

MADNESS OF PSYCHIATRY



BY SAXBY PRIDMORE

Special Publication of the German Journal of Psychiatry

Madness of Psychiatry
:for the general reader

By
Saxby Pridmore

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Madness of Psychiatry is a book for the general reader, which will interest psychiatrists and students. It is written by a psychiatrist with extensive academic, administrative, and clinical experience. It is illustrated with case studies and photographs. It describes the symptoms and syndromes of the severe mental disorders. It explains aspects of mental illness in court, and compulsory admission to hospital. It salutes electroconvulsive therapy and tentatively welcomes transcranial magnetic therapy. It grapples with deinstitutionalization, genius and suicide, and turns a critical eye on post trauma debriefing and recovered memory.

These are the views of the author. These are not necessarily the views of the German Journal of Psychiatry.

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CHAPTER 1

WHAT ARE WE TALKING ABOUT?

When I was growing up, people got most of their information about psychiatry from cartoons of patients lying on couches talking to a psychoanalyst, usually about sex (Illustration 1.1). After more than a quarter century in the profession, I have never seen a psychoanalyst's couch. Nor, by the way, have I seen a padded cell or a straight jacket. Either my training and experience are lacking, or there was something wrong with the common stereotypes.

The general public now appears better informed. But the quality of the circulating information is poor. Many heads are cluttered with "mental health" nonsense - the propaganda and wishful thinking of health authorities and the political correctness of pressure groups. For example, the wholesale closure of mental hospitals, compulsory debriefing of trauma "victims" and the recovered memory industry. These have all been uncritically nurtured and extolled by people who should have known better.

This book is an insider's view of psychiatry and psychiatric disorders, which are also called mental disorders, and related topics.

There is something about psychiatry and psychiatric disorders which people find strangely unsettling. Dr Josef Mengele, a German Nazi physician, tortured 400, 000 prisoners to death, Dr Harold Shipman, a British general practitioner, murdered at least 250 of his patients. Dr Ayman al-Zawahri, an Egyptian surgeon, was a central figure in the September 11 terrorist attacks on the USA. But in spite of the evil deeds by doctors in other fields, the psychiatrists are the doctors whom the public regard with greatest suspicion.

The definitions used in this field can be a little difficult to grasp, and often, like Russian dolls, they enclose



Illustration 1.1. A typical "patient on the psychiatrist's couch" cartoon. Jokes such as this were the source of the beliefs about psychiatry held by a large section of the general public. They lampoon some features of psychoanalysis, in particular, the patient lying on a couch and the psychoanalyst sitting out of view and apparently taking very little notice of the patients. Psychoanalysis has never fairly represented the main work of psychiatry. It was only ever performed by a very small percentage of psychiatrists and is beneficial in the treatment of only a small percentage of psychiatric disorders. In the original form, it has disappeared.

terms which themselves need to be defined and the chase for a precise meaning continues. A simple definition of psychiatry is “a specialized field of medicine concerned with prevention, diagnosis, treatment and research of mental disorders”. We can forget about prevention and research for the moment, in which case, the crux of psychiatry is the diagnosis and treatment of mental or psychiatric disorders. That begins to sound a little spooky, but what are mental disorders?

Mental disorders have been defined as, “psychological syndromes that are associated with distress or disability”. Some experts will not attempt to define “psychological”, stating that “it cannot even be easily characterized”. Forced to come up with a definition, others state that psychological has to do with “the science of the mind”. Then, mind is defined as, “the totality of mental processes”. There is no widely accepted definition of “mental processes”, instead some experts prefer to state that perception and cognition constitute the mental processes. Yet others claim this list is incomplete and that the will and emotions deserve to be included. Perception has to do with the making sense of physical stimuli (sound, light, touch, smell, taste). Cognition has to do with mental activities such as thinking, conceiving, reasoning, among others.

Professor Nancy Andreasen of Iowa, USA, says that discussions about the nature of mental or psychiatric disorders provide “much heat but little light”, but that a definition is unnecessary as there is general agreement about which disorders constitute the mental disorders. Examples are schizophrenia, bipolar disorder, major depressive disorder and obsessive-compulsive disorder. These are conditions which may manifest altered moods (depression, elation, anxiety), beliefs which are not supported by evidence (delusions), the hearing of voices when no one else is present (hallucinations) and odd behaviour such as washing the hands a hundred times (compulsions).

The psychiatric patient is not faking. The patient who is suffering major depression is not being self-indulgent or attention seeking. The depression of mood may be so deep that recovery is beyond the control of the patient and he or she is incapable of responding to the advice “pull yourself together” or “snap out of it”. This disorder may be so severe and of such a type that the patient commits suicide. This may occur to an individual who, when well, would not contemplate such action, being strongly opposed to suicide because of family responsibilities, or on religious or moral grounds.

The patient suffering delusions is not pretending to believe things which others find laughable. He or she may be so convinced of the truth of their belief that innocent others, even loved family members, may be attacked or killed. The patient who has washed his or her hands ninety nine times may agree that logically, his or her hands must be clean, but may be unable to resist the compulsion to wash them one more time. More common examples include patients who are suffering anxiety (butterflies in the stomach, tremor of the hands, headache, worrying and irritability), who know they have nothing to fear, but cannot shake off the symptoms appropriate to danger.

We are what we think, feel and do. We pick up real signals from the external world (not hallucinations) and respond appropriately. These abilities form our essence or being, they are central to our ability to function logically, independently and in accordance with our own plans and decisions. They enable us to function as autonomous (self-governing) individuals. Mental disorders, however, interfere with our ability to interpret the world accurately, to feel appropriate emotions, to think, to plan and to act appropriately to our external and internal circumstances. To lose a leg is a terrible loss, but to suffer a mental disorder is to lose the sense of control, of autonomy, of being a human being. It is no wonder that mental disorders are greatly feared and regarded with disgust.

Many measure their self worth by what others think of them, or more precisely, what they think others think of them. While concern about what others might think serves to inhibit individuality and sets the scene for widespread disappointment, it is fundamental to honor, manners and duty, and remains an important force in determining self-esteem. Mental disorders make people less productive and may even lead them to act in a socially humiliating manner (from being too anxious to respond to a greeting, to behaving in a sexually uninhibited, subsequently regretted, manner). This potentially damaging effect on social behavior is a further factor contributing to the threat posed by mental disorders. And of course, mental disorders, irrespective of actual or imagined impairment, are highly stigmatizing, which is yet another layer of potent threat.

A psychiatrist is a qualified medical doctor who has obtained additional qualifications to become a specialist in the diagnosis and treatment of mental disorders. Additionally, psychiatrists have a role in the prevention and research of mental disorders, but the diagnostic and treatment skills are the issues which worry the man in the street.

To make a diagnosis the patient needs first to be adequately examined. An examination can usually be conducted during one or more outpatient interviews. If the patient is unable to communicate for any of a number of reasons, including loss of the capacity for logical thought, delusions, or a state of abnormal mood, to gather sufficient information to form a diagnosis, it may be necessary to retain the patient in a hospital for a few days for observation. Some patients may not agree to spend time in a psychiatric ward, but if there is a psychiatric illness and the patient is a potential risk to themselves or others, it is the psychiatrist's duty to ensure that patients are retained, on legal orders and against their will, if necessary. When the risk to the patient or others continues, the psychiatrist may be responsible for ensuring that the patient is legally retained in hospital until treatment has been effective and the risk passes. Treatment often takes the form of medication. The medications that correct mental disorders are by definition mind altering and their effect is on the brain. Thus, the psychiatrist is a doctor who may prevent the free movement of a patient and prescribe mind-altering drugs. The psychiatrist may be viewed as a danger to the autonomy of the individual. Thus, the common concerns about psychiatrists are similar to those about mental disorders.

While many patients who could be benefiting from the services of psychiatrists are not doing so, because of their reluctance to consult a psychiatrist, there are many circumstances in which patients who can not fully utilize the services of a psychiatrist are seeking or being encouraged to do so. The psychiatrist has a significant contribution to make in the management of mental disorders, but is often expected to contribute to other areas, such as vandalism or other social issues.

By virtue of training in human behavior and skills in interpersonal relationships, the psychiatrist is able to contribute in many situations of distress. However, when the distress is not a feature of a mental disorder, the psychiatrist is no better placed to help than other helpers, most of whom are less expensive options. In fact, the psychiatrist may be less well placed to help than the social worker or religious officer, who have their own skills, experience and support systems.

This introduces one of the problems with the concept and terminology of "mental health". This is a basket into which is tipped a whole heap of human misery. This misery can be sorted out into two main categories, 1) mental disorders, and 2) other problems. The term mental health is often employed to put a positive spin on the facts, and is thoroughly modern in emphasizing wellness rather than sickness. Mental disorders and other problems, are different issues, however, and should not be cobbled together for the sake of administrative neatness.

"Health" the modern policy officer is quick to point out, "is much more than the mere absence of disease". Mental health is defined in Health Department policy documents as "the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well being, optimal development and use of mental abilities and the achievement of individual and collective goals." A central notion, then, is that mental health has to do with "subjective well being".

As well as mental disorders, have already been defined and include serious conditions such as schizophrenia and bipolar disorder, mental health authorities assume responsibility is "mental health problems". These constitute "a disruption in the interactions between the individual, the group and the environment producing a diminished state of mental health". This means that a mental health problem has occurred when something has disturbed the individuals subjective well being. A loss at the races, a disagreement with the spouse, being mugged – by definition, all of these can be seen as mental health problems (Illustration 1.2).

Having psychiatrists deal with mental health problems, as happens in some centers, is to medicalize the vicissitudes of life, and a ludicrous waste of resources. At the core of this issue is the misguided term mental health and the sweeping together of mental disorders [which would be better called psychiatric disorders] and a bunch of untidy social problems which cause human distress.

These views may be considered too harsh, but they are not without support from some respected social commentators. Frank Furedi (2002) of *The Spectator*, in a piece entitled “The Seven Deadly Sins” wrote, “In a world where the motto is ‘You mustn’t blame yourself’, sin has been replaced by sickness in need of therapy”. He claims that guilt, which underpinned the concept of the seven deadly sins exists only in caricature. Lust has become sexual addiction, a condition which is supposed to afflict 15% of Americans. He states that anger has received the label of impulse control disorder, and that gluttony and sloth have also been medicalised. He states that pride had been rehabilitated as virtually every social and psychological problem is attributed to low self-esteem, and that “pride has become one of the prime virtues of our time”.

Patsy Crawford (2001), of *The Mercury*, in a piece entitled “So take us back to BC” is critical of the excessive availability and use of counselling. She declares she comes from the days before counselling (BC). “If stress and bother were considered the normal byproducts of life, then why have minor setbacks suddenly blossomed into social service gravy trains?” she asks.

London based psychiatrist and social commentator Dr Trevor Turner [2003] echoes many of these points. He observes there is currently excessive importance placed on “personal convenience”. People want their own things [car, house, computer] and are choosing to live alone so that they can have things as they want them. However, they then experience of loneliness and develop maladaptive behaviours such as shyness, sexual promiscuity, and aggression. The “medicalisation of discomfort” recasts shyness as “social phobia”, sexual promiscuity as “sexual addiction” and aggression as “impulse control disorder”. Turner states that treatment of these new conditions “drains medical resources from the needy to the greedy”. He blames “too much counselling and chat shows”. His suggested solutions include encouragement to “get back to working and playing with other people rather than talking about ourselves”, and relearn to accept inconvenience.

Current national health policies, in addition to medicalizing the vicissitudes of life, attempt to demedicalize (reduce the central role of medicine and doctors) major mental disorder. The Australian National Mental Health Strategy was commenced in 1992 with a view to assisting those with mental disorders and mental health problems, and was a prominent force in the closure of the mental hospitals. It states, “Ultimately, the Strategy seeks to engage all members of the community in a partnership to eliminate the abuse, injustice, misunderstanding, ignorance, stigma and discrimination surrounding mental illness, so that the human rights abuses of people with mental illness can become a thing of the past”. While that sounds terrific, this approach promotes the social above the medical needs of sick people. Not to mention the funds diverted into spin-doctoring and promotion of the anti-clinical view of mental disorder. It is little comfort to the parent who can’t get a hospital bed or a doctor for their hallucinating, deluded, disorganised and hostile young adult offspring, to assure them that money has recently been spent in attempting to lower the stigma of mental disorder.

“I wouldn’t go near a psychiatrist. They’re as loony as their patients”. Statements such as this are not uncommon. There are some points of interest. The suggestion of consulting a psychiatrist is so threatening to the speaker that avoidance is justified by this denigrating generalization. But is there a grain of truth? That depends on what is meant by “loony”. If loony is intended to mean that psychiatrists are mad or psychotic, the statement is clearly wrong. Psychiatrists are doctors working in an exacting, specialized field. They could not function in a psychotic state.

Incidentally, the word loony has its roots in madness. Like lunatic, loony, comes from the word *luna*, which is Latin for moon. There are two explanations, both probably contributed to current usage of the word. The first is that many forms of madness or psychosis have a fluctuating course and as the full moon appears episodically, the conclusion was drawn, in Roman times, that the moon caused madness. The second is that, in the days before street lighting, people did not move around much at night, preferring to stay in the comfort of their homes. Mad people, however, lacking comfortable homes or aroused and disorganized, went out around the country at night, particularly when there was enough moonlight to show the way.

On the other hand, loony may be intended to mean different from the average person, or likely to be perceived by the average person as odd or eccentric. The contention that psychiatrists are different from the

average person and may appear odd or eccentric is more difficult to unreservedly refute. A religious leader looks at the world from the perspective of his or her particular religion, taking into account a concept of God and the relevant religious scriptures and moral codes. Would you discuss with a religious leader the intimate details you would reveal to a close friend? A dress designer has an expert knowledge of aesthetics, style and the human body. Very often he or she would not have the slightest interest in the appearance and clothing of people met in social situations, nevertheless, most of us feel conspicuous and uneasy when introduced to a dress designer. Would you feel comfortable telling a formula one driver about how many kilometers to the liter you get from your VW?

The people who become psychiatrists are well above average intelligence and they are able to focus on tasks and work hard. That is how they get into medical schools. After four to six years in medical school, they then work as doctors and study psychiatry for another four to six years. Particularly during this latter block of years they learn about human relationships, about what people find rewarding, about motivation and emotion. They examine the influence of culture and authorities on the private life of ordinary people. Working in this area they inevitably explore and think about the things which are important to them as individuals, about their own reactions to people and their place and role in society. Just as the Buddhist monk and the Army Colonel have different attitudes and bearing, so the psychiatrist may present as different from the average person. It is unwise to construe any such differences as oddness or eccentricity, and worse than unwise to construe them as justification for refusing to consult a psychiatrist.

Surprisingly to some, perhaps, psychiatrists do meet and make friends in social settings. When a new friend finally trusts the person who is a psychiatrist, he or she usually makes one confession and asks one question. The confession is, "I must confess, I used to be worried that you would try to analyze me".

If a breast surgeon desires to touch the breast of another person in a social setting, it will not be for professional purposes. There are reasons for feeling breasts other than checking for lumps, and the breast surgeon gets more than enough professional activity. If an endocrinologist offers to buy you coffee and you say yes, he or she will not be making a mental note that you appear to be thirsty and need a blood sugar test to exclude diabetes. If you miss an eighteen inch putt your neurologist golfing buddy is not secretly itching to get your head into a brain scanner. He or she is just happy you missed. So it is with psychiatrists, even if they seem a bit different, they are normal humans, they need normal human contact and socially, like other normal humans, they are interested in making contact rather than checking for normality. Like other doctors, they assume the absence of pathology until you turn up at the office. And they get enough work, at work.

The question is, "I don't really understand the difference between a psychiatrist and a psychologist?" As mentioned, a psychiatrist is medically trained and has additional qualifications in the diagnosis and treatment of mental disorders. There is a broad based understanding of mental disorders, incorporating psychological, sociological and biological components. Diagnostic activities involve the ordering and interpretation of medical tests, such as brain scans and blood tests, and psychological tests, such as memory and personality tests. Psychiatric treatment is a very broad field, which can be split into the talking therapies which include counseling and psychotherapy, and the physical therapies which include medication and electroconvulsive therapy (ECT).

Leading dictionaries of psychology find the term "psychologist" difficult to define. This is partly because psychology is difficult to define, and largely because there are many types of psychologist: educational, sports, health, industrial, research and clinical, to list a few. It is the latter group which is relevant to present discussion. Psychologists do not have medical training, they obtain first degrees mainly in arts or science and then obtain post graduate degrees. To become registered they usually perform a year as a trainee or intern in an approved training position. In the first degree, psychologists predominantly learn about normal mental function. Those who become clinical psychologists receive additional training in mental disorders. Clinical psychologists are skilled in psychological testing and usually have training in talking therapies such as counseling, psychotherapy and behaviour therapy (Illustration 1.3). They do not order or interpret medical tests, nor do they prescribe physical treatments such as medication and ECT. Clinical psychologists are very useful expert members of the mental health team. The majority spend most of their time in talking therapies. In certain places such as the USA, clinical psychologists are favored by insurance

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Illustration 1.2 This advertisement encourages young people to consult a web page which provides information about achieving and maintaining well-being, that is, mental and physical health.

The advertisement mentions only mental health and one of the three sponsoring authorities is a mental health authority. The target population includes young people with various problems including, conflict with parents, living on the street or drug use. While these are important issues, they are all qualitatively different from mental disorders such as schizophrenia.

The flaw in giving responsibility for well-being to those who are responsible for mental disorders is that money and attention must, to the extent that well-being is addressed, be diverted away from those suffering mental disorders. Mental health authorities should be responsible, not for mental health, but for mental ill-health.

companies as providers of psychotherapy as they provide this service at a lower price than medically trained psychiatrists.

There is a range of other disciplines represented in mental health teams. These teams exist almost exclusively in government services. Psychiatric nursing and social work have been represented for many decades; they were more recently joined by occupational therapy along with others. The latest additions to the team are paid patient advocates and consumer consultants, the latter being people who have recovered

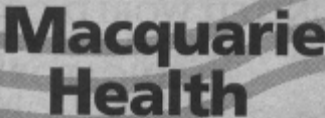



**Vietnam Veterans
Counselling Service**

Counsellor
(Psychologist or Social Worker)
DARWIN

A permanent full-time position is available in the Darwin office of the Vietnam Veterans Counselling Service. The Counsellor will be a member of a small professional team, which provides counselling in a specific region.

