The *Self & Society* Interview

Humanizing Psychiatry

Psychiatrist Rachel Freeth in conversation with James Davies

Rachel Freeth and **James Davies**

James Davies (JD): As a psychiatrist, Rachel, you take a fascinating position on how to understand and manage emotional distress – a position that many in psychiatry don't share. Could you tell us a little about this position and how you came to adopt it?

Rachel Freeth (RF): I don't think the way I think about and understand mental and emotional distress is in itself unusual, James, but you're right in saying that my perspectives are ones not commonly shared within the profession of psychiatry. Essentially, I draw on humanistic ideas, particularly those of Carl Rogers and the person-centred approach. I tend to view mental disturbance within an overall growth and developmental model that takes considerable account of a person's environment and their relationships, past and present. This inevitably brings me into tension and conflict with many aspects of the medical model, with its focus on categorizing and treating pathology seen as residing within the individual, whilst often attaching secondary importance, or even sometimes ignoring, socio-cultural factors.

As for how I came to adopt the person-centred approach, actually I did so very early on in my psychiatric training, rejecting a conventional medical career path and deciding to train as a person-centred therapist. This was in part a rejection of all that I viewed as flawed or harmful about psychiatry and the delivery of mental health care within health care organizations. But it was also because the values and philosophy of the person-centred approach chimed most strongly with my own values and ideals around how people should be helped. I've been trying to bring these values into my work as a psychiatrist ever since.

JD: Okay, Rachel, but how does that work exactly? You are a psychiatrist, so presumably people expect drugs and diagnoses, and what you offer them is process. Don't they get frustrated? – after all, the new president of the Royal College, (Sir) Simon Wessley, believes our current prescribing epidemic is largely due to patients demanding drugs. Even though he wrongly shifts the blame here, he's surely correct that people do demand pills – so how do you manage those demands?

RF: This question highlights what has become a constant challenge. Yes, drugs and diagnoses are what patients expect from a psychiatrist. It's also what many General Practitioners (GPs) expect, and certainly what health-care organizations see as a core part of the role of a psychiatrist. Whilst I naturally lean towards process and a psychotherapeutic way of working, I obviously need to be mindful of others' expectations and work within the demands of the organization that employs me. That doesn't of course mean that I just give people what they want, but clearly what I do in practice is influenced by those demands, and the pressure I'm placed under.

I do find it very difficult when patients expect medication and are reluctant to hear any reservations I might raise, such as potential side-effects, risks of long-term harm outweighing any short-term gain, or risk of psychological dependence. It's also difficult to

share my uncertainty around whether there may be any benefit at all from medication for that particular individual, especially when they've pinned huge hope on the medication removing their distress. It's not uncommon for my clinical judgement and opinion to be dismissed, and it's very unpleasant when my unwillingness to recommend medication for an individual patient is met by a threat by the patient to make an official complaint about me, as happened only very recently.

At the end of the day, assuming patients have the mental capacity to make decisions about their treatment, I see my job as providing information about drugs, helping them to think through the potential benefits and risks, as well as considering alternative forms of help or courses of action if available. But it's hard when patients expect me as the expert to provide 'a medication fix' – and probably quite a few people do feel very disappointed or frustrated when I share my reservations, concerns or uncertainties. I often find discussions about medication with patients and GPs, and sometimes with my immediate colleagues, demanding, and rarely easy.

JD: Demanding and rarely easy? Could you say a little more. Rachel? I only ask because having worked as a therapist in the National Health Service (NHS) myself, I know how demanding having a different view can be. What are the strategies you use to navigate such tensions? And what about job security – do you ever think your views could jeopardize that?

RF: The personal and professional difficulties and risks of holding different views are things I do think about quite a lot, James – and increasingly so as cultural and political forces head us ever more in the direction of risk-averse clinical practice, and the increasing liability of being criticized and blamed when things go wrong, or when tragedy occurs.

