosis is based on talking to the patient, observation and intuition based on experience; diagnosis suffers from varying interpretations from different practitioners; and difficult therapy implies a long, demanding relationship that can be emotionally draining for the therapist.

Before moving on it is important to stress here for the reader several important points about psychotherapy.

- Although research findings suggest strongly that the mentally ill are best treated with a judicious combination of therapy and medicine it is the case that therapy, based on European styles of analysis originating with Freud, has become somewhat discredited in America. Analysis, stereotypically with couch, is today the preserve of well-heeled analysts treating a tiny minority of well-heeled clients, 'the wealthiest and healthiest'. The vast majority of psychiatric patients in the public health system do not ever receive the luxury of such treatment. Given the nature of psychotherapy, it is difficult to establish scientifically its influence on the mentally ill.
- Diagnosis in psychiatry forms a significant problem. Luhrmann cites a revealing illustration. Eight perfectly healthy people approached hospitals complaining of diffuse symptoms and one specific complaint (of persistently hearing one word, 'thud'); all were diagnosed as mentally ill, seven as schizophrenic, and all were admitted for treatment.

#### THE BIOLOGICAL MODEL

The 'biological' model of mental illness has a long history going back to Kraepelin (born 1856, the same year as Freud). It took off particularly in the nineteen fifties and sixties with the marketing of new anti-psychotic medicines that allowed doctors to treat patients with clear results. The drugs 'work' and work quickly. They helped to de-institutionalise the sometimes awful custodial mental hospitals of Goffman's *Asylums* (1961) and *One Flew Over the Cuckoo's Nest* (Kesey 1962). But no one is quite sure why they work or why they work with some patients and not with others (they do not work with about a third of a patients). The pharmaceutical industry has, however, invested vast amounts of money in research, producing continually improved medicines with fewer side-effects ('atypicals'), and allowing many people to lead relatively normal lives. In an insightful and moving book, for

instance, Kay Redfield Jamison (1999) explains that she is alive today, and functioning well as a Professor of Psychiatry at Johns Hopkins University, thanks to lithium – and a good therapist – having been seriously ill with manic depression.

In a nutshell, anti-psychotic medicines have enabled some psychiatrists to abandon the couch and to don the white-coat again. Disease has become conceptualised as a condition of the brain, relatively easily diagnosed, and treating it allows the psychiatrist to feel like a ‘real’ doctor. In this part of the book Luhrmann is very good at taking us into the world of doctors in the making and the identity struggles they go through. She allows us to see how they face dilemmas related to diagnosis and treatment; and showing how the biological model is for some a liberation enabling them to return to the medical paradigm of illness. The psychiatrist has to invest far less in stressful and uncomfortable relationships with patients who do not seem to improve, who may prove most ungrateful, and can be highly abusive as well.

The biological model is also attractive to many young psychiatrists because of the field’s traditional lack of status within the medical profession. Psychiatry tends to be low if not the lowest in the pecking order – it’s seen as just ‘talk and tablets’ compared to the high-tech superstars of complex surgery. The production of scientific knowledge in research and publications further more is shaped by academic grants and commercial funds for laboratory and other research; today money is more likely to be found with biologically-oriented projects than with those proposals adopting the traditional psychotherapeutic approaches. We can witness through Luhrmann’s vignettes how young doctors follow certain professional paths within that changing paradigm with its fads, fashions, rewards and institutional cultures. Gender also plays a prominent role. Luhrmann’s description of medical training as a ‘cruel system’ that ‘breeds callous survivors’ relates to macho behaviour and attitudes. Toughness can be applied to biomedicine while therapy is feminine (and emotionalism is not only equated with weakness but displays a ‘lack of scientific objectivity’).