Illustration 1.3 Counseling has become widespread. It is closely related to psychotherapy, but it has more to do with helping people take an objective look at their problems and come to a solution rather than attempting to fundamentally change the personality or produce enduring change in the behaviour of the individual. This form of verbal assistance can be provided by non-medical professionals.

Macquarie Health
 MENTAL HEALTH SERVICES
MENTAL HEALTH WORKER
 Gilgandra, Coonamble, Warren

This position offers the opportunity to work as part of a dynamic, rural Area Mental Health Service. This position services the communities of Gilgandra, Coonamble and Warren and may be based in any of these towns. Duties include acute care, case management, consultation/liaison, telehealth, and innovative practise in rural communities.

Essential:

- Qualifications in one of the following professional disciplines: Registered Nursing; Psychology (4 years); Social Work or Occupational Therapy
- Affiliation with an appropriate professional supervisory body
- Knowledge of or interest in contemporary mental health strategies and interventions
- Current NSW Class C Driver's Licence or equivalent



NORTHERN RIVERS AREA HEALTH SERVICE



Primary & Extended Care Services
 Eastern Cluster Mental Health Services
Mental Health Worker
Acute Care Team

Permanent Full Time
 (Position No: M001/011)

Suitably qualified health professionals either Registered Nurses, Social Workers, Occupational Therapists or Psychologists with sustainable recent experience in crisis and acute care in a Community Mental Health setting are invited to apply for the above position.



Department of Health
 Government of Western Australia

Kimberley Health Service
 Northwest Mental Health Service

Community Mental Health Professional

You will be eligible for registration (with appropriate Western Australian Professional Board) as a Clinical Psychologist, Psychologist, Social Worker, Occupational Therapist or Mental Health Nurse. You will have clinical experience in community mental health with effective communication, time management and team working skills. An 'A' Class driver's licence is required.

Illustration 1.4 These are examples of advertisements seeking the services of generic mental health workers. The employer will accept either a nurse, social worker or psychologist. This suggests that much of the service supplied by these professions is general, or in modern terminology, generic, and can be provided by them all. It is impossible to reconcile the interchangeability of these professions with the politically correct view that it is essential to have multidisciplinary teams, because "each profession makes a unique contribution".

from an episode of mental disorder.

The origins of the imperative for multidisciplinary teams in mental health are somewhat obscure. One source was the egalitarian view that each profession has a unique contribution which the others cannot provide. This argument is largely false, in many circumstances it does not matter whether service is provided by a psychologist, psychiatric nurse, social worker or occupational therapist. This is substantiated by health departments newspaper advertisements for "generic mental health workers" (Illustration 1.4).

Another main source of the multidisciplinary team was the anti-authority sentiment of post-modernism, the fashionable distrust of experts and the notion that the opinion of each is valid and valuable. In the field of health, this took the form of anti-doctor movement. The term "medical-model" emerged as a term of abuse and was applied to everything to do with doctors. There are as many definitions of medical-model as people who use the term, but a major plank is that doctors think of things in terms of biological diseases. It is relevant that psychiatrists are trained in incorporating psychological, sociological and bio-

logical principles, but just as importantly, it has recently been unequivocally demonstrated that the major mental disorders, those with which most psychiatrists are most concerned, have a strong biological basis.

Other motivation for promoting the multidisciplinary mental health teams included fiscal issues. Under the cloak of the above propaganda, disciplines which were less expensive than psychiatry were given roles. A related matter was that government services simply have not been able to recruit psychiatrists as they preferred to go into university positions or private practice. A sorry situation has now developed such that government mental health services do not understand psychiatry or psychiatrists and the retention of recruited newly qualified psychiatrists is poor. The flaw in employing large numbers of less expensive workers is that they are less efficient and getting the job done, in fact, becomes more expensive. Private mental health services, which depend on efficiency for survival are not studded with large number of less expensive workers.

The National Mental Health Report 2002 [Australia] summarises the achievements of the National Mental Health Strategy over the preceding decade. Over a five year period [1994/5 to 1999/0] the number of psychiatrists employed in public services declined by 1.3%. Also over this period, the number of psychologists employed in public services increased by 56.7% and the number of medical officers [not psychiatrists or psychiatrists in training] increased by 61.8%. This reflects the inability of the public service to attract and retain psychiatrists. Psychologists and medical officers do not bring to the clinic, the range of skills possessed by psychiatrists, and people with major mental disorders require the skills of psychiatrists.

“Out of Hospital, Out of Mind”, the recent review of mental health services of Australia by the Mental Health Council [Groom and Hickie, 2003] makes many observations, including “that the current community-based systems are failing to provide adequate services”. With respect to the staffing matters, however, they criticised “the inappropriate mix of medical and psychosocial services provided by government-financed systems”. This is code for, too many non-medical staff and too few medical staff.

The National Mental Health Strategy has achieved some gains [Goldberg, 2000]. However, the commentators who strongly support this strategy are leading administrators and policy gurus who are commenting on their own creation. The majority of working psychiatrists report a decrease in the quality of care provided by public psychiatric facilities in the previous five years [Rey et al, 2003]. Significant progress is unlikely unless more grass-roots psychiatrists are involved in public service policy and clinical work.

Phillipe Pinel, the father of modern psychiatry, was removing chains from the insane people of Paris in 1800. Thus, advances in the field have been swift. Late in the nineteenth century, Emil Kraepelin, in Germany, made the important, fundamental distinction between the two major forms of madness, schizophrenia (which he called dementia praecox) and bipolar disorder (also known as manic depressive psychosis). In so doing, he took a first step in bringing order into the chaos of madness. At the end of the nineteenth and in the first decades of the twentieth century Sigmund Freud, in Vienna, theorized about the causation and treatment of neurotic illnesses (these are not forms of madness, but mild mental disorders). He introduced the concept of unconscious mental process and sexuality in early life. His treatment, psychoanalysis, is now little practiced in the original form, but is the basis of much psychotherapy. While Freud’s work had minimal impact on the management of madness, it greatly influenced psychology, philosophy, literature and fine arts.

In the 1930s, Ugo Cerletti, in Rome, pioneered the use of ECT. This treatment has been subsequently refined, but remains in common use in severe mental illness.

In 1949 John Cade, in Melbourne, introduced lithium as a treatment of “psychotic excitement”. Lithium was the first prophylactic in psychiatry. It is a treatment of symptoms, but more importantly, it prevents the emergence of symptoms in serious recurring mood disorders.

In 1952 the first edition of the “Diagnostic and Statistical Manual” [DSM-I] was published. This was the first attempt to provide operational definitions of all the various categories of mental disorders. Psychiatrists are now using the fourth edition. The various editions of the DSM have allowed psychiatrists to diagnose according to widely agreed criteria, encouraging clear communication and better research. During the 1950s a wide range of psychiatric medications became available. Prior to this time, medication was

largely limited to sedatives, but this decade brought specific treatments for depression, psychosis and anxiety.

In the 1960s a number of new talking therapies were developed. These relied on thinking, behavior or relaxation. For example, in 1963, Aaron Beck, in the USA, described what has become known as cognitive behavior therapy [CBT]. He emphasized the importance of logical thinking, observing that the emotions settle if the patient can assess his or her situation accurately.

Commencing in the 1970s and continuing to the time of writing, there has been progressive reduction in the number and size of psychiatric hospitals. This has resulted in disadvantage to some, but the associated changes in professional attitudes toward patient self-determination, range of choices and maintenance in the least restrictive environment, has brought undoubted advantages to others. In the early 1970s the antipsychotic [madness treatment] drug clozapine was released for use in Finland, but was withdrawn due to some patient deaths.

In the late 1980s studies showed that, with appropriate safeguards, clozapine can be administered with minimal risk. In the 1990s this drug, which has antipsychotic actions superior to all others, became available in many countries. In the last quarter of the twentieth century, various imaging techniques began to reveal brain abnormalities in many mental disorders. These had always been suspected, but psychiatry had to wait on the development of sophisticated technologies for satisfaction.

In the late 1990s psychiatrists around the world began to explore the possibility of using transcranial magnetic stimulation [TMS], a means of producing tiny painless electrical currents in the brain of conscious patients, in the treatment of mental illness. While not yet fully explored, TMS appears to offer promise.

Psychiatry, like the rest of medicine, continues to advance. But psychiatry may be lagging behind some other fields. In making a diagnosis, psychiatry still depends on the patient's account of his or her symptoms, while in much of the rest of medicine, objective tests and investigations provide information, some even showing the pathogenic organism (bacteria in urine), or clear evidence of a pathological process (high levels of blood sugar in diabetes). In treatment in other fields, such as contagious diseases and medical oncology, the aim in most cases, is cure. In psychiatry, at the moment, however, special investigations are not particularly helpful and treatment is generally aimed not at cure or prophylaxis, but at reducing the impact of patients' symptoms. The future of psychiatry holds objective investigations, both brain imaging and blood or skin cell tests, and new treatments, including genetic engineering.

Psychiatry is a medical specialty and many mental disorders are based on brain abnormalities. It follows that "pull yourself together" recommendations will fail in mental disorders and succeed only in bringing distress to both the recipient and the provider. However, psychoanalysis and the newer psychotherapies have much to offer, particularly in the mild mental disorders. To understand this point, which has bearing on the areas shared by psychiatry, clinical psychology and the other mental health professional groups which use psychotherapy, we will return to the two times table. What does $6 \times 2 = ?$ How on earth did you remember that? Sure, you said it with the rest of the class thousands of times, and you wrote it down thousands of times. But, so what? That doesn't explain how you remembered $6 \times 2 = 12$. You were able to remember because when you repeated $6 \times 2 = 12$, over and over, as a child, the connections between particular nerve cells in your brain changed. Microscopically, they became darker and thicker - in current scientific jargon, they were "strengthened". There is evidence from laboratory animal experiments that strengthening of connections occurs following the activation of genes in the nucleus of the involved nerve cells. Stronger connections are more likely to transmit impulses than less strong connections. Thus, like now, in adult life, when you are asked about 6×2 , those circuits are activated which give you the answer 12 (hopefully). This illustrates that learning results in modification of brain structure and consequently, function. It is hypothesized that mild mental disorders may have a similar basis and that psychotherapy may be helpful by strengthening alternative connections, that is, by modification of brain structure.

Psychotherapy is a set of skills. While the most influential pioneers were the psychiatrists Sigmund Freud and Aaron Beck, these skills can be learned by non-medically trained people. In recent times, progressively more psychotherapy has been provided by these less expensive professionals. Psychotherapy also remains, however, an important component of the treatment offered by psychiatrists. The optimal management of

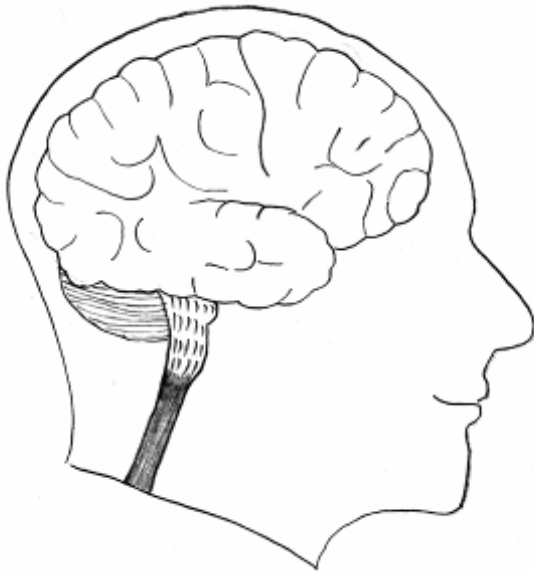


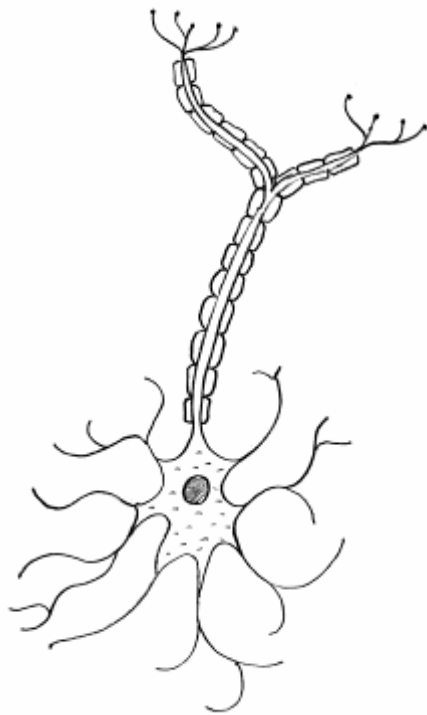
Illustration 1.5 The Brain. View of the human brain, which looks like two scooped handfuls of cocktail sausages and has the consistency of a cold boiled egg.

the serious mental disorders which undoubtedly require medical/physical intervention, also call for psychotherapeutic intervention. For example, when a patient becomes aware that he or she has schizophrenia, this bad news frequently leads to clinical depression. Support and psychotherapy is the best treatment of this reaction, thus the psychiatrist needs to possess these skills.

The above statement is relevant in general adult psychiatry, which is the main focus of this book, and many other types of psychiatric practice. Psychiatry may be practiced in the public and private arenas. Some psychiatrists choose to work exclusively in one, others have a foot in both. The proportions depend on national sociopolitical arrangements. In the USA where medicine is largely privatized, most psychiatrists work most of the time in private practice, and the opposite is the case in the UK, where medicine has been nationalized. In Canada and Australia the proportions are more equal. Public psychiatry means psychiatry conducted in public hospitals, clinics or other places, such as jails. Universities and research organizations employ a small number of psychiatrists. Psychiatrists may work in general adult psychiatry, or sub-specialty areas such as child psychiatry, geriatric psychiatry, liaison psychiatry [where assistance is provided to people who have other concurrent medical problems], forensic psychiatry [where legal and compensation matters are considered], rehabilitation psychiatry [where the focus is on helping people who have been disabled by severe psychiatric disorders to achieve the best possible level of function], research or teaching. It is possible to specialize to an even greater degree, some psychiatrists being concerned exclusively with victims of psychological trauma, psychotherapy or chronic pain.

It is not necessary, for present purposes to delve deeply into the structure of the brain, a 1.4 kilo white/cream/grey structure which looks like two scooped handfuls of cocktail sausages and has with the consistency of a cold boiled egg (Illustration 1.5). It is sufficient to accept that this is a complicated, miraculous organ. The brain is enclosed in the hard bone case called the skull, and wrapped in three special layers of soft tissue. It floats in a fluid, called the cerebrospinal fluid [CSF]. It is not in immediate contact with the blood, being shielded as is no other organ, by a special arrangement of cells in the walls of the blood vessels, which is called the blood brain barrier. This extraordinary level of protection indicates the importance of this organ to the organism. It is also a major reason why mental illness has been so difficult to study. It has been extremely difficult to “get a handle” on the electrical and chemical processes of the normal and pathological brain.

It is necessary, however, to know a couple of facts about the neurons, the special cells, which compose the brain (Illustration 1.6). Each brain is composed of about 25 billion of them. Each neuron has about 1000



A neuron

Illustration 1.6 Each brain is composed of about 25 billion neurons, or nerve cells. Each has about 1000 connections. Thus, there are as many connections in the human brain as there were leaves in the Amazon jungle.

The illustration shows the body of a neuron with from which extends a thin structure called the axon. The axon may be very long, extending, for example from the spine to the foot. In the middle of the body is the dark region called the nucleus. The nucleus influences the health and activities of the cell. It contains the genetic material. Around the body are shown fine extensions which are called dendrites and at the far end of the axon there are other fine axon terminals which make contact with the dendrites or cell bodies of other neurons at connections called synapses. Around the axon are bead like myelin sheaths which assist in insulating the axon and speeding the transmission of messages. There are many different types of neurons – this illustration demonstrates the basic structure of one of the more common types.

connections, which are called synapses, to other neurons. Thus, in any human brain there are about as many synapses as there were leaves in the Amazon jungle.

Every organ of the body is composed of cells that are specially designed to perform specific tasks. Neurons are designed to receive and transmit electrical impulses (signals). They are so fine that they can only be seen with a microscope, but like electrical wires, they may be very long. The longest neurons in the body are outside the brain and pass, unbroken, from the spinal cord down the leg to the foot. In the middle of synapses there is a tiny gap, a space between the membrane at the end of the first neuron and the membrane at the start of the second neuron. The impulse in the first neuron cannot pass to the second neuron by electrical means, as it would on a switchboard. Instead, when the electrical impulses reach the first membrane in a synapse, they cause the release of a chemical from that membrane. This chemical, or “neurotransmitter”, passes across the “synaptic cleft” and attaches to a specially designed “receptor” on the membrane of the second neuron. The correct fit of a neurotransmitter onto a receptor causes an electrical impulse to be initiated and pass along the second neuron. Thus the signal passes first by electrical means, then by chemical means and then by electrical means, again. This process of alternating electrical and chemical transmission may continue indefinitely in particular circuits.

It is believed that many mental disorders are the result of abnormalities at synapses, in particular, too little or too much release of neurotransmitter. It is at the synapse that most psychiatric drugs operate. For example, some increase the availability of neurotransmitters, while others block the receptors so that impulses cannot be triggered. Thus, the couple of facts to know about neurons is that many are long and thin and resemble electrical wires, and that at synapses, the signals are transmitted by chemical means, which creates an opportunity for medicinal drug intervention.

The next wave of drug intervention may include hormones and other agents which will more directly influence the working of the neurons. But these are unlikely to be available in clinical practice for at least a decade.

The next wave of non-drug intervention in the care of those with mental disorders will have to address the housing and clinical services to people living in the community. The closing of the psychiatric institutions has caused many problems. These are discussed in Chapter 6, which deals with schizophrenia, and Chapter 10 which deals with “care” in the community. Expert psychiatrists from England, Continental Europe,

USA and Australia have claimed that deinstitutionalisation [the movement of people out of mental hospitals into the community] has failed. Professor Allan Fels, Chairman of the Australian Competition and Consumer Commission, who has a daughter with schizophrenia, is also of this opinion. He pointed out [2003] that deinstitutionalisation has “not been matched by the level of services required” [Yallop, 2003]. The state of New South Wales (Australia) has a population of six million and was well supplied with mental health beds before deinstitutionalisation began. It is now 1500 beds short. “I think I’ve been cheated” said a deinstitutionalised woman on the radio [ABC, 2004].