First of all, I think it's important to be prepared for the emotional demands of holding and practising from a different viewpoint. The emotional implications will be different for each person, according to the degree of our individual needs to belong and to feel accepted, whether by our professional group, team or organization. In the early stages of our careers, the need to fit in may be particularly important. I've certainly felt very lonely and isolated at times, and I'm also aware of running the risk of rejection and misunderstanding, which can be very painful.

On a practical level, working within an organization such as the NHS, as a psychiatrist, I think there is a need to tread a pragmatic path that tries to find a way of fitting in to some degree, particularly as much of mental health care is multi-disciplinary in nature. I don't think I'm that vocal in expressing differences in my day-to-day work (although perhaps my colleagues would disagree), which may partly be to do with my personality. But then keeping quiet when I feel really strongly about the harms and inadequacies of certain aspects of care isn't something I can do, either. I've always found it easier to protest or disagree through writing than in speech. Perhaps, then, the issue is about how we express differences.

In terms of risks to my job – yes, I think that does have to be considered. When it comes to prescribing medication, the main risk I'm taking by not prescribing in certain situations is of being accused of neglect or negligence by not providing treatment that other psychiatrists would deem necessary. I remember experiencing criticism for supporting a patient to come off an antipsychotic drug who subsequently became ill – the criticism being that I should have used my medical authority to persuade or coerce the patient not to come off the drug. The fact that this was a fully informed decision that the patient made after we'd discussed the risk of withdrawal effects, and the fact that there were unforeseen personal stressors that may also have contributed to the patient's deterioration, weren't taken into consideration.

In reality, I worry more about professional isolation than I do losing my job because of my beliefs and views. I suspect there are enough psychiatrists out there now who would support my practice with little hesitation. I'm thinking here of fellow members of the Critical Psychiatry Network (CPN). As you know, within this network there are a number of psychiatrists who hold alternative views and who have made them public through various publications or social media (see www.criticalpsychiatry.co.uk).

In terms of strategies to manage the tensions, allies such as the CPN are important. I also have peer supervision with a psychiatrist working in another mental health Trust with whom I feel safe to explore my fears and anxieties in the work. It has also been important to find support locally, and currently I value the support and understanding of several psychologists who work within my Trust. When I receive affirming and encouraging messages from counsellors and psychotherapists I encounter at workshops or via email, this also strengthens me.

I think one thing that is most important, though, is self-awareness, which includes sensing how far I can compromise on my values and ideals without compromising my overall integrity. There isn't any neat formula here, and I need to approach each situation individually. However, the key things I factor in are my need to take care of myself, whilst also being prepared to get hurt, and the need to speak truth. They don't of course easily balance.

JD: So what can we do about all this? – I mean, I'm concerned that the strategy for most doctors (whether conscious or not) who harbour similar concerns as you is to rationalize their objections away and safely return to the dominant discourse (in fact, there's ample anthropological research on how a central part of all professional socialization involves penalizing dissent). How can we support dissenters in training and early careers? How can we help younger practitioners struggling in the way you've done?

RF: I agree that we need to focus on thinking about doctors in training and those at the beginning of their careers. I'm also aware that working as a trainee doctor in the UK today is a very difficult place to be. Emotional survival for many is an extremely pressing concern, which will make it more difficult to take career risks by voicing dissent. I think there's a real need to create a safer and far more supportive climate for doctors in training. Perhaps only then will they feel freer to take the risk of daring to question orthodoxy.

But there is also an issue of what gets taught to trainee psychiatrists, i.e. the training curriculum. I believe what's needed is much greater emphasis on the humanities (e.g. literature, history, cultural studies, ethics, philosophy, anthropology, etc.) and for these subjects to be covered along with the natural sciences. But also to strive towards an integration rather than, as tends to be the case, humanities just tacked on like an optional extra.