#### DIAGNOSING AND TREATING THE MENTALLY ILL

Psychiatrists cannot look into people’s minds and cannot know what is making them mentally ill. They can only ask, observe and interpret – and endeavour to treat the symptoms. It was to help doctors diagnose those symptoms that the ‘D.S.M.’ - Diagnostic and Statistical Manual of Mental Disorders – was developed. The DSM III (1980), for instance, divided symptoms into Axis I and Axis II as a kind of division of spoils attempting to

combine the views of the two schools in psychiatry that had emerged in the seventies. Axis I referred to the more 'biological' based illnesses – schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, panic disorders, post-traumatic stress disorder, etc. Axis II, in contrast, was seen more as encapsulating 'personality disorders' – narcissistic, schizoid, obsessive-compulsive ('as distinguished from the Axis I clinical syndrome'), borderline, antisocial etc. In practice, Luhrmann observed, nearly all admissions were categorised as being for Axis I as if these categories reflected underlying diseases and Axis II did not. Indeed, admissions are limited by hospitals and insurers to patients with an Axis I diagnosis in an acute phase. In effect, a number of factors have conspired to push doctors into perceiving the categories as 'real'.

Mental health institutions in the USA can be crudely divided in two. One type is private, or a privileged institution, with good facilities, excellent staff and middle-, or upper-, class patients who often, but not always, have strong family support (and a reasonable educational and/or professional background). Treatment may take months if not years: but important factors in the healing process are the social benefits (money, accommodation, work, education, supportive relationships, and so on) that the patient and his/her network can bring to the treatment process. People may be very ill, may suffer considerably, and may not be particularly responsive to treatment. Nevertheless, they have potential advantages that can be highly significant in aiding treatment, rehabilitation, reintegration and avoidance of relapse. They are often able to benefit from university-based clinics and progressive, experimental units with dedicated staff, new ways of treatment, sustained efforts at after-care, and other advantages.

The second type of institution, in contrast, is the coal-face of public mental health in large urban areas, with patients who may be chronic, homeless, unemployed or on some form of substance abuse (or may have 'double trouble', a combination of these). The patients are not 'attractive' people in attractive settings; instead, they are part of the weak, vulnerable underclass who need treatment but often resist it. They are brought in by anxious family members, by concerned flatmates, or by police officers who have found them in a seriously disturbed state, or in a dangerous state (say doused in petrol and brandishing a lighter), or committing an offence. In fact, quite a few mentally ill suspects get processed through the criminal justice system and end up in prison (Peay 1999): prisons have become the mental asylums of the 21st century – except they are poorly equipped to deal with the mentally ill.

Some of these are repeaters who may be trying to con the doctor into a bed for the night; some can be treated and released; but some are seriously ill and need to be committed. But unless they are judged to be 'dangerous', the law requires that they be released within a short period. In effect, if they are coherent, not causing immediate danger and want to leave, there is almost no way to stop them. This becomes part of the 'revolving door' of mental health provision whereby many ill people are turned out back onto the street, virtually untreated, where they are unlikely to take their medicine and where family and social support is often weak if not non-existent. This is a depressing and sad world of sick people not receiving the treatment they need. Luhrmann's peripatetic fieldwork took her to a variety of settings and she vividly sketches life in San Juan County in California as an example of the latter type of institution and Norton Inn, Virginia, as an example of the progressive type of mental institution discussed earlier.

In practice, doctors faced with this difficult and often recalcitrant clientele resort rapidly to medicine. The reasons are multiple. Firstly, medicine works to alter the symptoms of many patients; second, insurers *demand* that patients be medicated (and take their medicine) – otherwise they will not reimburse the hospital for whatever treatment is involved; thirdly, there is too little time these days to spend on patients so, rather like at 'Kwik Fit', they get a swift, impersonal 'oil change' (in this case a dose of Prozac, Risperdal or Cogentin); and, fourthly, that is what the profession claims is the 'right way'. But is it the right way to deal with the mentally ill?