Psychiatric or mental disorder is a huge, mysterious, frightening agenda, a major challenge to contemporary science, government and humanity. There is uneven understanding, some aspects of some disorders being known with certainty, but with no disorder has been completely explained. Depending on the diagnostic criteria employed, up to 25% of western populations may be classified as having a mental disorder. The suffering of individuals and their families may be immense. In an age when hundreds of millions of dollars are spent on interplanetary projects, which even if they worked, would yield no information of immediate value to the community, the pittance spent on research and the treatment of madness is a disgrace.

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CHAPTER 2

CLASSIFYING MENTAL DISORDERS

This is not a textbook, but we do need to look briefly at the classification of the mental disorders. The purpose of classification, the putting of apparently related material into boxes or categories, is to simplify and to help us understand large amounts of complicated information.

The current method of classifying mental disorders is frustrating because it depends largely on words. Words will be less important when psychiatry has objective tests. At the moment, the only data the psychiatrist has is the appearance and behaviour of the patient and the words he or she uses to describe thoughts, feelings and other experiences. We have to package these in the best way possible, so that we can communicate with each other as clearly as possible.

All the available words have a history and they are understood a little differently by all of us, because of our different backgrounds and education.

To make matters worse, there may be no words to describe certain psychotic experiences. For example, what is the word for a symptom which is half way between an hallucination and a delusion? What makes me think there is such an experience? It's just an impression I gained over the years. But, instead of trying to prove the existence of such an experience and then coining a term, I am content to wait for the invention of a big brain assessment machine which will give us "readings". (I dream of psychotograms, hallucinoratis and insightolevels.)

MADNESS

In attempting to classify mental disorders, let us first look at the old term, madness, one of Shakespeare's favourite words (Illustration 2.1). The English Dictionary offers three meanings for the word madness. They are all in current use and this is the cause of some misunderstandings. One meaning is senseless folly and imprudence – as when the two young, unsuited, incompatible people have a wild love affair. A recent newspaper headline: "US Mad About Harry Potter".

Another meaning has to do with anger, as when the fathers of the young people mentioned above discover the affair, splutter, cancel credit cards and talk of redrafting wills etc (Illustration 2.2). A bumper sticker that used the term to indicate angry read, "Cigarette companies – the truth will make you mad!"

GUILDENSTERN: *'Ob, he is surely mad!'*

OPHELIA: *'Well, there again*

Opinions differ, some men hold

That he's the sanest of all same men,

Some that he's really sane but shamming mad.

Some that he will be mad, some that he was –

Some that he couldn't be. But on the whole

(As far as I can make out what they mean)

The favorite theory's something like this;

Hamlet is idiotically sane,

With lucid intervals of lunacy.'

Illustration 2.1 Shakespeare's Hamlet, four hundred years after being described, continues to be a character of great interest and debate. Whether he was truly mad or simply feigning madness is considered an important question. The above extract from Gilbert's *Rosencrantz and Guildenstern* comically summarizes the debate. However, without a clear definition of the word, then or now, how could there be debate?

Incidentally, feigning psychosis is rare, but when it does occur, it is usually easily detected.

The third meaning, the one we are concerned with here, has to do with mental disorder or insanity (Illustration 2.3). It has already been stated that the term mental disorder is unsatisfactorily defined as psychological syndromes associated with distress or disability. The English dictionary defines insanity with the words senselessness and madness, so we again encounter circularity and a lack of clarity.

Turning to technical sources, the term madness has not been used in medical books for over a hundred years. Further back, at different times, it was used interchangeably with the words, delusion, delirium and mania. These currently have separate and distinct meanings, but madness does not. Thus, this word no longer has precise meaning in either common English or technical lexicons.

For mental health professionals, madness is a slang (picturesque, unconventional) word, roughly inter-



Illustration 2.2. Crown Prince Dipendra. Headlines in newspapers and magazines around the world, dubbed Crown Prince Dipendra of Nepal, "The Mad Crown Prince". He is shown here holding an assault weapon of the type he used to kill his mother, father, seven other royal relatives and himself. He wanted to marry a woman who was unacceptable to his parents. He was caught between two cultures and addicted to alcohol and illegal drugs. He had previously reported depression and had taken some anti-depressant medication. He could have been called mad by a number of meanings of the word. His murder-suicide was senseless and imprudent, it almost certainly involved great anger and he may well have been mad due to the effects of illegal drugs.

While there is some evidence that he Crown Prince Dipendra had suffered depression in the past, there is no evidence that he was still depressed at the time of the murder-suicide, or that he had ever suffered a psychotic disorder.

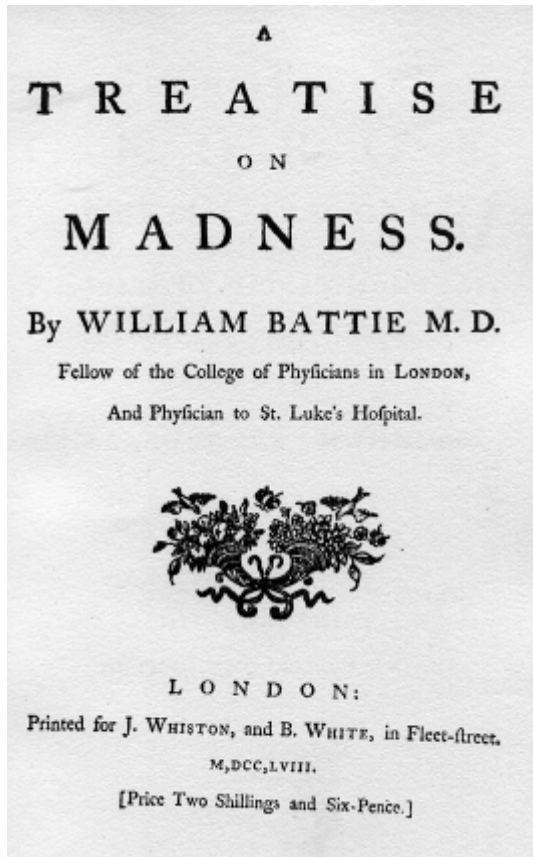


Illustration 2.3 Treatise on Madness, By William Battie M.D. This is the title page of a treatise on madness published in 1758. Note that the author is a Dr Battie. Is it coincidence that people with mental illness are still sometimes referred to as “battie”? It is generally believed that the term comes from the saying, “Bats in the Belfry”, referring to having something amiss in the top story or head. Maybe so, but having an early monograph on the topic of madness written by a Dr Battie may well have contributed to the popular acceptance of this euphemism.

changeable with the term psychotic.

PSYCHOTIC DISORDERS

Psychotic, as an adjective, can be applied to both symptoms and disorders.

A symptom is a feature of a disorder, such as abdominal pain is a symptom or feature of appendicitis. Symptoms do not belong exclusively to any one disorder, so abdominal pain is a symptom of gall bladder disease, tubal pregnancy and many other disorders in addition to appendicitis. A disorder is a particular collection of symptoms. For example, in addition to abdominal pain, appendicitis is often associated with bad breath and diarrhoea, and tubal pregnancy is often associated with a missed period and some vaginal bleeding.

Psychotic symptoms indicate a “loss of contact with reality”, for example, when the individual believes something which has no basis in reality (delusions) (Illustration 2.4) or hears a voice when no one has spoken (hallucinations) (Illustration 2.5).

Individuals are only referred to as being “psychotic” when they have a psychotic disorder.

Psychotic disorders are those in which there are psychotic symptoms plus gross impairment of the capacity to function in everyday life. It is possible to have a psychotic symptom, but not to have a greatly reduced capacity to function in everyday life, thus, it is possible to have a psychotic symptom without having an active psychotic disorder. For example, some healthy people regularly hear their name called just as they are falling to sleep. These are called hypnogogic hallucinations. There is no doubt, these people do hallucinate, they hear their name called when it was not called, but in the absence of additional symptoms, clearly, they are not suffering a psychotic disorder.



Illustration 2.4 This was written by a young Christian man who developed schizophrenia and began to believe that Satan had taken control in heaven. He had not decided to change his religion, that is, he had not become a devil worshiper, and he was distressed by his new belief. Given this man's personal history and cultural group, this belief was a delusion.

There is also the suggestion of thought slippage. This man had despised Satan, and it is unlikely that he would wish to apply the words "but beautiful" to that subject. It is probable that when he thought of heaven, he thought about the attributes of God, and stayed on that line of thinking while writing about Satan.

Consider a person who has suffered an acute psychotic disorder, who with treatment has returned to work and normal life, but who still hears a voice a few of times a day. This person may have full insight, meaning that he or she knows that the voice he or she is hearing is, in fact, an hallucination. Such an individual experiences occasional psychotic symptoms, but their psychotic disorder is in remission and he or she would not be described as being psychotic.

Consider a person with anorexia nervosa who purposefully restricts food intake and exercises because of a fear of being fat, who is emaciated to a dangerous degree, who nevertheless believes she or he is overweight. By strict criteria, this person has a delusion. Further, when such patients see themselves in a mirror, they frequently "see" themselves as fat, a phenomenon which suggests mistakes of perception. Although the condition is often disabling, some people with anorexia nervosa are able to perform rewarding work and maintain stable relationships. In spite of the "delusions" and mistakes of perception, these patients are also not, even when there is reduced ability to conduct a normal social and working life, described as being psychotic.

At this point the reader is excused if feelings of exasperation and irritability have permeated a normally sanguine disposition. The complexity and imperfection of the terminology of this branch of medicine would send anyone crazy (please, let's not get into defining crazy, instead, let's just move on).

Let's give pragmatism a chance, let's try to name the psychotic conditions. Schizophrenia is a term which commonly appears in the lay media. It is the archetypal psychosis. It should not be confused with the doubtful condition of "split personality" in which two or more "personalities" are supposed to inhabit the same body. The symptoms which occur in schizophrenia include hallucinations, delusions, reduced ability to think due to excessive thought slippage, behavioural signs such as the holding of unproductive postures, the loss of emotions and spontaneity, social withdrawal, and personal neglect. During acute episodes the hallucinations, delusions and thought slippage are the most prominent symptoms. With treatment or natural remission these symptoms are less prominent and the loss of spontaneity, social withdrawal and personal neglect, which are overshadowed during acute episodes, again become more noticeable. Even in better outcome cases, this is a painful and distressing disorder.

Delusional disorder is a psychotic disorder in which the only symptom is one or more delusions. Usually the delusion is paranoid in type, and the patient believes he or she is being watched and is in danger from spies, organised crime or aliens. The patient may be able to work and may appear normal to others. As there is only one symptom and the patient appears to function reasonably well outside the home, some may question whether this is truly psychotic disorder. However, in most instances the life is severely damaged by this disorder. Suspiciousness or frank delusions result in conflict at work and the patient is usually finally placed on some form of pension. The social life is also severely damaged, the patient eventually withdrawing to live behind reinforced doors with an array of locks, in a state of constant fear and apprehension.

Dr Pridmore
The voices are real bad +
it's worse than being tortured
+ I wish I was dead. I can't
control them. Would you give me
another chance to give up
make-believing and having sex
with the visions I can feel
in my pillows. Could you have a
talk to Dr Self + fill him in.
They took me off my medication
even Cogentin altogether. I
feel lousy + helpless, weak and
lazy. Do I need shock treatment
if so could you tell Dr Self and
could you tell Dr Self everything
I told you

Dr Pridmore

*The voices are real bad +
it's worse than being dead or being
tortured + I wish I was dead. I can't
control them. Would you give me another
chance to give up make believing
+ having sex with the visions I can feel
in my pillow/s. Could you have a talk
to Dr Self + fill him in. They took
me off my medication even Cogentin
altogether. I feel lousy + helpless, weak +
lazy. Do I need shock treatment if
so could you tell Dr Self + could you
tell Dr Self everything I told you.*

From

Signature

Illustration 2.5 This letter was written by a man with schizophrenia. He had once been a patient of, but had not been seen by the author, for more than a year. During most of that year he had been in a psychiatric hospital and was under the care of Dr Jeff Self. The patient writes that his hallucinations (voices) are worse than being dead or tortured.

He also had long experienced visual hallucinations of attractive women. He writes about having sex with his visions which he can "feel" in his pillows. It is very difficult to classify the information that he is having sex with his visions. If it is not possible to have sex with visions, then this is a false belief and could be classified as a delusion.

But, was the vision of the patient having sex with the attractive women who appeared in his earlier visions? He has not given enough details of his experience for us to make firm conclusions.

He has some difficulty with logical thought so he might not have been able to describe things better, even if he had been asked. This case may support a comment in the text, that there are phenomena which fit somewhere between hallucinations and delusions.

There is evidence here of great suffering.

There might be a question about whether Hamlet was feigning a mental disorder, but there is not here.

Bipolar disorder is also called manic-depressive psychosis. This disorder is characterised by mood elevated (manic) phases and mood depressed phases. These phases may last for months or even become chronic (constant). For a given patient, swings may predominantly occur in one direction, alternatively, about equal numbers of swings may occur in each direction. In the mood elevated phase the patient is often over confident, grandiose and disinhibited, with rapid thoughts, reduced need for sleep and abundant energy.

In depressed phases the mood and energy are low, and the ability to concentrate is reduced. Sleep is disrupted, the patient often waking in the early hours and unable to return to sleep. There is loss of interest in food, sexual or any other activity, and weight loss is a frequent feature.

Episodes in either direction may fail to satisfy the criteria for psychosis, thus the term manic-depressive psychosis is gradually being superseded. The patient in a manic phase is clearly acting out of character. There are rarely fully formed delusions or hallucinations, and strictly speaking, the term psychosis should be reserved for when such symptoms are present. Nevertheless, problems frequently arise as patients en-

engage in risky behaviour such as unwise investments, fast driving, sexual liaisons or audacious activities which have mood elevation as a springboard.

The patient in a depressive phase may also act out of character, becoming inactive and withdrawn. Delusions of guilt are not common. However, frequently, the patient thinks of death and regrettably, suicide is not uncommon.

Psychosis may be induced by drugs, particularly LSD and amphetamines, as well as some prescribed medications, and other medical conditions such as brain tumour and degenerative diseases. The degenerative diseases include dementing conditions, such as Alzheimer's disease, in which the most prominent difficulty is usually with memory and disorientation, rather than psychosis.

FURTHER CATEGORIES

By now you would probably agree that it is hard to arrange mental disorders in neat sets or bunches. Recently, the decision makers began classifying mental disorders into "serious" and "mild". As mentioned, bipolar disorder does not easily fit under the heading of psychosis, however it did seem to fit, along with schizophrenia and delusional disorders, under the heading of serious. The problem was that disorders other than the psychotic disorders, those which at first glance appeared rather mild, like agoraphobia (reluctance to leave the home), can dominate and ruin your life, which is pretty serious. Thus, the serious/mild classification division has not advanced the field very much.

Mental disorders is not the only field which lacks discrete and mutually exclusive categories. Literature has, "fiction", "non-fiction", "poetry" and "theatre, and some works are famously difficult to categorise. The categories "fiction" and "non-fiction" would suggest that every work could be accommodated in one or the other. But life is not that simple and there is need for at least one more category.

The mental disorders have been categorized as "psychotic", "non-psychotic" and one other category in which psychosis is not a feature, "personality disorder".

NON-PSYCHOTIC DISORDERS

The non-psychotic disorders are what Freud referred to as the "neuroses". This is a mixed bag of conditions. The symptoms of the non-psychotic disorders are not as unknown to healthy individuals, as are the voices heard by patients with schizophrenia. Instead, the main symptom is usually distressing anxiety, which is similar to worry and fear, which in a mild form is familiar to everyone who has taken an exam or been out on a date. General anxiety disorder is characterised by continuous, unprovoked anxiety (Illustration 2.6). In panic disorder there are sudden attacks of extreme anxiety during which the patient may struggle to get enough air, feel the heart thumping as if to burst, and fear that he or she may collapse or die. In the phobias, anxiety is experienced which is way out of proportion to the danger of a particular situation. In agoraphobia anxiety is triggered by the thought of leaving the home, and panic attacks may occur if the home is left. In specific phobias there is great anxiety at the thought of meeting a feared, specific agent or circumstance (spiders or lifts, for example), and life may be disrupted by the steps taken to avoid those agents or circumstances.

Dear Dad

I Love you heaps

Be very very careful
at work and always
keep an eye out
for dangerous things

Love Billy

I don't want to
lose you I Love
you and mum

More than anything
in the world

xxxxxx love
Billy

Illustration 2.6 This note was written by a pubescent boy to his father. The boy was refusing to go to school. This was damaging his education and consequently, his future prospects. As is often the case, his school refusal was because of high levels of anxiety.

The boy was anxious not for his own safety, but for that of his parents. His concern for his father is clearly stated in the note. School refusal is often not because the pupil is afraid of school, but because he or she is afraid something may happen to his or her parents while he or she is away at school. In such circumstances, the term "separation anxiety" may be applied.

Obsessive-compulsive disorder is a curious condition. Obsessions are repetitive thoughts which make no sense. Patients accept that these are their own thoughts, but they are unable to stop them. For example, the patient may have the irrational and unwelcome thought that his or her hands are contaminated by dirt or germs, alternatively, the patient may be dogged by the irrational thought that he or she "killed God". The patient is distressed by the loss of control and by the silliness of his or her thought. Compulsions are repetitive actions or urges in which the patient engages. Sometimes the compulsions relate to obsessions, as when the thought is that the hands are dirty and so the hands must be washed. But the compulsion may be that the hands must be washed 10 times, when washing once would be enough. In other cases, compulsions may have no relationship with obsessions, as for example when the patient feels anxious or uncomfortable until something is performed "correctly" and that may be that when walking into an unlit room, night or day, the light switch must be flicked a certain number of times.