I also think that when doctors learn to notice how values influence practice as much as scientific facts, this is when they start to question things. I think that was a key moment for me – when I realized how much of psychiatric practice and mental health care came down to values (which informs ethical thinking and behaviour). But that can be a hard nut to crack, because medical school is by and large a process of learning a huge range of facts, and methods of applying them. Many doctors feel very uncomfortable when they feel they lack objective knowledge to grasp on to.

So it's something about helping psychiatrists in training to ask questions, question evidence (and what counts as evidence), and above all, pay very close attention to patient experience and meanings. It's really the latter that should most inform us, and help to motivate our dissent.

JD: Very interesting, Rachel – but nothing approaching your sensible suggestions is in my view occurring. Being a pragmatist, I'm always looking for what we can do to change the current state of affairs. Not wishing to put you on the spot here, in what ways do you think you're personally making a difference outside the clinical setting, to furthering reform of psychiatry? – to re-humanize it, so to speak? In other words, what can you or others do to make change happen?

RF: I agree that we need to find ways of translating ideals into practice and to be pragmatic. And I don't mind being put on the spot! – if it helps me to reflect on what I'm doing, what I want to do, and what I can do to make a difference. Perhaps many of us wrestle with the question, 'What difference can I really make?'.

I mentioned earlier that I'm a member of the Critical Psychiatry Network. I suspect that as a group we are often experienced as an irritant to the broader psychiatric establishment, but I believe our existence

as a group of psychiatrists who are prepared to challenge the status quo and to voice dissent is very important. I'm not naïve enough to think that psychiatry is going to reign back from pursuing a rather narrow biological course and embrace its holistic potential any time soon. But I do think there will continue to be numerous individual examples of holistic and humanistic practice. I also think that alternative services and approaches to care will continue to develop. Many psychiatrists despair at the current culture of organized mental health care, and are in the mood for change.

When I feel bold enough, I've given talks and presentations with a humanistic bias locally within my organization – for example, giving a presentation to psychiatrists on Carl Rogers' understanding of empathy. As you know, I've also written about 'Humanizing Psychiatry and Mental Health Care', where I've drawn on my person-centred counselling background and tried to argue for a form of mental health care informed by person-centred values, whilst acknowledging the considerable challenges of doing so. It actually got a positive review in the *British Journal of Psychiatry*, to my surprise and delight!

I don't think we ever really know what difference we make, or what might be achieved further down the line. It would be nice to see more immediate fruits of our efforts, but I think I'm content (most of the time, anyway) to just see myself as making a contribution to an ongoing process. There we are again... – it's all about process!

JD: Process indeed! So on that point, Rachel, where do you see yourself heading in the future?

RF: In my previous response I was uncomfortably aware of my limits in being able to reform and re-humanize psychiatry, at least at an individual level. However, I think I can have more influence and make more of a contribution within the counselling and psychotherapy profession. For the foreseeable future I intend to continue to practise as a psychiatrist and as a counsellor, straddling these two worlds. I think this puts me in a good position to support the counselling profession to work with clients with more severe forms of mental and emotional illness and distress, who've perhaps had contact with the mental health system and been given a psychiatric diagnosis. A lot of counsellors feel ill-equipped or anxious working with this client group, and yet increasing numbers of such clients are turning up at the counsellor's door. I strongly believe that many counsellors and psychotherapists can offer something valuable that's not being offered within mental health care organizations.

I would also like to spread the message to counsellors and psychotherapists (which is what I'm doing here) that the psychiatric profession is very diverse with regards to philosophy, belief and practice, and therefore to caution against making assumptions. Whilst there's a great deal about psychiatry that warrants challenge, criticism, and at times even condemnation, many of us are also unhappily caught up in an oppressive system and experience personally the effects of organizational bullying and manipulation. Ultimately, I would like to support the development of a shared understanding and mutual respect, where psychiatrists, counsellors and psychotherapists see themselves as equals and allies, which of course does mean creating more opportunities for dialogue.

Notes on contributors

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