#### MANAGED HEALTH CARE

A number of pressures push mental-health in the direction described above. One factor is those cases where patients sued hospitals for not medicating them. In one case a patient was treated for months in a traditional psychotherapeutic unit with a strong antipathy to prescribing drugs (this refers to the Osherhoff case of 1979 and Chestnut Lodge). His symptoms became aggravated. Eventually his family removed him to a programme where he was medicated; he improved rapidly and the family then sued the first hospital for negligence.

Another factor is powerful commercial interest. The pharmaceutical industry is large and sophisticated and exerts a strong influence through funding medical research, sponsoring conferences, advertising in academic publications, and through its own considerable research prowess. A successful drug, like Prozac, is a gold-mine (with 20 million users in the USA alone) and the consumption of medicines in western countries – and of



seductive new markets in 'developing' countries – promises dreams of increased global market share and soaring profits. Doctors are whisked off by the planeload to exotic resorts where they are entertained by the drugs industry and loaded with free samples. [I once asked a doctor if he had any ethical qualms about attending these junkets; he looked at me as if I was deranged and I felt obliged to hasten away before he had me medicated with one of his free samples and committed to a closed ward].

But the strongest influence in the USA has undoubtedly been 'managed health care'. Health budgets in America are astronomical and have risen dramatically in recent years (\$ 900 billion in 1994). In an attempt to control what they are paying for insurance companies began to determine financial limits and to impose these on provision of care. They enter into tough bargaining with hospitals, and other providers such as states, on costs. It has sent shock waves through some institutions with unit closures and mass sackings but it has also forced the health industry to become cost conscious. From a business point of view this makes eminent sense. Difficulties arise especially in the mental health area when doctors are dealing with diffuse diagnoses, prolonged treatment and poor criteria for determining success. This is a managerial bean counter's nightmare: 'What am I paying for and what result do I get for my money?' The demand from the insurers is plain: 'I want a clear diagnosis, I want the "disease" treated with medication, and I want treatment limited in time and money.'

Even though the battle between the two wings of psychiatry (that experts tried to unite in DSM III), was already swinging towards the biological, medical paradigm, this powerful impulse finally and unavoidably determined the outcome. Mental health institutions have to medicate; otherwise they do not get reimbursed and may literally have to close down. With a monthly caseload of 100 patients there is perhaps 15 minutes available per patient during the weekly consultation. Since doctors do not have time to conduct an adequate diagnosis at intake, they prescribe what is already in the patient's 'history' (medical record) – and hope it works. If their documents do not turn up in time or are not available then they prescribe on intuition – and pray that it will work. And when their insurance runs out the patients are either taken to the bus station and left there or, under more enlightened and creative health regimes, they are given a ticket to another state.

#### CONSUMERS

In the USA there are estimates that 1 in every 5-10 persons suffer from depression and 1 in a 100 from schizophrenia. Of the 'big three' – depression,

manic depression (bipolar disorder), and schizophrenia – the latter is the most debilitating. Its causes are unknown, it cannot be cured, it can last a lifetime and it frequently cuts down young people in their prime. But most people suffering from schizophrenia never become diagnosed and never receive treatment. The mentally ill are sick, and often sad, people who are a continuing concern to their families. They form a massive, largely submerged societal problem related to poverty, class, race and social exclusion. The dominant opinion of the medical profession in the USA has, in effect, chosen to refer to these people as having a ‘diseased’ brain. The powerful NAMI, National Association for the Mentally Ill, with many family members involved, also adheres to this medical definition because they believe it will get ‘real medical’ treatment, meaning equivalent to that given to non-mentally ill patients, for their family members and other clients. The radical wing of the client movement, reinforced by various anti-psychiatry gurus, tends to deny mental illness, to reject medication, and even turn it into something positive – for example, wearing t-shirts carrying the text ‘I’m psychotic and proud of it’. But where does the average mental health ‘client’ fit into this?