The movie, "A Good As It Gets", portrays a man with obsessive-compulsive disorder. He walks down the street in an odd manner, swerving from side to side. He is trying to avoid two things which worry most of us very little: touching people and stepping on cracks in the pavement. These are common concerns of people with obsessive-compulsive disorder. The wish to avoid touching people is often related to fear of contamination, which leads to excessive washing behaviour - which is also depicted in the film. The desire to avoid stepping on cracks is a piece of behaviour for which seems to lack logical explanation. When asked to explain, these sufferers say simply that they feel distressed when they do, and better when they don't. Interestingly, the desire to avoid stepping on cracks is quite common in children, as are some other features of this disorder. This childhood disposition led to the rhythmical "song" which some children say as they walk along the footpath, "Step on a crack and break you mother's back".

Also in "As Good As It Gets" the main character takes his own plastic cutlery, in a plastic bag, to a restaurant where he regularly eats, and locks and unlocks the door to his apartment each time he leaves or returns. The plastic cutlery would be related to fears of contamination. The elaborate locking and unlocking procedure would lack a logical explanation, but it would be related to safety issues. The patient would be aware that his actions are illogical, and would probably feel embarrassed by admitting to them, but would state that he is more anxious if he doesn't and less anxious when he does follow his routine. The anxiety which such patients experience may be overpowering and compliance with the behaviour which they know to be illogical may be irresistible. Thus, patients are secretive about this condition, and it is probably more common than we think.

Post traumatic stress disorder (PTSD) is an anxiety disorder which follows exposure to a traumatic event, particularly protracted traumatic events such as sustained involvement in war, but sometimes following briefer, severe stress, such as rape. The main symptoms include intrusive recollections of (re-experiencing) the event, the avoidance of reminders of the event, distressing dreams, numbing of emotions, persistent arousal and irritability.

The eating disorders are also categorised among the “other disorders” because they fit nowhere else better. This is a curious group of conditions, the best known being anorexia nervosa and bulimia nervosa. In anorexia nervosa there is purposeful weight loss through restriction of eating, excessive exercise and sometimes purging and vomiting. In spite of emaciation and threat to life there may be the conviction of being fat, which cannot be dispelled by the use of scales, mirrors or photographs. In bulimia nervosa there are episodes of binge eating and compensatory behaviour to prevent weight gain, such as purging and vomiting. The aetiology of these conditions is unknown, but cultural and social factors are believed to be important.

Various other disorders may be placed under this heading, including adjustment disorders and somatoform disorders. The adjustment disorders are states of distress which are triggered by strong stressors such as sudden loss due to fire or betrayal. The somatoform disorders are conditions in which there are physical symptoms, such as pain, inability to walk or conviction one has a disease, in the absence of organic findings.

PERSONALITY DISORDERS

Personality has been defined as the predictable response of the individual to other people and the world in general. If we know people well, we know what they will like and dislike, how far we can rely on them in tough times, whether they spend or save their money, in short, we know their personality.

Personality may be described in terms of the scores obtained on a number of different measures or dimensions. As many as 500 aspects or dimensions of personality have been suggested. Examples of personality dimensions include interpersonal warmth, honesty, sense of humour, confidence, impulsivity, curiosity and determination. If each of us could be measured on a range of dimensions, each of us would have a unique personality “fingerprint”.

Exciting research by Professor Robert Cloninger of Washington University Medical School has identified a seven-factor model of personality. He separates personality into two parts, which he calls temperament and character. He describes temperament as influencing automatic responses, and as being composed of four dimensions: 1) novelty seeking, 2) harm avoidance, 3) reward dependence, and 4) persistence. He describes character as influencing personal and social effectiveness, and as being composed of three dimensions, 1) self-directedness - the ability to act autonomously and take responsibility for action, 2) cooperativeness – including social tolerance and compassion, and 3) self-transcendence – which involves spirituality in a broad sense, the person is aware of being part of the cosmos, nature or similar.

The personality is the individual’s characteristic way of responding. Personality disorder is present when personality features cause subjective distress to the individual or significant impairment in social or occupational function. Impairment in social or occupational function involves others, thus it can be said that personality disorder causes distress to the individual or those associated with the individual.

Professor Cloninger points out features of temperament have a powerful influence on personality, but do not determine personality disorder. For example, consider two individuals who are low in harm avoidance, such people are inclined to take risks. Sure, car thieves and intravenous drug users take risks, but so do racing car drivers and helicopter rescue crews. While the first two activities suggest personality disorder, the latter two do not. Cloninger believes that the character dimensions of self-directedness and cooperativeness hold the key to personality disorder. It can be convincingly argued that if individuals lack a self-

directedness and cooperativeness both they and the people with whom they interact will experience distress.

It is important not to automatically label all those people who are different or eccentric, or with whom we don't get along, as personality disordered. Unless the eccentric is distressed or, through interactions, causes others to be distressed, personality disorder should not even be considered. The fact that we can't get along with someone means little. If the individual can get along with almost no one, this is suggestive of disorder. Personality is a subtle diagnostic matter, and should not be attempted without appropriate training.

There are three groups of personality disorders. There is an odd and eccentric group in which a prominent feature is the absence of close relationships. There is an anxious and fearful group in which a prominent feature is self doubt. Finally, there is a dramatic, emotional and erratic group in which prominent features are stormy relationships and sudden excessive anger.

Two particularly difficult personality disorders are found in the last group. The first, borderline personality disorder is characterized by stormy relationships and sudden shifts in mood. An additional feature is the cutting of the body as a means of reducing stress and episodes of intense anger. The second, antisocial personality disorder is marked by disregard for and the violation of the rights of others and usually features lying, aggressiveness and law breaking. A forensic history is common. This latter disorder is generally considered to be unresponsive to treatment, or, "untreatable".

A 30 year old man was interviewed in goal. This was his second goal sentence, but he had been before the court many times for drug or alcohol related behaviour, including illegal drug use and minor trafficking, some drunk and disorderly behaviour, and shoplifting. He was handsome and intelligent. He had received a large amount of counseling, support and second chances from a range of professional carers. He was asked by the author, "Mr. Pohl, you keep getting into trouble with the Police, and other people. Does the problem lie with you, or the other people in society?"

"Oh, definitely, with me," he replied. "I keep expecting other people will give me a fair go."

This answer strongly suggests personality disorder. This man did not accept that responsibility lay with him, instead, he saw it lying with the people with whom he came in contact. Others do, of course, have shortcomings, but when an individual has frequent interpersonal difficulties, that individual needs to closely examine his or her contribution to events.

This man indicated that others had not been given a "fair go". In fact, he had been given every possible opportunity to improve his life. His failure to acknowledge the efforts of others on his behalf is an example of the lack of gratitude and complaining behaviour which makes people with personality disorder unpopular with others, including many professional carers.

At the beginning of Mr. Pohl's response, you can hear what is probably the effect of past counseling. That is, he started by indicating that he accepted responsibility, but that was almost certainly what he had heard from counselors and knew was the "correct" answer. However, he had not incorporated these elements into his concept of himself, and he indicated that his shortcoming was his unquenchable faith in fairness of others.

CLOSING COMMENT

When you have large group of butterflies, motor car parts or mental disorders, it helps to simplify the field if you can put things in boxes or categories. This is more difficult with mental disorders than with butterflies, but even with butterflies there are different systems you could use, such as wing span, colour, habitat, length of legs or those feeler things that stick out of their heads.

At the moment, mental disorders can only be classified using our observations of the patients appearance and behaviour, and what they tell us they are thinking, feeling and experiencing. In the very near future,

we should be able to use sophisticated medical diagnostic machines. The electroencephalogram (EEG) which was developed over a century ago and measures the electrical activity of the brain, has been quite helpful in the management of epilepsy, but it has not been useful in psychiatric practice. Coaxial tomography (CAT) and magnetic resonance imaging (MRI) are late twentieth century discoveries which give us beautiful pictures of the brain. They pick up abnormalities such as blood clots and tumours. When images from large groups of patients with certain psychiatric disorders are added together, subtle changes can be statistically demonstrated, but these statistical findings are of little use in individual cases. Thus, we wait, impatiently, for the next generation of diagnostic technology.

However, psychiatry is about being a human being. About mood, desire, thinking, hearing, seeing, priorities, ambition and judgement. Like the stealth bombers, new medical technology will be able to do much more than current technology. But there will probably always be a place for hand to hand combat and face to face psychiatric assessments.

The classification system described above is about the best we can do at the moment. The psychotic disorders are marked by “breaks with reality” that is, symptoms such as hallucinations and delusions. But some conditions such as bipolar disorder have very few such symptoms, while normal people may experience occasional psychotic symptoms. This category is not watertight.

The non-psychotic disorders are also an odd mix of conditions. Anxiety is a common theme but generalized anxiety in which there is a fairly constant level of anxiety is very different from PTSD, in which triggers may set off the reliving of past traumatic experiences. In obsessive-compulsive disorder anxiety may flow as a consequence of unwanted thoughts and may be reduced by the performance of apparently unrelated acts. The discrete group of eating disorders seems to be placed here for the “Goon” reason. The “Goon Show” was a British radio comedy of the 1950s. In one episode a “Goon” turned up at the door of another, and when asked why he was there he replied, “Everybody’s got to be somewhere”.

Finally, there are the personality disorders. Here, personality features cause subjective distress to the individual or to those associated with the individual. Central features are low levels personal and social effectiveness due to the failure to act autonomously and take responsibility for actions, and impaired social tolerance and compassion.

So, there you have the broad map of the territory of clinical psychiatry. The psychiatrist wends his or her way through uncertain terrain, doing good whenever possible, with tools of modest potency: psychotherapy, information/education, medication and ECT. The psychiatrist also has non-clinical duties, but clinical work is the public face of the profession. In subsequent chapters some of the above terrain will be explored in greater detail.

CHAPTER 3

DELUSIONS

Delusions are false beliefs that are sustained despite evidence to the contrary. They are out of keeping with the patient's social, cultural and educational background. Supporters may be convinced that their football team is better than any other, in spite of arguments to the contrary by the supporters of other teams, and healthy scientists may be slow to accept the results of studies which disprove their pet theory. The term delusion is reserved for use in cases where fixed beliefs are symptoms of mental disorders.

There are many ways of classifying delusions. No particular delusion is limited to one particular type of mental disorder, any delusion can arise from any psychotic disorder, but some are more often associated with particular disorders. A selection of delusions will be mentioned to give a feeling for the field. Bizarre delusions are absurd and factually not possible (Illustration 3.1). The subject matter may involve supernatural or space creatures. Grandiose delusions are beliefs that the individual has exceptional beauty, intelligence or influence. Persecutory delusions are usually beliefs that the individual is being harassed, watched or bugged. They often involve spies, bikies, God, Satan or neighbors (Illustration 3.2). Delusions of reference are the belief that the actions of others are premeditated and make special reference to the patient. Very commonly patients complain, "They're talking about me on television". Here, statements or words heard on television are believed to have been said to identify or annoy the patient. People crossing the street or coughing may be interpreted as premeditated actions, performed to indicate something to or about the patient. Delusions of control involve the belief that others are controlling the patients thoughts, feelings or actions. Nihilistic delusions are the belief that part of the individual, the entire individual or other parts of the world do not exist or are dead. The financially comfortable individual may believe he or she is destitute, despite bank statements to the contrary. Patients who believe they are dead, are unable to explain the contrary evidence, but this does not shake their conviction. Nihilistic delusions can occur with a range of psychotic disorders, but perhaps not surprisingly, they are far more common with psychotic depression. Somatic delusions are false beliefs about the body, which may be bizarre or non-bizarre. An example of the latter is the person who believes he or she has cancer of the rectum, in spite of negative tests and a competent doctor who has sighted the rectum giving reassurance. Delusion of guilt is the belief that the individual is guilty of purposeful or non-purposeful actions which has damaged the individual, some other individual or important property. These are more common in psychotic depression. Delusion of jealousy is the belief that the partner is being unfaithful. It may involve checking the partner's underclothes for stains or foreign pubic hairs, and is often a feature of chronic alcohol abuse. Erotomanic delusions are the belief that another person is in love with the patient. This may result in stalking or attempts to contact the other person. This delusion is frequently a feature of delusional disorder. Systematized delusions are united by a single theme, and are detailed and unchanging. Non-systematized delusions may change almost from minute to minute.

Chain Letter
Time For True Colours

PUBLIC NOTICE

By Order of the King

Please note: If I was crazy I would have been locked up by now

WARNING: YOU ARE GOING TO LIVE FOREVER (Z provides absolute proof)

There is a hell of a lot to the saga but some of the more interesting points of the WAR so far include my entire body verging on combustion, my brain being physically altered to the point where it is in tune with the entire universe (but it's still me) including God, Satan and all living things, and flying fully conscious in the flesh (100% link).

Be Aware: You are all in the hands of the Gods. Magic is compulsory. Have a magic day.

'Tis a fantastic tale vouched for by the fact that Bad Bill and his army of darkness are too scared to touch or even talk to me when I've told the whole world that they've done and where they're going is no fun but my hands are clean. The entire planet is coated with agents of Satan, they hate me just because I've told them the truth. Hotspur himself still tries it on occasionally but he knows he's lost. (God and Tom incorporated)...

14.

After about six months off the injections the belief that some tragedy was imminent and pressure from other people had overtaken me. I was worried. I believed Ellen and Kerry had been backbiting. This hurt me. I went to Ellen's youth group where the Minister, Rev. Anonymous, politely called me Peter (the Apostle) and said that I belonged in prison.

Illustration 3.2 This is a passage from a biography written by a man who subsequently drowned himself in a river.

The injections referred to are injections of depot antipsychotic medication. These can be given once a month, and they help prevent relapse, in psychotic disorders. After this man had ceased his injections for six months and his body was completely free of antipsychotic medication, he began to misinterpret the environment in a persecutory manner. He believed his friends had been "backbiting" and that a church leader (whose name has been covered) said that he should be in jail.

This man's name was not Peter, but another biblical name. It is reasonable to conclude that the clergyman used the name Peter by mistake and the patient failed to see the mistake, concluding instead, that this misuse was purposeful. Another possibility is that the patient had begun to hallucinate.

Illustration 3.1 The above "public notice" was part of a one page document widely distributed, throughout a city, by its writer. The full document is not presented because the second half made accusations against named people. The writer believed the owners of a coffee lounge were persecuting him. One night he burned the business down. He was jailed and died within days by suicide in prison.

The most prominent pathological feature is the bizarre and paranoid delusional content.

CASE DRAMATIZATION

John Miller was 31 years of age and lived with his wife Helen and their five-year-old daughter, Julia, in a white limestone brick house in the Adelaide foothills. John was a clerk at the Taxation Department in the city center and Helen worked part time as a hairdresser, near their home.

John's father, now deceased, had been a motor mechanic and his mother was a registered nurse, who still worked in a nursing home. John had one sibling, Kevin, who was one year younger. They were always close companions. They kicked the football in the street every night, until it was too dark to see. At school they had good friends and had good relationships with their teachers, except that kicking the football left little time for homework.

Halfway through high school, John, who was already nearly six-foot tall, joined the Glenelg Surf Lifesaving Club and Kevin, who was clever with electrical gadgets started building model airplanes and yachts.

Helen had always played excellent tennis. Her parents owned a take-away food shop and she left school to take up an apprenticeship in hairdressing.

John met Helen at the beach when he was "on duty" for the Surf Club. He was nineteen and she was seventeen years of age. He was in the first year of an Arts degree and she was halfway through her apprenticeship. John was not enthusiastic about his studies and left before the end of year exams, opting for a clerical job which would leave his evenings and weekends free of work commitments.

The couple spent time together at the beach and on the tennis court. They lived together for periods of months on two occasions before they married, an event precipitated when Helen became pregnant with Julia. They had one brief separation, but that was a past and forgotten event. Julia was not planned, but the couple was not taking preventive measures. They were pleased when marriage became "necessary".

John achieved some promotion at work, but his prospects were limited by his lack of tertiary education. He was a fitness trainer at the local amateur football club; he kept himself fit and was an instructor in Surf Club. Julia, born by caesarian section, was a healthy, clever, blonde child. Helen had returned to work half time when breast-feeding finished and planned to return to full-time work when the girl was well established at school.

The living grandparents were healthy, except that John's mother was worried about her heart, perhaps because her husband had died from a sudden heart attack.

John traveled to work each day by train. Conveniently, the Taxation Department was close to an inner-city railway station. He had accepted that staff with greater ambition would gain more promotion. He shared an office with a married woman, Penny Hicks, who was a few years and one public-service level senior to him. He had a good knowledge of his area of work; he had learned what he needed to know about computers and felt secure in his position.

One day Penny came back after lunch and found that John had moved his desk. Their desks had been against opposite walls. He had moved his, so that it was now on the wall adjacent to hers. This wasn't really a problem for her, but it wasn't a good use of the space, they were now both cramped up in one half, while the other half of the room was relatively empty.

While this rearrangement didn't particularly annoy or distress Penny – it did happen without any discussion. But then, she had no authority or responsibility for the positioning of fellow workers' desks. When she asked John about it, he was evasive and said that it was "for the best".

Difficulties associated with the change emerged. They now had to share one pair of power points, while the power points on John's vacated wall stood unused. Next day, to bring electricity to his computer and printer, John produced long extension cords which tangled around under Penny's desk and then his own.

Penny thought this was an unsightly and unnecessary mess, but again, she said nothing. She had recently found John to be tense and serious. She soon found him to be quick to take offence and prepared to argue over minor details.

Any discussion they had about the taxation of multinational companies ended in an argument – even if Penny was careful.

“I know you’re not one of their people, but you help them, by defending them so much,” he once said, angrily.

Penny noticed that John was not working effectively. He began spending so much time checking his calculations that he was not getting through the necessary volume of work. Then he began doing his calculations with a pencil and paper. Because their tasks were inter-related, his slowness was reducing her output. For months, she tried to carry him. She hinted, she would be prepared to take over some of his tasks.

“What are you saying?” he snapped, “So, you want to get me sacked, do you?”

“Don’t be silly,” she replied and dropped the topic.

Partly out of concern for him, and partly out of concern for herself, she went to her superior.

“He seems to be unhappy or something. Perhaps it’s that he doesn’t like working in an office with me, but things have been fine between us as long as I’ve been here....I don’t like to be disloyal, but he’s not getting through his work the same....I’m afraid that’s making me look bad.... I need his figures before I can do my estimates...”

“He’s not the man he used to be,” she was told. She was surprised, saddened and relieved to hear that others had noticed a change over the last year.

As long as anyone could remember, John had bought his lunch at a sandwich shop and eaten it with the same group of men in the staff room. In the summer he had talked about cricket, and in the winter, football. During both seasons, he had tried to recruit their sons and all new employees for the Surf Club. That changed a year ago. Now, he brought his lunch from home and ate it alone, in a park.

People in other sections had begun to complain about him. In the past, when he detected inaccuracies or oversights in the work which came to him he had done the usual thing, called the authors, teased them and passed on. Then he took one to his section head; it seemed that he could not accept that an honest mistake had been made. Eventually, he had said,

“Well, if you don’t want to make waves, you must be happy with what’s going on,” he said, walked out and left the building for an hour. It wasn’t clear what he meant by this remark. It was taken as an insult, but it was an awkward situation and the section head let the matter drop.

Over the next year things changed little. John continued to be tense, snappy and slow. But not so slow that he could be challenged or demoted. Penny didn’t want anything said to him while they were sharing an office. But she finally found conditions so uncomfortable, she got out of Taxation and went to Customs. Still, as John had not “done” anything illegal, improper or contrary to the Public Service Act, they had no grounds to discipline him. But they now knew they had a problem. The Divisional Director called John to his office.

“Mr. Miller. You’ve been here for twelve years. You have been a valuable employee. But over the last couple of years you’ve slowed down quite a bit. I understand that you don’t mix with the other staff much. I just asked you to come up to have a chat, to see if you like it here, and whether there is anything we can do to help you work things out,” he said in a kindly manner.

“You had better talk to my Union Representative and my Lawyer,” said John, terminating the interview by walking out of the room.

Thus commenced a union, legal and medical wrangle which lasted for two years. John contacted his Union Representative and stated he had been threatened with the sack, without warning or reason. This was believed and repeated by the Union Representative. John’s lawyer got involved, demanding copies of the “charges” and the “evidence”. Then John went on sick leave, his doctor claiming that he was suffering from “nervous” exhaustion, due to “industrial harassment”.

After months of discussions and letters, denials that there had been harassment and agreement that there was no hard evidence, John (possibly agitated by this turmoil) made an unexpected visit to the Consumer

Protection Authority. He claimed that multinational companies were colluding to reduce their taxes. His “proof” was that, as he knew about it, he was being victimized. This information, which suggested a delusion, was conveyed to the Union, the lawyer and his general practitioner. They all protested that a person under this much pressure could sensibly conclude that he was being victimized. Nevertheless, they all soon agreed that it was appropriate for John to be examined by the Commonwealth Medical Officer.

The Commonwealth Medical Officer recommended that John be assessed by a psychiatrist. Initially John refused to see a psychiatrist, apparently taking the suggestion as an affront. A month later he agreed, “just to prove” there was nothing wrong with him. By the time the appointment arrived, John was doubting the wisdom of his decision. After the exchange of names and hand shaking, he made an apprehensive, but angry statement,

“Everybody knows that it’s easy to silence people by saying they’re mad. They do it in Russia all the time. I’m not here for that. I won’t agree to being hypnotized or anything like that. My lawyer knows I’m here. I’m here to get a clean bill of health.”

The psychiatrist was calm and respectful.

“OK, sure,” she said. “My role is simply to find out what the difficulties are.”

“Who pays for this?” John challenged, looking from the power points to the telephone and around the walls.

“The Commonwealth Government. This meeting was requested by the Commonwealth Medical Officer. But, Mr. Miller, can you tell me what you think the purpose of this meeting is, and what has led up to it?”

They sat silently looking at each other. She said nothing. He started.

Three years ago people in the train had started to hold newspapers up in front of their faces. He realized they were giving him the message that he was being watched. He didn’t know them, but they knew him. Sometimes he would be sitting in a carriage and find himself surrounded by them. Changing carriages didn’t help, there was always at least one in every carriage. He was afraid at first but then he realized they weren’t going to do anything violent. They always had the business pages pointing toward him, showing rows and rows of stock market figures. They were from the multinationals. Their message was, don’t rock the boat, don’t increase the taxes on the multinationals.

“But with respect, you don’t have much to do with determining policy, what could you do that could hurt the multinationals?”, she asked.

He explained that if he started getting tough on them, like a snowball, it would get bigger as it went from him to others, like compound interest, and it would hurt them, make no mistake. The proof was that they had people watching him. They had already silenced half the people in the Tax Department. Once friendly work-mates “made remarks” and he had to start keeping to himself. That led to the multinationals watching him with fiber-optic devices through power points. They also bugged his office and his computer so that he had to do most of his work with pencil and paper and shred each page as he went along.

This had led to the multinationals, through mining company subsidiaries, to drill tunnels under the building, and line them with bulletproof glass. John didn’t say precisely how the tunnels fitted in with the surveillance activities. The psychiatrist didn’t push him on the point. It was unnecessary, he was clearly mad.

John had a delusional system. He believed that multinational companies believed that he was a threat to their prosperity, that his actions may force them to pay higher taxes. Supporting this central delusion were other delusions including that the multinationals were having people give him messages in the train by holding up the financial pages of the newspaper and having him watched in a variety of ways, including via fiber optic devices in the power point. He also had the delusion that the multinationals had dug tunnels under his place of work. These are persecutory or paranoid delusions. Such delusions have a grandiose flavor – in this case a clerk, with relatively little influence, believed that multinationals were concerned that he could hurt them. He even believed he was so important to them that they employed dozens of people to watch him and even went to the enormous expense of digging tunnels under his building.

This case illustrates the interesting point that people with complex delusional systems can, sometimes for years, function reasonably effectively in the community. This is possible when the delusional system is the only psychotic symptom and the delusions are limited to certain areas of life. In the case of John Miller, symptoms were present only when he was traveling to and at work. It is possible for a person with a delusional system to work through to retirement without serious work problems, particularly when the delusions do not involve the workplace. Usually, fellow workers find such people to be tense, secretive and isolative, but also, precise and determined. Generally, the better the individual is able to function, the slower they come to attention and receive offers of help.

It is very difficult to obtain a clear understanding of the beliefs and to initiate treatment for people with persecutory delusions. The nature of their condition leads them to construe all attempts to discuss their beliefs or performance as attacks. Believing they are being persecuted rather than sick, they “sensibly” reject all, and sometimes all, offers of treatment.

Helen had noticed changes in her husband. He laughed less and was often angry about the events of the day at the office. She saw this as a reaction to the additional responsibilities of fatherhood. She had married him “for richer or for poorer” and had known he disliked stress ever since they met. She was glad he still had the Surf Club and the local football team to take his mind off the stress of work.

Helen knew nothing of John’s delusional system until after he went off on sick leave. Spending more time at home and more than usually worried, he started to talk to her about being watched at work. She thought it was a terrible way to treat employees, and that she should go and complain to the Federal Minister for Taxation. Eventually she had some contact with the family doctor, the union officials and the psychiatrist and came to know the full story. She continued to support her husband and protested that,

“He would never be like this if they didn’t keep cutting the public service work force and putting more and more on the few who’re left”.

John had total lack of insight. Lack of insight is a central requirement of delusions. By definition, if you come to accept that your belief is incorrect, you can no longer believe it and you no longer have a delusion. That is how it works in theory. In practice, interestingly, people can have partial insight, which means they may be able to see that their delusion is incorrect in fact, but still not reject it completely.

John’s lack of insight made it difficult for him to accept that he needed medical intervention. He went to the Commonwealth Medical Officer because his job depended on it. As he wanted to continue in the employ of the Commonwealth Government, he had no alternative, but to comply with that instruction. The same thing applied to the Commonwealth Medical Officers recommendation that he see a psychiatrist. John finally agreed to see a psychiatrist to prove that he was well and that his account of events was accurate. While giving such reasons, patients sometimes also have a small degree of insight, some tiny doubts about the accuracy of their thinking and agree to see psychiatrists to reassure themselves that they have got it right.

The psychiatrist did not get into a discussion about whether or not she believed John’s story. She believed that he believed it. She got him to bring his wife along. The three of them talked about “the problems” John was having at work.

“Well, Mr. Miller, as you know, this is pretty much the first Mrs Miller and I have heard about these issues. I’m sure you will understand if we ask you to explain how some of these different things happened”.

Helen was distressed to hear the full extent of the things her husband believed, but she was reassured by the psychiatrist’s composure and supportive approach.

By this stage the general practitioner had a better understanding and his name could be used. Toward the end of the interview, the psychiatrist said,

“All of us want the best for you. Worrying about all these things must be very distressing. I speak for myself and Dr Chen as well, and I suspect, Mrs Miller. We all believe you should probably take some medicine which will help you deal with the stress you are currently under...How about that? Do you think some medicine might ease some of your distress and help you deal with things?”

A belief does not deserve professional attention because it is wrong. If a patient holds a delusion which does not cause them to suffer in any way, there is no place for psychiatry. The suffering secondary to delusions takes many forms. Fear or anxiety and insomnia are common and are a natural consequence of the belief that one is being spied on or in dangerous circumstances. Some individuals waste money by spending on items such as additional locks and security devices, new television sets and telephones and a range of unnecessary medical investigations. Whether others are aware of the delusions or not, they lead, by various routes, to conflict at home and work, and all too often end in dismissal and divorce.

The medicines which correct delusional thinking also have biological actions which ease fear or anxiety and insomnia. Naturally, as the delusion weakens, the distress which is a direct consequence of the delusion also subsides. Thus, in the present case, the psychiatrist is genuine in offering treatment to help John with emotional distress. His distress was secondary to his delusion, the treatment would initially treat this secondary feature, and shortly thereafter, it would impact on the primary symptom, the delusion.

John refused medication when it was first offered. He remained off work, supported by his wife and general practitioner. Helen explained the situation to John's mother who also became angry and distressed. However, Helen got good support from John's brother, Kevin, and her own parents, who visited and took their granddaughter over night, every second night. John was still troubled by his delusion and his continued absence from work placed a cloud over his employment.

He had been suffering mild insomnia, but this worsened and at a subsequent appointment with the psychiatrist, he accepted some medication. The next day he felt more relaxed. A week later he was beginning to have doubts about the multinationals digging tunnels under the Taxation Department building. Two weeks later he no longer believed that the multinationals had watched him through the power points. A month later he was free of delusions, but he was more suspicious and aloof than he had been before this all started.

John remained on medication. His suspiciousness and aloofness were perhaps a natural awkwardness, given that he now realized that he had behaved irrationally and that at least some of his fellow workers would know, via office grape-vine, that he had been diagnosed as having a mental disorder. One option was to apply for a transfer to another Commonwealth department. But that would bring a new set of stresses, the need to learn a new job and meet new people.

"I think I would be safer where I am," he told Helen.

She wasn't sure what he meant by "safer" but chose not to ask. John stayed with the Taxation Department, and bought himself a car so he didn't have to travel with people with whom he was still not entirely comfortable. He remained married and continued as a good and loving father to his daughter.

John Miller suffered a paranoid delusion. Using the current classification system, the Diagnostic and Statistical Manual, Edition 4, the most appropriate diagnosis would be Delusional Disorder. Essentially, the person suffering delusional disorder has a delusion, but no other psychotic symptoms, such as hallucinations.

When other psychotic symptoms are present, another diagnosis is usually more appropriate. The most common is schizophrenia.

In rare cases a delusional system may be a feature of a medical disorder such as a brain tumor.

Delusional disorder is probably more common than we think. People with this disorder can often function reasonably well in the community. Lacking insight, they usually don't believe they have a medical problem and don't go to the doctor for a medical solution. Feeling persecuted, they avoid contact with others and try to attract as little attention as possible. In blocks of flat there are frequently people who have many locks on their doors, who believe that the neighbors come into their living rooms and move things around or steal things, under the cover of darkness. Some are well known to the police as they make frequent calls about being persecuted. Probably most never speak of their persecution. These are frequently elderly people and many have suffered paranoid delusions for decades.

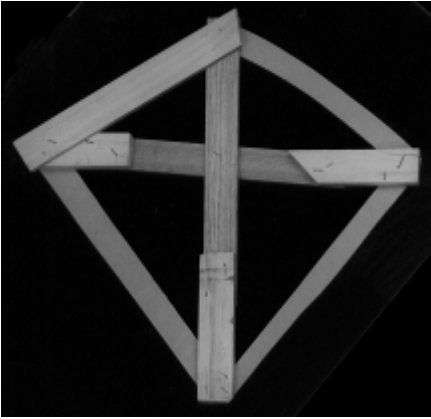


Illustration 4.1 This construction was made by carpenter who was admitted to hospital with acute schizophrenia. He had severe abnormalities of the form of thought. This is a rare example of abnormality of the form of thought being reflected in physical performance; it is usually detected in speech.

In the Occupational Therapy Department this man set about making a crucifix to hang on the wall of his home. Rather than fix together two pieces of wood symmetrically and at right angles, he nailed two pieces of wood together such that the left and right arms were different lengths, and the angles they made with the upright were not quite right angles. Apparently to correct the asymmetry, additional pieces of wood were roughly nailed to the arms. These increased the weight, others observed, made the central join unstable. Apparently to increase stability, he then nailed pieces of wood between the ends, thus producing an outer diamond with a cross in the middle. The patient's parents stated that this structure was much below he usual standard of his work.

Some may see artistic value in this work. However, this man had no artistic training or aspirations and when he recovered he was embarrassed, considering his work while sick to be poor craftsmanship.

CHAPTER 4

FORM OF THOUGHT

In the previous chapter we looked at the things patients believe. Technically, this is termed the “content of thought”. We will now look at what is called the “form of thought”, that is, the connections between thoughts, when patients are thinking.

The content and the form of thinking are separate matters. A particular patient may have no delusions whatsoever, but still have severe problems in connecting one thought with the next. Patients are generally unaware and do not complain about abnormalities in the form of their thinking. Abnormality in the form of thought is often unrecognised, and may be dismissed as an eccentric style of expression. However, abnormalities in the form of thought are powerful diagnostic pointers.

The detection of abnormalities of the form of thought can be difficult. Like reading an X-ray, it calls for training and technical skill. The examples given in this chapter, however, are reasonably clear, and can be readily grasped by the general reader.

In everyday conversation we tend to ignore changes of subject and direction. Instead, we pay attention to content, paying particular attention to “the bottom line”. It is necessary to take the conventions or common conversation into account when examining the form of thought. The conclusion that an abnormality exists is only made when the evidence is irrefutable.

The form of thought is usually assessed by examining what the patient says while talking in and outside interviews. It is taken that thought is reflected in speech. The form of thought is also reflected in behaviour, but abnormality can only rarely be identified with certainty, because a greater number of factors, such as fashion, opportunity, custom and other rules, impact more heavily on behavior. A clear example, however, was produced by a carpenter who was admitted to hospital with disorganized speech and behaviour. His ability to perform his work was impaired by his ability to think in the usual manner (Illustration 3.1).

In highly a structured interview, particularly where the patient is mainly asked for factual information, abnormalities of the form of thought may be difficult to detect. If the symptom is suspected but not confirmed, the examiner may ask vague or abstract questions and encourage the patient to speak freely. These questions give fewer clues on how to structure answers and there is a greater chance of loss of logical connections. Religious or philosophical questions are useful, and are tailored to suit the patient - if patients have talked about having faith, it is reasonable to ask, “Why do you believe in God?” If patients have talked about outer space or scientific theories, it is reasonable to ask, “What would the relationship be between the space creatures you have described and the Christian God?” or “How could time travel contribute to pollution?” Other tasks which call for abstract and logical thinking include explaining the meaning of proverbs, such as, “A stitch in time”, “People who live in glass houses” and “Still waters run deep”.

As an example of a vague question, a patient was asked, “Why should we pay taxes?”

He replied “Taxation, we have representation... taxation without representation is treason...”

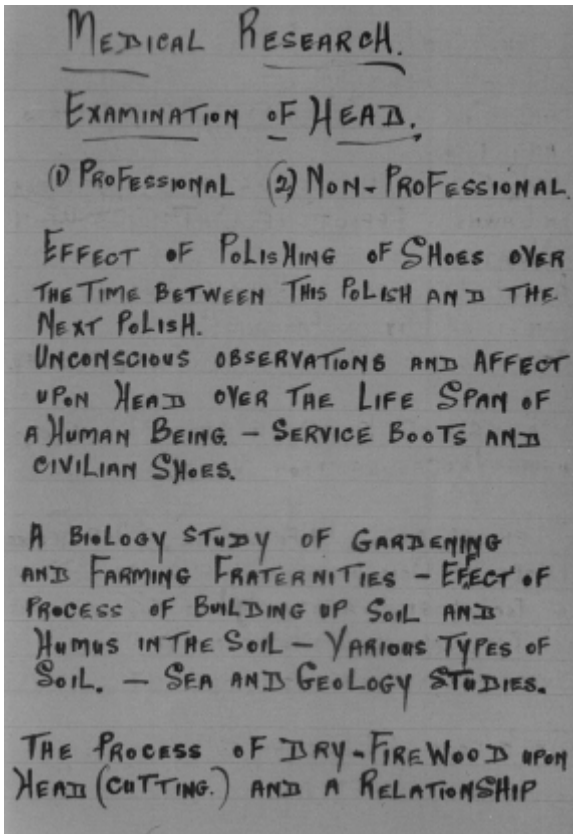


Illustration 4.2 This is the first page of five exercise books written by a man who was educated at university in mathematics during the second world war. He then worked in administrative posts for more than a decade, but developed schizophrenia and lived for some years in a psychiatric hospital.

This excerpt has a large number of derailments. The page heading reads, Medical Research.

The sub-heading reads, Examination of the Head - this sounds like a first aid book or a medical student book on how to perform a physical examination - there has been a derailment from the heading subject of Medical Research onto a very basic medical subject.

The next line reads, (1) Professional (2) Non-professional - there appears to have been further derailment. The topic of "medicine" suggested the notion of a profession, which in turn suggested the word non-professional.

There can be no debate about the next lines as an example of derailment - they read, Effect of polishing of shoes over the time between this polish and the next polish - they bear no relationship to the preceding words. In these lines we can see the approach of the mathematician, the effect of the patient's extensive training. The whole page is clearly set out with headings and paragraphs and the writing is legible, but the derailment is so frequent as to produce incoherence.