Many people can be helped with medicine and social support to return to normal or near normal functioning, say after treatment for manic-depression. Others face years on medicine, with various side effects, and a restricted social life. But one of the key characteristics of mental illness is that people refuse to accept the definition, deny their illness and often refuse to take their medicine (so-called ‘non-compliance’ is around 70 % for those diagnosed as suffering from schizophrenia). They have an understandable aversion to carrying the stigma that society attributes to severe mental illness. It may be reinforced if they are told they have a brain disease that they can do nothing about, are then dosed with medicine (while there is a tendency to over-prescribe), receive little in the form of after-care and find it difficult to sustain relationships and return to employment.

Here Luhrmann adds a final chapter that in a sense was not necessary for her original anthropological study but which gives the book its strong and humane message. Much of it is based on her interviews with people who have survived mental illness and have learned to take responsibility for their lives, have come to terms with their illness, and have started to help others – some have started patient advocacy groups. For them, the medical label is an insult that denies their right to be seen as a person. They do not want to be labelled as ‘diseased’. These former patients have engaged in a considerable if not heroic struggle and want to be recognised as morally responsible hu-

man beings. The medical profession treats them as a disease, or a diagnosis, and society has a tendency to think that there is something morally blameworthy in mental illness. Luhrmann is very good at illuminating this dichotomy in the way we view illness, with a measure of personal blame attributed to the mentally ill which is far less apparent in attitudes to conventional illness.

Finally, let me reiterate that I am impressed with this book. It restores one's faith in social science because it conducts empirical research on various aspects of medical education, treatment of the mentally ill, and other aspects of the medical world yet manages to illuminate the 'big picture' of a massive societal problem rooted in an intellectual battle around two competing social constructs. Luhrmann focuses on young doctors learning a profession and uses that portrait to illustrate the deep dichotomy within the profession. She shows that their occupational socialisation and career choices raise profound questions on how we view and deal with mental illness. Young doctors in training have to learn how to conduct themselves and how to cope with the multiple pressures of medical life and, in some cases, with the specialisation of psychiatry. They adjust and adapt to their social environment and make sense of coping with difficult situations and tough dilemmas. But they do it within a context that largely unconsciously shapes their professional identity and the working choices they make. It offers two approaches to mental illness and constructs two different types of people – both for doctor and patient – that fit the dichotomy.

They also learn from the social construct that the biological model has become dominant, that insurance companies now dictate medical treatment, that a doctor may be legally liable if he or she does not prescribe medicine and that the professional and scientific culture has decided that mental illness is organic. For some this means they can feel like 'real' doctors, they can avoid potentially bruising intimacy with patients, can evade emotionally painful rejection by patients and can avoid entering into psychically draining therapy with patients. These doctors have found personal solace, and a professional identity, within the medical paradigm – and by wearing the white coat. Others retain their faith in the therapeutic model, seek each other out – if possible in progressive enclaves (as in the Lacey Hospital, California), and are committed to trying to help clients through deep, personal involvement in the therapeutic relationship. The very organisational regimes of their divergent working environments – as manifested

in the dress codes, humour, forms of interaction, hierarchy, etc. – reflect that split into two worlds: and, indeed, into ‘two minds’.

The mentally ill need medicine but they also need acceptance and support. Luhrmann acutely raises this issue. For her, madness is real; ‘It is an act of moral cowardice to treat it as a romantic freedom’. And it is real in its consequences, bringing an immense amount of misery. Reducing it to a biological problem appears to make it treatable but has the danger of filtering out the person crying for help. The conventional wisdom of enlightened practitioners is that the mentally ill require long-term help with education, work, relations, housing, social skills and insight into the illness (for instance, learning to deal with their voices). In essence, they need to be seen as responsible people with an active role in reconstructing their lives. To treat them as a disease is to lock them into the wrong paradigm for their illness. To limit treatment to medicine is to negate their person in a way that creates immense societal problems that we ignore at our peril. The distortion of psychiatry to accord with the biological model has turned many psychiatrists into ‘pushers’ and mental-health care into a ‘crazy system’ (Singer 1980).

### *Maurice Punch*

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