This answer makes little if any sense and does not fit within the gamut of normal responses. When the loss of logical connections between ideas is clear, there is an abnormality of the form of thought. While opponents of psychiatry may argue that they can "see what he is getting at", this can only be with the eye of the antagonist. The question was why do we have taxes and within three phrases, the topic of treason was introduced.

TYPES OF ABNORMAL FORM OF THOUGHT

Derailment is one of a number of types of abnormal form of thought (Illustration 4.2). It stands alone, but is also the foundation stone of some other types. Derailment occurs when a train jumps off the track. Derailment in thinking occurs when ideas slip off one track onto an obliquely related track, or even onto one which is completely unrelated to the first. The term "thought slippage" is sometimes applied.

Flight of ideas is characterized by rapid continuous speech with frequent shifts from one idea to another (Illustration 4.3). It is similar to derailment, but may appear different, because the patient is having an abnormally large number of thoughts which tumble out, the speech is fast, loud and difficult to interrupt. Clanging is the term used when the sound of one word suggests another word, such as when asked how long he had been ill, a patient replied, "Ill? I'm not ill. I'm not even illegitimate!" Another type of flight of ideas is when the meaning of one idea suggests another idea, such as when a doctor introduced himself as Dr White and the patient said, in a quick and forceful manner, "White, black, grave".

Up and Down like
a very rough sea:

Psycho - (log - i - cal
| eye ca?love
| a
| rhythm

raising the
number
or
anchor at
last from 0 to smooth
sailing.

Am I psycho or logical
was the question I
could not answer.
Now I hope I'm logical

Illustration 4.3 This was written by 25 year old female suffering bipolar disorder, in an attempt to make sense of her thoughts. She had a history of one manic and one depressive episode; this was written during her second episode of mania.

Up and Down like a very rough sea – she was referring to the ups and downs of her mood (the main feature of bipolar disorder). Thoughts about her mental disorder suggested the word psychological, which she then split into syllables (giving the word up and down beats).

The syllable log suggested the word logarithm (a mathematical concept) and the letter i suggested the word eye, these are examples of flight of ideas of the rhyming type.

Triggered by the word logarithm, she wrote of raising the number – this comes the definition of logarithm: “a base must be raised in order to produce a given number”.

The word raising (which returned to the motif of up and down) then suggests raising an anchor – this is an example of flight of ideas of the meaning type - in which the meaning of one word (raising) suggests a new idea (anchor).

The anchor led to the notion of sailing, which could be smooth, the opposite of that referred to in the first and second lines.

There was playfulness in splitting psychological into the two parts, psycho and logical, which can be taken to have opposite meanings. The final line, now I hope I'm logical, has poignancy, the lady having insight into the fact that her thinking was at the time, disordered.

This writing could be misinterpreted as having great intentional complexity and the flare of genius. The complexity may have been exaggerated by the above analysis, which may be, in part, incorrect. It is true that most of us could not write such a piece, with all its various connections and recurrent themes. But this writing did not achieve its intended end. It did not help the writer understand her thoughts. It is a jumble of thoughts which are pouring out at such a rate that they cannot be beneficially arranged. The reader is advised to view the chapter on madness and genius.

The form of thought may be so abnormal as to be incoherent (Illustration 4.4). This arises when derailment or flight of ideas is very severe. An example, a patient was asked, “What do you think about current political issues like the energy crisis?”

He replied, “They're destroying too many cattle and oil just to make soap. If we need soap when you can jump into a pool of water, and then when you go to buy your gasoline, my folks always thought they should get pop, but the best thing to get is motor oil, and money.”

Neologisms are “new words” which are “made up” by the patient and have no meaning to other people. They are not “made up” by conscious effort, they are a result of the impact of a disease process on the ability to think. It is as if the stream of thought is disrupted within words, and syllables are connected to-

There's a finish line at the back of the jetty where
those navel oranges grow
Upside down video clips of emus talking to foxes.
I see vegetables growing and those carrots have a lot
of venom. Keep still or they'll spot you and kill you.
I'm going mad. Stop this dribble. Fuck Fuck

Write them as they come bitch baby
Don't mess with your mind. Ring yourself
on that mobile because you're going to die
upside down. Carry this with you on your
toes will drop off Bing. Like rollerblading on
a strawberry patch 'round + 'round.

Illustration 4.4 These lines were written by a young woman during a manic episode. There is some evidence of flight of ideas, but this is not particularly obvious. There is mention of a jetty (small pier). This may have been suggested by the words finish line, which could have suggested fishing line - fishing is sometimes conducted from jetties.

In the next line there is mention of naval oranges - naval as in navy was probably suggested by the word jetty - boats are moored to jetties.

There is the suggestion of insight in the words, I'm going mad. The patient is distressed, and wants the experience to stop. She expresses distress with the words, Fuck Fuck.

There are two mentions of death - a subject which is more commonly mentioned in depressed phases, but may also be mentioned when mood elevation is distressing.

The impression is that there is pressure of thought with ideas tumbling out over each other. The net effect is incoherence. Each phrase and line seems to be saying something and heading somewhere, but then the direction is lost and the 12 lines are empty of overall meaning.

gether which do not make recognized words. Patients who present with neologisms also have other abnormalities of the form of thought that make communication difficult. Thus, in my experience it has been unclear whether a neologism has meaning to the producer. Neologisms were once quite common in clinical practice, but now they are very rarely encountered. Perhaps this is because these days people come to attention earlier, and we have effective treatments. Examples include "a tastro", "replaper" and "an ellis".

Poverty of thought is a term applied when there is a decreased amount of speech; there is little if any spontaneous speech, and questions, if they are answered, are answered with a single syllable or very brief answers. The psychiatrist takes care to exclude other reasons for a low output including sulking, malingering and medical diseases such as Parkinson's disease. For example, consider the response to the question, "Do you have children?" If the answer is in the affirmative, the person without poverty of thought, undergoing medical examination, usually responds immediately, stating the positive case and usually gives the number of children, often the ages and sometimes even the names, of the children. The patient with poverty of thought may not make any response when the question is first asked. The interviewer may ask the question a second time and after a long pause, the patient may answer, ".....Yes.....", usually without any supplementary information. Even the word yes may be mumbled or otherwise difficult to discern.

CASE DRAMATIZATION

Phil Biro was 18 years of age. He was exceptionally clever at physics and mathematics and was to commence at University in a few weeks. His life was otherwise unremarkable. His mother was a science teacher; his father was a pharmacist. He enjoyed football and skateboarding. He had some male and female friends and took no illegal drugs.

Over six weeks Phil had become isolative and hostile. In the days before the following interchange, it became clear that he had a delusion about bikies threatening him and was experiencing auditory hallucinations which he believed was Stephen Hawking. Stephen Hawking is an eminent physicist who has motor neuron disease and speaks with the assistance of a machine which gives his voice a metallic, robotic timbre.

Phil Biro was interviewed in a psychiatric ward by a young doctor. After introducing herself as “Grace” and stating that the interview was to gather information so that he could be helped with his difficulties, she asked,

“So, could you, please, just tell me what’s been troubling you over the last couple of days?”

Phil was slow to answer. “Nothing at all...They can stay out of trouble...If they’re in time.”

“Sorry”, Grace said, “When you say ‘They’, who do you mean? Who is it that will stay out of trouble?”

“Bikies.” He was silent for some ten seconds then finished with, “Everyone really. Because of Stephen King.”

“Do you mean Stephen Hawking?” Grace asked.

“Yes, Stephen King,” he nodded. He paused, then continued, “He’ll put the bikies in another time force if they make trouble.”

“Phil, I asked, what’s been troubling you over the last couple of days. Can we go back to that? What’s been troubling you over the last couple of days?” she repeated.

“I’m going to University next month. If the bikies come, Stephen King...he can change the secret of time.”

Normal thought, reflected in speech, is a string of ideas which are connected in a logical way such that the listener or reader can make sense of the message.

This man has derailment, meaning his ideas slip off one track onto another. His derailment (or slippage) is so severe that his thinking approaches incoherence. In the second phrase of his response to the question about what had been troubling him recently, Phil introduced the topic “They” and stated that this unknown group of people (presumably) would be able to stay out of trouble. He has slipped off the track of what had been troubling him, perhaps onto what may be troubling others. The listener does not know the identity of “They”, this is another indicator of derailment, but some healthy people also make this oversight and talk without making the listener aware of the identity of those they are talking about.

In his next phrase, Phil spoke about being “in time”, this also suggests derailment. It is known that he has been hearing the voice of Stephen Hawking, who has written many books about “time” and the patient may have derailed onto this topic. There is the impression that pieces of connecting information have been lost, which makes the message difficult to follow.

When the interviewer sought to clarify the identity of “They” she is initially told “bikies”. This is no surprise, it was known that Phil had a delusion which involved bikies. In the same response, the name of Stephen King was introduced. This man is a famous writer of science fiction, thriller and horror books. He may have been incorporated into Phil’s abnormal thought content (delusion); on the other hand, as the name Stephen King shares a first name with Stephen Hawking, and they are both well known writers, there may simply be an abnormal thought connection (derailment) from Hawking to King. The question had been about, who was meant by “They”, in Phil’s response, the word “because” indicates the beginning of a new, derailed, direction.

The patient was asked whether or not he meant Hawking. He confirmed that he did, but immediately repeated the name of King, suggesting that he had immediately slipped off the Hawking track back onto the King track. He then spoke of a “time force”, a term which is unfamiliar to me. It is impossible to know the origin of this utterance without asking the patient for details. It may have had roots in either delusional thinking or abnormality of the form of thought. It’s my guess that Phil had a delusional system and meant that if bikies showed up and caused trouble, Stephen Hawking would somehow put them into another

time or parallel universe. However, the word “force” does not express that idea clearly and appears to represent another derailment. Alternatively, “time force” could constitute an arrangement of words which had an idiosyncratic, private meaning to the patient.

Phil was again asked what had been troubling him in the recent past. In the last sentence of the excerpt he immediately derailed from that question and said what he would be doing in the immediate future (going to University). He went on to say, of Stephen King, “...he can change the secret of time.” Again, it is difficult to be sure what he meant. While there was probably a strong delusional basis, there may also have been an abnormality of the form of thought. The aim of responding to a question is to communicate information. In this instance the listener does not know what is meant by “the secret of time”, but the patient did not clarify the issue.

Phil was successfully treated with standard medication, discharged and able to commence the university year with the other students. Before the end of the semester, he relapsed. He had ceased taking medication. Phil’s father said that even before he ceased taking medication, Phil had not been doing well. He had not had delusions, but he did not seem able to think clearly and his performance on assignments was below what was expected of him, given his pre-university scholastic achievements. On this basis, on his second admission, Phil was commenced on clozapine, a highly effective medication which may have dangerous side-effects. In view of the potential side-effects, regular blood monitoring is necessary. Phil recovered remarkably well and completed his university degree with excellent marks. At follow up visits his psychiatrist was unable to detect any signs or symptoms of mental disorder. Phil developed no significant side-effects.

CASE DRAMATIZATION

Roy Webster was 58 years of age and lived in a boarding house. He had never married and had no children. He had been an apprentice butcher, but he developed delusions and hallucinations and did not recover sufficiently to work again. Both his parents were alive and lived in their own unit. He had two brothers, Brian, 57 and Phillip, 55, and no sisters.

The boys had been raised in the country. Starting as children, they had been hunters, going after kangaroo, rabbits, pretty much anything that moved. When the steam trains stopped running, their father, a stream-train driver, was transferred and brought his family to the city. At the weekends they went back to the country to go shooting. Roy had been named after Roy Rogers, an early motion picture cowboy.

He had little interest in school. With his country upbringing he was physical and tough and was good at school football. He smoked and wanted to get out to work. He was rebellious and reckless and attractive to females of the same age. He had a string of conquests in his teen years. He left school to take up his apprenticeship at 16 years of age.

Two years later he stopped going hunting at the weekends. At first the others thought he wanted to stay in the city to go carousing. But that was not the case; he was not leaving the house. He became suspicious and broke the shooters’ rule – he kept his gun loaded.

He began to “talk a lot of rubbish”. The family couldn’t follow what he said but it became clear that he believed Roy Rogers was out to kill him. Roy believed the film star thought the patient had stolen his (the movie star’s) “identity” and wanted revenge. The patient heard a voice outside his head calling him “a homosexual”, “a poofter”, “a queen” and “a queer”. He believed this was the voice of the movie star.

The family let Roy go his own way until he stopped going to work. His boss was pleased to be able to sack him for failing to turn up, as Roy was no longer a useful worker. The family then took him to the doctor and he was put in a psychiatric hospital. He was given medication which helped with his delusions and hallucinations. But he had lost his energy and sense of fun, and he couldn’t carry on a conversation any more.

Over the first ten years he had half a dozen acute attacks, when his delusions and hallucinations would get worse. During these times he was sometimes angry and would raise his hand to anyone. He would be put into hospital until he settled down. Over the last twenty years, however, there had been no such attacks. Roy's florid symptoms had diminished or at least, no longer distressed him.

One brother came to take him for a drive every Saturday. Phillip came along the narrow, damp passage and knocked at Roy's door. He waited a few seconds and knocked a second time. Knocking was a formality, Roy rarely answered the door to knocking.

"Come on, Roy, let me in, please. It's Phillip."

He gave a third, frustrated knock. There was movement from the other side of the door. Then the clicking of unlocking. The released door went back one centimeter from the jam. Roy never pulled the door open for his brothers, perhaps he did for others. Phillip pushed it and went in.

Roy was already lying down again. His movement back was faster than his movement from his bed. The air was cigarette smoke soup. Roy was unshaven, his clothes were dirty, his fingers were brown with nicotine and he stank of body odor. You could smell him from the door.

"G'day, mate. How are you doin'?" asked Phillip.

Roy did not respond immediately. After half a minute he said, "Ahh..." It was not clear what this utterance was meant to indicate. It could have been a mumbled, shortened, "All right". It could have been the thinking time at the start of a sentence, "Ahh...Not bad, thanks". If this was it, the second part never came. Experience had taught Phillip to wait a while, but not to wait too long.

"You need to open a window, mate. Listen have you had a shower today?"

After another silence, Roy said, "Naa..." which sounded like, and other evidence suggested, "No".

"Well listen mate, I want to take you for a drive. But you need to have a shower first."

Roy made no response to the suggestion that he take a shower. He looked past his brother.

"I need cigarettes," he said.

"OK, sure, we can get some when we go out. Where's your shower stuff?" Phillip went to the where a towel was clumped over the towel rack. It was dry and stiff. There was no sign of soap in Roy's toiletries bag. "You need a clean towel. I'll go and see the bloke in charge. And you need some soap. I'll go and get you some. I'd take you with me, but you smell terrible."

Roy slowly put his legs over the side of the bed and let gravity drag him into the sitting position.

Delusions, certain abnormalities of the form of thought and hallucinations (which will be addressed in the next chapter) are called the "positive symptoms" of schizophrenia – meaning that they are additions to one's usual mental life. Loss of drive, loss of ability to experience pleasure, loss of interest in others, social withdrawal and reduction in the amount of thinking (called poverty of thought) are called "negative symptoms" of schizophrenia - meaning they represent reductions in one's usual mental life and social functioning.

In the early stages of schizophrenia, the positive symptoms are prominent and disruptive. In the later stages, acute attacks of positive symptoms occur less frequently and may cease completely, but by this time, the negative symptoms are more likely to cause problems.

Roy had severe negative symptoms. He had reduced drive – this was one of the reasons he had not returned to work, it also underpinned his failure to clean his body and engage in activity other than lying on his bed. He had a loss of ability to experience pleasure – this underpinned his failure to engage in even passive pursuits such as listening to music or collecting stamps. He had loss of interest in others – he didn't even open the door and greet his brother with any enthusiasm. He had social withdrawal – he lay on his bed day after day, he had to be approached, he made no effort to engage others.

The topic being considered in this chapter is the process of thinking. Not the things which are being thought about (abnormalities of the content of thinking are delusions) but the connections between

thoughts and the quantity of them. When an individual has suffered a mental disorder which has resulted in a reduction in the amount of thoughts experienced, the term poverty of thought may be applied. This term is reserved for use in a setting of negative symptoms. It is not applied in normal situations such as the exhausted surfer or the writer who has been unproductive recently.

If there is very little said by the individual, the assumption is made that there is very little thinking going on, in other words, there is poverty of thought. Clearly there is need for caution and when there is doubt the psychiatrist is trained to leave the question open and make no conclusion.

When poverty of thought is present, the words which are spoken are often mumbled or difficult to understand. In response to the first question directed to him, Roy said "Ahh", and in response to the second, he said "Naa". With neither of these did he make his meaning clear to his brother.

Roy made no verbal or physical response to the suggestions that he needed to open a window, and take a shower, or to the observation that he needed a clean towel, or to the question about the location of his toiletries. Roy did not extend a greeting to his brother. He made only one spontaneous comment – that he needed cigarettes. His statement "I need cigarettes" was unusually brief and transmitted a single piece of information. He used no adjectives and his utterances were stark. All indications were that Roy was thinking less than a healthy individual who did not suffer schizophrenia.

There was one possible example of derailment, that is, an idea slipping off one track onto another. Roy's brother suggested that he take a shower. Roy did not address this suggestion but stated, "I need cigarettes." Roy was asked about showering, but may simply have derailed onto another of his needs. On the other hand, failing to answer the question put to him may have been a negative symptom of schizophrenia, an expression of loss of interest in others and social withdrawal.

Derailement was probably severe forty years before when it was reported that Roy "talked a lot or rubbish".

CASE DRAMATIZATION

Melanie Roberts was a married sales representative of 30 years of age who had one daughter. She was admitted to a psychiatric hospital suffering from mania. It was very difficult to converse with Melanie as she would "talk over the top" of others and she paid no attention to what they said. She continuously sought company. If she was in a room alone for some reason, she kept talking – not intermittently and softly as does the reader when alone and doing some work around the house, but continuously and in a loud voice, such that someone passing would assume she was having a lively conversation with another person. She was sleeping less than two hours each night and had been euphoric, irritable and disinhibited.

She had been trying to contact her husband using a phone supplied on the ward for patient use. She was dialing her home phone number but, presumably because of disorganization, she had succeeded only in reaching wrong numbers. She stood alone next to the telephone, looked through her purse and discovered she had no more coins. She said in a loud voice,

"I'll have to write a letter send a pigeon in a cage. He must be in gaol and can't reach through the bars. He's got a great singing voice and he's a terrific dancer. Have I told you about the first time we made love? Fuck, I hate the bastard. But, his mother's a real tight-arsed bitch"

It is difficult to analyze the form of her thought from this overheard snippet with absolute certainty, but some conclusions can be attempted. This young woman wanted to contact her husband. When she could not reach him by telephone, other forms of communication sprang to mind, letter post and carrier pigeon. The better solution would be to persist with the telephone, best of all, with the staff doing the dialing. Communicating by post in these circumstances would not be appropriate and the carrier pigeon option was not possible. In the same first sentence the thought of a bird brought a cage to mind. In turn, the thought of a cage triggered thoughts about gaol. As she was having difficulty contacting her husband, she

incorrectly concluded, “he must be in jail” and unable to reach the phone through the prison bars. She next thought about singing. The prison bars may have suggested “bars” of music or “bars” in night-clubs, where live singing can be an attraction. In either of these cases, it would have been the sound rather than the meaning of the word bars, which was the determining factor. Singing suggested dancing. Either the physical activity of dancing or the association with nightclubs and good times led to thoughts about making love. This thought may have led her to the word “Fuck”. However, Melanie had been frustrated in her attempts to contact her husband and this word may simply have been an expletive, an expression of irritation by a somewhat disinhibited person. It seems the word “love” then triggered mention of the opposite emotion, “hate”, or this may have arisen as a consequence of her irritation. This sentence ended with the claim that her husband was “a bastard”. She mentioned her husband’s mother, which may have been connected to the comment about her husband being a bastard, as this can mean illegitimate. This possibility is strengthened by the use of the modifier “But” and the statement that this person was a “tight-arse”, which means stingy, haughty and constrained. Alternatively, in colloquial Australian “a nice little tight arse” is sometimes used about younger people and refers not to stinginess, but there to well shaped rather than dropped buttocks. The suggestion of bastard and illegitimacy could have led to thoughts of the mother as a young, attractive person, presumably with well shaped buttocks. This may then have led to the words “tight arse” in the second, stingy sense.

The abnormal form of thought which usually occurs in mania is termed flight of ideas. This is a consequence of the patient having a pathologically increased amount of thoughts. Other symptoms of mania include euphoria and undue confidence, a general increase in activity, reduced need for sleep, disinhibition, irritability and pressure of speech, which is present when the individual speaks louder and faster than normal and is difficult or impossible to interrupt.

There are two main types of flight of ideas. One is when the sound of a word suggests another rhyming word or idea, the other is when the meaning of a word suggests another word or idea. There are no examples of the rhyming type, but many examples of the meaning type of flight of ideas in the above abstract.

CASE DRAMATIZATION

Josh Kimber was a 22 year old farmer who had a long history of mood disorder. His mother had suffered bipolar disorder, meaning she had elevated mood periods and depressed mood periods, measured in weeks to months. She had died by suicide during a depressed period, two years earlier. His maternal uncle also suffered bipolar disorder and his maternal grandmother had suffered severe depression.

The following examples were produced toward the end of one long hospitalization. Josh was leaving the psychiatric ward to walk a few city blocks a couple of times per day. He still felt “a bit racy”, a term universally understood by people who suffer mania which refers to racing thoughts and the desire to keep moving. The raciness could hardly be detected in conversation. When he returned to the hospital he would come to my office and if I were engaged, he would leave a note with my secretary. It is quite common for patients who are a bit racy to write notes. This is partly because they can’t always find someone to talk to and partly because experience has taught them that they forget thoughts easily. Being mood elevated they often think their thoughts are very clever or important and they have the energy to go to the trouble of writing them down.

The notes Josh wrote were very brief. One was, “Hello Mister Mellow”. This is a perfectly acceptable, friendly greeting. However, Hello and Mellow, rhyme, and Mister Mellow is an alliteration. It would be unwise to make too much of a three word greeting from a person who is relatively clinically settled. Nevertheless, there may be subtle evidence of the abnormality of form of thought called flight of ideas. It is also worth noting that while charming, the leaving of such messages is somewhat disinhibited and pointless.

Another of Josh’s notes read, “I just saw a cop with a cappuccino. What do you know.” There is alliteration with cop and cup, and rhyme with cappuccino and know. Again, the reader may think too much is

being made of a few words. However, seeing a police officer drinking coffee is not worth reporting to others, and writing notes to this effect suggests abundant energy and disinhibition. There is a strong, playful rhythm in the line, which also suggests mania.

During an earlier admission, Josh had the delusion that he was God. Delusions are not common in mania, but when they occur, they are usually of a grandiose type. Josh wrote on a piece of paper, "I am the sun, the moon, the seas and the trees". Again, rhyme and rhythm are present. It is interesting that current culture influences the content of

delusions. Amazonian Indians do not feel controlled by television, but by snakes, witch-doctors and other relevant elements. In the past the delusions of western citizens often involved the KGB, the spy organization of the USSR. With the demise of the USSR it is likely that delusions will less commonly feature this clandestine group.

Returning to Josh's mention of trees. The surface of the earth is covered by sea and land, and in the past Josh may have been the sea and the land. It is not clear whether Josh included trees in his statement because of rhyme or as a result of the increased public awareness of the environment in recent years.

At the age of 24 Josh experienced his first depressive episode. He was treated and made a good recovery. He ceased his medication, suffered a further depressive episode and shot himself. He put the rifle under his chin and fired. The bullet went through the floor of his mouth, and out through one eye. His brain was not touched, and though blind in one eye, he survived. This terrible event and the series of plastic operations which followed had some positive effects. Josh got rid of his guns and was henceforth totally compliant with his psychiatrist's recommendations. He was well a decade later.

The inability to remember or to find one's way around the house, which occur in head injury or dementia, may be considered to be abnormality of thinking. However, by convention, these are placed under other headings. The phenomena considered above are the abnormal connections between ideas which occur in schizophrenia and bipolar disorder, formerly called manic depressive psychosis. These sometimes pass unnoticed or are dismissed as eccentricities of expression. This is a mistake as abnormalities of the form of thought are diagnostically important and have a great impact on the ability of people to function in daily life.

If a neurologist asks a patient to walk across a room in a straight line, but the individual veers off at 45 degrees, this is evidence of a serious underlying problem. The same can be said when a person is trying to think in a straight line but jumps tracks and goes off in an unprofitable direction. With an abnormality in the form of thinking, patients naturally have great difficulty planning and executing the actions necessary for a happy and productive life.

CHAPTER 5

HALLUCINATIONS

We are concerned here with hallucinations as they occur in mental disorders. It is important to be aware that similar phenomena may be experienced in the absence of mental disorder. Throughout history, people have heard voices when there has been no one with them, and seen things which, to say the least, were unexpected.

In the Judeo-Christian records, God spoke to Adam on the sixth day, giving him instructions about how to behave in the Garden of Eden (Genesis, 2:16-17). God spoke to Moses from a burning bush, and on another occasion, He dictated the Ten Commandments to him (Exodus, 34:27).

In the Islamic records, the Angel Gabriel spoke to Mohammed on at least three occasions. On the first occasion he said, "Oh, Mohammed, of a verity thou art the prophet of God". On subsequent occasions the angel made revelations which became the Koran.

Voices of secular origin have also been experienced by many prominent people. Sigmund Freud, the father of psychoanalysis wrote, "During the days when I was living alone in a foreign city....I quite often heard my name suddenly called by an unmistakable and beloved voice....". Such hearing of a family member's voice when separated from them is not uncommon among the bereaved and those lost in the wilderness. It probably has more to do with being alone and wishing to be with loved individuals than the supernatural or mental disorders. Mahatma Gandhi, the man who almost single handedly achieved Indian independence from Britain, relied on an "inner voice" for guidance. Toward the end of his life the voice said, "You are on the right track, move neither to your left, nor right, but keep to the straight and narrow." Others of great resolve have described similar "inner voices", which probably have much to do with determination and focus of their goal.

Studies have indicated that healthy ordinary individuals may hear voices which are not spiritual or pathological events. The first was conducted by Professor Henry Sidgwick who conducted an "International Census of Waking Hallucinations in the Sane", in the 1890s. Seventeen thousand people from England, Russia and Brazil were surveyed. Nearly 10% reported they had experienced an unexplained perception, 2.9% of the total reported having heard a voice. One hundred years later Professor Allen Tien conducted a study of 15 000 members of the general population in the USA and found that 2.3% had heard voices. In a number of careful studies of small populations of university students the experience of hearing voices has been reported by a much higher proportion of respondents – in one, 71% gave a positive response.

The exact proportion is unimportant. It is beyond doubt that healthy people may, from time to time, hear voices. Care has been taken in these paragraphs to avoid calling these experiences, hallucinations, although they satisfy the technical criteria. There are differences, however, between the voices heard by healthy individuals and the hallucinations of those with mental disorders. In healthy individuals, the voice is usually as if from one person, speaking comprehensibly, in a helpful and comforting manner. Auditory hallucinations in mental illness, in contrast, are often as if from two or more people, sometimes arguing, sometimes

commenting about the patient, frequently making little sense, often in a threatening and frightening manner.

HALLUCINATIONS IN MENTAL DISORDERS

Perception is the process of converting physical stimulation, such as light waves arriving in the eye or airwaves arriving in the ear, into psychological information, that is, the recognition of images or sounds. Hallucinations are false sensory perceptions, that is, perceptions which occur when there have been no external cause or stimulus.

Pathological hallucinations take many forms. A brief outline follows. Note that the categories are not mutually exclusive, for example, an hallucination can be both commanding and persecutory at the same time.

Auditory or heard hallucinations are usually of voices, however “non-verbal” auditory hallucinations do occur, and include clicking and mechanical noises, muttering or mumbling and music. In musical hallucinations the patient often hears a complete piece of music.

In the case of verbal auditory hallucinations, one or more voices may be heard. They may come from inside or outside the head. Two or more voices may speak in unison, or at the same time, conduct a conversation between themselves, or address the patient. A voice or voices may speak to or about the patient. They may comment on his or her thoughts or actions. They are usually heard as speaking but they may be heard as singing or shouting. Voices rarely speak in complete sentences - they usually say only a few disjointed words in brief utterances. While the content of verbal hallucinations may have immediate meaning for the patient, more frequently, they do not.

The patient may recognize the voice because it has been heard before, either first hand or via the media. It may be that the patient has never heard the voice before, but nevertheless “knows” who is speaking, often it is God, Jesus or the Head of the KGB (Illustration 5.1). If the voice has never been heard before, but the patient “knows” the identity of the speaker, the patient may have delusions [believe things which are untrue] which are secondary to the hallucinations.

Voices may instruct or command the patient to perform an act. Usually this is a trivial act such as making a cup of tea, but it may be to injure self or others. It is important to note that patients do not automatically comply with command hallucinations. When a command is first given, the voice is usually spoken, perhaps with a hint of insistence. For some patients, when command hallucinations are ignored, there are no consequences, the command is not repeated, or may be repeated essentially in the same relatively unobtrusive manner and the patient is able to continue with his or her activities. In some cases, when commands are ignored, they are repeated with much insistence, perhaps shouted, with abuse and much foul language. Generally, patients do not like complying with command hallucinations, perhaps because to do so threatens the sense of autonomy. However, it is very distressing being subjected to raised, abusive voices. A

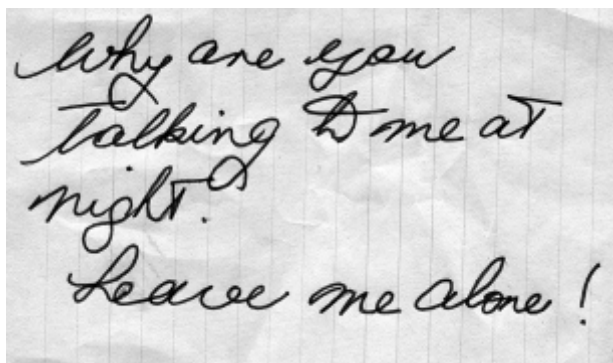
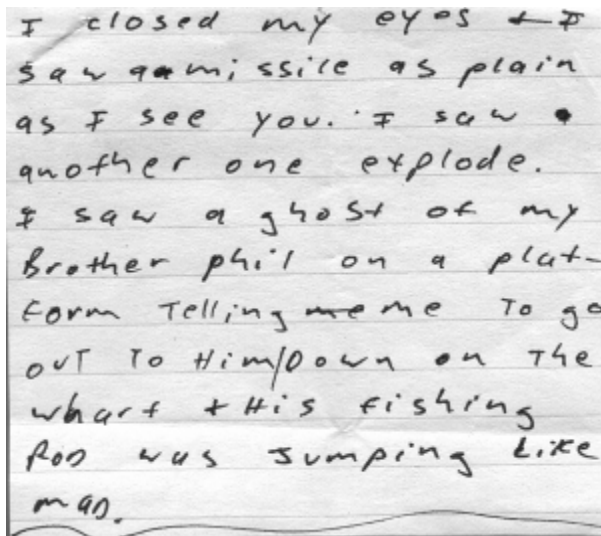


Illustration 5.1 This note was placed under my hospital office door. It was written by another psychiatrist's patient, a middle aged woman with psychotic depression. She was hallucinating, hearing accusatory voices. She was insightful and irritable. Whether this note was intended for me, and whether she thought I was responsible for her hallucinations was never clarified. She received ECT, her mood lifted, her hallucinations disappeared and she was discharged, with little memory of her period of suffering.



I closed my eyes + I
saw a missile as plain
as I see you. I saw a
another one explode.
I saw a ghost of my
brother phil on a plat-
form telling me to go
out to him / Down on the
wharf + his fishing
rod was jumping like
mad.

Illustration 5.2 This note was written by a man with schizophrenia. In addition to the more common auditory hallucinations, he experienced almost continuous, detailed visual hallucinations. In this example he states he saw a missile explode “as plain as I see you”, and his brother on a wharf with his fishing rod “jumping like mad”.

“I closed my eyes + I saw a missile as plain as I see you. I saw another one explode. I saw a ghost of my Brother Phil on a platform telling me to go out to him / Down on the wharf + his fishing rod was jumping like mad.”

common response of patients is to comply with the trivial commands such as, “Look out of the window”, and to resist the uncomfortable or dangerous ones such as, “Jump out of the window”. Command hallucinations are not a major factor in suicide or homicide.

Verbal hallucinations may be a feature of depressed or elevated mood. In the case of elevated mood the hallucination may assert the patient has exceptional beauty, intelligence or other qualities - “They know you should be king”. In the case of depressed mood the hallucinations may denigrate or make persecutory statements, or may suggest or command suicide - “You deserve it. Coward. Do it.”

Visual hallucinations may have the form of circles or lines, as occurs in migraine. In schizophrenia they are often indistinct or distinct figures, often humanoid, standing to one side (Illustration 5.2). In some types of epilepsy they may be complex scenes such as two trucks and a rickshaw driving through the room.

Tactile hallucinations are the experience of being touched or of crawling under the skin.

Somatic hallucinations are the sensation of things happening inside the body, such as organs moving from one part of the body to another. These are rare, but may occur in schizophrenia, and they are often accompanied by delusional explanations.

Gustatory hallucinations, the hallucinations of taste and smell may occur in mental disorders, but they are most commonly experienced in epilepsy.

Whereas hallucinations are perceptions that are not associated with any outside stimulus, illusions are perceptions that are associated with an outside stimulus, but the stimulus is wrongly interpreted, for example, lapping water may be heard as laughter. Illusions are frequently visual, and they are usually the result of some medical condition. The condition which most commonly causes illusions is delirium tremens (DTs), the disturbed state which can complicate alcohol withdrawal. Objects such as creases in bed covers may be perceived as snakes, insects or other forms or animals. Folk law says that people in DTs see pink elephants. In clinical practice, however, small organisms are more commonly seen.

Other perceptual difficulties include heightened and changed perceptions. By heightened perceptions is meant sounds seem unnaturally clear, loud or intense, colors appear more brilliant or beautiful, details of the environment seem to stand out in a particularly interesting way. By changed perceptions is meant changes are perceived in the shape or size of people and inanimate objects in the environment. Changes may continue while the patient watches. It is probable that when some psychotic patients are difficult to engage in conversation, they are concentrating on continuously changing perceptions. Heightened and changed perceptions may occur in a wide range of disorders, including the non-psychotic disorders.

CASE DRAMATIZATION

Cynthia Campbell was 17 years of age and attended Sacred Heart College, a local Catholic school. She lived with her parents and younger sister, Melissa, who was 15 years of age, in a middle class suburb of a large city. Her only other sibling, Libby, was older and stationed overseas in the Army. Cynthia's mother was a dentist and her father was a fireman.

She had been distressed. She was about to leave high school but didn't have a clear plan. She had found schoolwork difficult and, although she had daydreamed about becoming a teacher and helping children like herself, who had struggled, she was adamant that she would not go to University. She liked the idea of a job in a plant nursery. That would mean a part-time Technical College course, but she thought she could probably manage, and she knew some sort of qualification was essential for a comfortable working life. The problem was, such jobs were few and far between. If all else failed, she could join the Army, like Libby. Although, her father had said he didn't want her to go in that direction.

She had just broken up with Sam, an 18 year old who was attending St Virgil's College, a Catholic school. She had loved him and given him her virginity, but he found someone else.

When she was going out with Sam she started smoking some marihuana at parties on Saturday nights. On one occasion she took one "speed" (amphetamine) tablet. Since the break-up she had sought a supplier of marihuana and had smoked after school two or three times a week.

A week ago, when she was smoking at her girlfriends house she heard her father's voice. She quickly stubbed her "joint" out, grabbed Emily's and stubbed it out, pushed the ashtray under the bed, and pretended to be reading a magazine. Emily looked at her quizzically, "What's up your knickers?" she asked.

"Shhh. My father's out there," Cynthia replied, flapping her magazine frantically to disperse any residual smoke. For a moment, Emily was startled,

"How do you know?" she whispered.

It soon became clear that Mr. Campbell was not in or near the house.

"I just thought I heard his voice," said Cynthia, making a huge effort to sound nonchalant.

A week later, while the family was having dinner, "That's Libby.... She must be home!" Cynthia interrupted, dropping her cutlery and standing up from the table. She turned as if to run out of the room, but froze, standing, listening.

"I didn't hear anything," said her father.

"No. It couldn't be," said her mother. "She didn't say she was coming."

"Yes. Yes it is," said Cynthia. She continued to listen.

Then they all went quiet and listened. Only Cynthia heard something.

There was a common sense of alarm. There was something wrong. Melissa was frightened and cowered back and down as if to hide under the table. Her parents stood up, not quickly, as when faced by an attacker, but questioningly. Cynthia's expression changed from surprise and pleasure to bewilderment, through some level of comprehension, to terror.

“What’s happening! What’s happening!” she wailed, and was suddenly crying. Her parents took her from the table to the sofa and sat on either side.

Cynthia’s experience was of a voice outside her head, which she heard through her ears. She could not say if it was a male or a female voice, but she heard her name clearly called. There were some other words and short sentences, most of which were muffled. What she heard did not seem to make much sense. As when she hallucinated her father’s voice, the hallucination was totally convincing, but once it stopped, Cynthia could agree, she had been mistaken. That is, she lacked insight while the hallucinations were being experienced, but she gained insight into her situation when they stopped and she was able to check with her companions.

Learning that this was the second of these events, and distressed by her distress, Cynthia’s parents insisted that she stay at home and rest the next day, which was Saturday. That morning she saw a palomino horse walk through the kitchen wall, turn left and walk into the hall before disappearing. She was calm and interested while this was happening, but terrified when it was over. She did not know what was happening; it was as if she was no longer had control of her environment or her mind.

Cynthia’s palomino experience also startled her parents. They immediately arranged for her to see a general practitioner. They thought the break-up of her relationship with Sam and the pressure she was under to make decisions about what she wanted to do in life were the root of the problem. Secretly, her father thought she could be pregnant. The general practitioner thought drug abuse or schizophrenia was the most likely diagnosis.

Cynthia was referred to a psychiatrist who arranged an EEG and a form of epilepsy was discovered. She was treated with medication for epilepsy and advised to avoid illegal drug and the hallucinations ceased. Epilepsy is associated with a physical brain abnormality, but can be worsened by emotional stress and the use of certain drugs.

CASE DRAMATIZATION

Michael Wells was a twice married chef of 29 years of age. He lived with Holly, his second wife and her child from another relationship, in an inner Sydney tenement house. Ned was his son by his first marriage; he rarely saw the boy as his ex-wife had moved interstate. Michael had a good job at a good restaurant less than a kilometre from the house.

“You’re not getting sick again, are you?” asked Bob, without smiling, as he pinned another order on the board.

“Absolutely not. Why, what’s the problem?”

Five years ago Michael had suffered an attack of schizophrenia. He had the delusion that Ned was going to be sold by his ex-wife, and hallucinations of voices and sirens. The most disabling symptom, however, had been his inability to think clearly. His thoughts kept slipping off the track. He could not orchestrate his cooking, he could not get everything coming together and ready to serve at the same time. He would start thinking about one dish and then be distracted by another, and then another, and in the end, they would all be spoiled. Bob had very kindly kept Michael’s job open for three months, till he had recovered and returned. But there was a note of apprehension and irritability in his voice, which suggested he would be reluctant to do the same again.

“You’re slow today. We’ll talk about it later,” Bob said over his shoulder as he went back out to smile and greet and reassure people their meals were well in hand.

Michael shook his head as if to clear it of sleep, and the look of concentration on his face doubled. He pushed on, “Fuck off, fuck off, fuck off, fuck off...” he muttered, like a muted machine gun, to himself, from time to time. But not when Bob was in the kitchen. Michael’s output increased and the promised discussion did not eventuate.

He got an earlier appointment with his psychiatrist.

“I need to go back to the higher dose,” he said.

One month before Michael had wanted to stop his medication. He discussed this with his psychiatrist. He made the point that he had been well for five years and that his medication had side effects: it reduced his sexual drive and made him tired. His doctor said that he was still at risk of a recurrence of acute schizophrenia, that things were going well for him and that his relationship and his job could be at risk if he got sick again. In the end they decided it would be reasonable to first try a reduction to half his dose of medication as a first step, and to reassess the situation in a month or so.

Michael explained that he had felt much better on the reduced dose. He felt as if he was making progress, he felt encouraged and he had more energy. There had been no delusions and his thinking was still clear. The auditory hallucinations, however, had returned. He had two voices, both male. Sometimes they seemed to be outside his head; sometimes they seemed to be inside. It was similar to when he was sick, and he had known they were hallucinations from the day they came back, a week ago. Although he knew they were a symptom and not “real”, it was hard not to listen to them, and they distracted him from what he was doing. They often commented on what he was doing and told him what to do. They sometimes got loud, insistent and abusive if he failed to comply.

“He’s separating the egg white,” one voice might say, when he was separating egg white for a sweet. Michael would find himself listening, to see if they were going to say what he should do next. It was comforting, in a way, they were company, even flattering. But then,

“Add a teaspoon of water,” they might say. If a teaspoon of water was not a good idea, and he failed to comply, the voices, which usually spoke separately, might speak in unison.

“Hey, add a teaspoon of water!”

If he still failed to comply they might shout (sometimes Michael was concerned that folks nearby would hear) and add insulting words.

“ADD SOME WATER, YOU FUCKING PRICK!”

On occasions, even though he knew they were hallucinations, he would comply, just to shut them up. He resisted if their commands would ruin the meal or his reputation.

The Psychiatrist explained that staying on the half dose of medicine had prevented a full relapse with loss of insight, but that there was a great risk that a full relapse with the need for hospitalization may follow. This warning was unnecessary. Michael’s recognized that his reduced productivity was threatening his job and returned to the higher dose of medication. The hallucinations quieted, and then disappeared. He never had that talk with Bob. A year later he took Holly and his stepdaughter over the border to visit Ned.

CASE DRAMATIZATION

Pho Robertson was a 51 year old Australian citizen who was born in Vietnam. Her husband, Bill, died of an unexpected heart attack, two months previously. She lived in a comfortable four-bedroom home in a middle class suburb of Sydney. They had two children, both now married: Janice was in the Australian Embassy in Washington and Ken was unemployed and lived further up the coast.

Pho, the daughter of a schoolteacher and his wife, was raised in Saigon (Ho Chi Minh City). She had a good education, learning English and French and becoming a teacher in her late teens. For reasons and by authority which were never clear, her parents were imprisoned and she was told that if she wanted to avoid jail herself, she was to go into a rural district as a teacher, and never return. She did not see her father again; he died or was killed within a year of being imprisoned. She did not see her mother for another fifteen years.

Bill completed training as a surveyor. He found the last years boring and the thought of going directly into practice filled him with dread. He joined the Army for some excitement. Being a qualified surveyor he was given a commission and was among the first Australian soldiers sent to Vietnam. He arrived in 1967, a month after the first Australian was killed. He spent most of his time in the field, exposed to the danger of land mines and enemy fire.

He met Pho in a small village close to Nui Dat, the Australian task force base. She was tiny and beautiful; he was big and fearful. She was sad and fatalistic, but was nevertheless able to comfort him. And, in spite of his own needs, toward her, he felt protective. Within months they talked of marriage, but there would be huge hurdles to overcome. Bill finished his tour of duty and came home. Although psychologically afflicted by his war experience, he volunteered for a second tour so that they could be together, at least for small amounts of time.

When he finished his second tour he came home, and Pho followed six months later. They settled in Bill's hometown, Brisbane. There were many problems. Bill's parents and siblings were not supportive. Many Australians thought Pho was Chinese or Japanese; when they learned she was Vietnamese, they behaved as if she was a communist and an enemy.

They were delighted when the children came along, and they could form their own complete, if somewhat socially isolated family. When the children were entering secondary school, Pho's letter writing paid off and she regained contact with her mother. Bill had built up his own surveying company, they were doing well financially and Pho was able to get the next plane to Vietnam to see her mother. The old lady would not leave her native land, so the family went to visit her three times.

Both the children were clever at school. Both had straight black hair and looked part Asian, but neither spoke of suffering significant racial prejudice. The girl was ambitious and proud of her heritage. She went to university with the intention of joining the diplomatic service. Her life had run according to plan. The boy was less ambitious. He started taking drugs in high school and did not seek further education. He married a waitress. It was an open secret that the couple made a fair living growing marijuana, drifting from one coastal town to the next, staying one step ahead of the law.

Bill suffered posttraumatic stress disorder following the war. He felt like a weakling because Pho's experiences seemed worse than his, but she had not been damaged. Along with most other Australian Vietnam War Veterans, he felt betrayed by his country. They had been sent to fight and risk their lives overseas, but on return they were criticized rather than appreciated for having done what they were bid. Then, along with others, either out of guilt, wisdom or forgiveness, Bill got involved in rebuilding Vietnam. Gangs would go together, taking tools and materials, and build a school or orphanage or anything else they could put up in about a month.

He was buying roofing materials for a dormitory when, at fifty-five, he fell down dead.

Pho had cried little. The children had come home for a week and she had looked after them. She was sad, had lost her appetite and had difficulty sleeping. She expected and accepted these difficulties. She did not expect to ever again be happy, or to eat or sleep well. She was in a foreign country and had lost the husband who had been her best friend, her financial supporter and only lover. But, she had not expected hallucinations.

"Doctor, can anything be done," she asked, "I am going mad."

She explained that on the night of Bill's death she did not sleep, she did not go to bed, she sat in the living room, she had his picture on the coffee table but she stared at the wall. About four in the morning she heard Bill say,

"Don't worry sweetheart... We can fix it."

For a cruel instant, she was bewildered. He is alive, it's a big mistake, she thought. No, he was dead, it was his ghost. No, it must have been a dream; she must have drifted off to sleep for a moment, without noticing.

Next afternoon, she was sitting in the same chair, staring at the wall. She glanced over at Bill's chair, and there he was in his dressing gown reading something. He raised his head and smiled back at her. He was calm and loving. She wasn't scared. He went back to his reading. She looked away, not knowing what to do, when she looked back, he was gone.

She heard and saw nothing of Bill in the week the children were at home. Or any time when other people were around. She only saw him twice more. One Saturday afternoon she went into their bedroom and he was having his Saturday nap on the bed. She froze. Not out of fright, but not to wake him. She looked at him, he was perfect in every way. There was grease on his cheek from the lawnmower. After a good long drink of looking at him she backed out of the room to let him sleep. It felt warm to have him there. When she went back half an hour later, sadly, he was gone.

The last time she saw him was a week later. She had been to the lawyer to finalize something she didn't understand about the company. As she came slowly up the drive, he was standing on the lawn. Their eyes met and his look of concentration softened and he raised his eyebrows in recognition. She drove into the garage, when she came out, he was gone.

Pho didn't believe in ghosts. Vietnamese culture is awash with various deities, but these experiences didn't fit with anything she could accept. She knew little of mental illness. In the first few weeks she did not care if she was mad or not. The day before going to the doctor, she heard Bill speak to her again.

The earth had settled on his grave. The elevated mound had become a dip. She had gone to the stone mason to talk about a headstone and was undecided about black or red granite. It was something which once done could not easily be undone. As she sat in the car, after the drive home she heard him say,

"Black or red? It's not worth worrying about."

She looked over to the passenger seat and the back seats, she would have liked to see him, but he wasn't there.

"I like hearing his voice," she explained to her doctor, "but I know I shouldn't. Is there something you can do, to stop me getting worse".

The hearing or seeing of a close, recently deceased friend or relative is not evidence of a mental illness. Figures are not available, but it is common. Usually these experiences become less common and cease over subsequent weeks or months. The grieving process is also normal, and a depressive disorder is only considered when the suffering persists or worsens.

Hallucinations may occur in very severe (psychotic) depression, but in this case they are usually associated with feelings of guilt and usually denigrate or accuse.

The hallucinations Pho experienced were typical of the bereaved person. They are comforting and benign. Perhaps they have a role in helping the individual adjust to the loss. Pho was raised in social, political and military turmoil. Although she had been an adult when she lost her parents, the circumstances were still damaging. She was powerless, she did not have reliable information regarding their fate; thus her grieving for them was disrupted and protracted. She was traumatized by war. She migrated to a foreign land, peopled by another race, where she experienced prejudice. She was relatively isolated. Her main social network and support was her family. Her children left home and the vicinity. When her husband died she lost most of her human contact. While there is no clear evidence that persons with limited social supports experience more hallucinations during bereavement than those people with extensive social supports, such a finding would not be unexpected.

Pho was given reassurance by her doctor and seen twice a week to talk and keep working through the grieving process. The doctor later recommended Pho spend some time with a psychotherapist to look at the other losses of her life. At one point she took a small amount of a sedating antidepressant, not as an antidepressant, but to help her sleep. Her hallucinations ceased without antipsychotic or full doses of antidepressant medication. Pho eventually visited her daughter in Washington, which she enjoyed greatly, and on return, she started corresponding with an American veteran.

These three cases illustrate that hallucinations can occur in a range of human conditions. In the first case the hallucination was an expression of a tiny brain abnormality. In the second case the hallucination was a symptom of schizophrenia, which on any given day is probably responsible for more hallucinations around the world than any other disorder – given that the condition is common and that this symptom is usually present. In the last case the hallucination was the result of bereavement. Hallucinations in bereavement are not unusual and are not considered pathological. In only one of these cases was the use of an antipsychotic medication appropriate.

CHAPTER 6

SCHIZOPHRENIA

Many of the symptoms of schizophrenia have been described in the chapters dealing with hallucinations, delusions and abnormal form of thought (Illustration 6.1). They have been described separately because each is complex and deserves to be considered in detail, and because each of these symptoms can occur not only in schizophrenia, but also as a feature of other disorders.

Late in the nineteenth century, Emil Kraepelin, a German psychiatrist, separated psychotic mental disorder into two main parts. One he called dementia praecox, and the other was the psychotic mood disorders. Dementia praecox was renamed schizophrenia by Eugene Bleuler, a Swiss psychiatrist, in 1911. In using the term dementia, Kraepelin was drawing attention to a disorder which had a poor long term prognosis (course of the disease). The term praecox denotes this is a condition which commences in young people. Dementia was perhaps not the best term, as dementia praecox/schizophrenia does not have the profound memory problems encountered in the dementias such as Alzheimer's disease, and while the prognosis is not always good, the unrelenting deterioration described by Kraepelin does not always occur in every case.

There cannot be any argument with Kraepelin, however, about age of onset, this disorder does generally commence in the late teens or early adult years.

Bleuler's term, schizophrenia, which literally means split mind, has also been a source of concern. Split mind has been confused with split personality. In the condition called split personality, more than one personality is believed to inhabit the same body. This gave rise to the idea that people with schizophrenia are Jekyll and Hyde organisms, with a good personality and a bad personality. Even today, to some extent, the public is afraid of people with schizophrenia, fearing that the bad personality could pop out at any time and strike down innocent individuals with an axe or machine gun.

What Bleuler was really referring to with his term split mind was that people with schizophrenia have loss of connection between thought content, thought processes, emotion and behavior. For example, a particular thought may not be associated with an appropriate emotion, or a particular emotion may not be associated with appropriate behaviour. Thus, he was proposing a large number of splits in the mind, making normal functioning very difficult. Shattered may have been a better word than split. But shattered is also taken, shattered is what happens when painters or writers get bad reviews.

Schizophrenia is a serious mental disorder that affects about 1% of the population. Careful studies have proven a significant genetic contribution in schizophrenia. Monozygotic twins have exactly the same genes. If one monozygotic twin develops schizophrenia, there is a 50% chance of the other twin will also develop schizophrenia. This tells us two things. First, as the chance that people in the general public developing schizophrenia during their lives is 1%, and the chance of the monozygotic twin of a person with schizophrenia of developing schizophrenia is 50%, genetic factors play a huge role. Second, as the monozygotic twin of a person with schizophrenia does not have a 100%, but only a 50% chance of developing this disorder, factors beyond genetics must also be important.

September

This ~~is~~ pain causes me
 a lot of ^{suffering} anguish. There's
 some-one or some people
~~Some-one or some people~~
~~man~~
 hurting me with torment
 and torture. The person
 or persons put negative
 words on my body and in
 the room. The voices tell

1999

The ~~the~~ images burn me on
 the feet and the back and leg
 and face. When I'm indoors --
 through the window and outdoors.
 The voices echo and are there
 day and night.
 It's causing me to want to
 give up and not wanting to
 continue. I can't tolerate the
 thought of this pain in an

1999

2

me things that I do not
 think are right. They tell
 me to stand on your head
 and cut the vagina area with
 glass and use ^(a towel and smell it for five or six hours) ~~objects~~ on that
~~drinking cup~~
 and to go round and round, and up and down on a
~~machine in a torture chamber.~~
 area. There's some kind of
 (black and grey)
 devil in the air and in the
 room. The voices scream
 at me.

4

enclosed space. They are trying
 to control me so I'm not
 able to have freedom. I'm not
 sure what's the race of these
 people - it's a very ^{unhappy} ~~way~~ way
 for me. I can't tolerate them
 much longer. What I do is
 monitored - all this coming
 from a machine! I can't use

1999

5 this torture to (me) Its sharp and
this body and mind
(top of neck)

seethes - back of this head feels

much water or soap - cleanliness is

not easy - those people and/or machines

or whatever it is give me pain to

the back of the head when I use
enough ~~plenty~~ soap and ~~plenty~~ water and quantity of food & water
I can't sit

stand or lay in the room for too
long - they give torture pain to
make me jump. The area for baby
making is painful and the area needs
an operation. I don't know the
way out of this kind of pain.

I want a way out of this pain.
I want to know who is doing ~~it~~ or giving

feel sick and very unhappy..

Some-one or some people in the air
or where-ever they are are watching
every move I make. They are trying
to make me do something I don't
want or like. It's like they are
making me into another kind of
person that I don't want to be or
don't like to be by using negative
words and by printing them on

7

walls and on food and water and other
things in life and they put negative
words outside ^{inside} the windows and doors.

It's not easy for me to believe that
such a ^(pain) thing exists and its happening
to me in a country where there is
freedom.

I want freedom.

I don't know whether I have the freedom
to ~~write~~ print it and whether I'll get loud
voices in the night or pain in the night.

1999

Illustration 6.1 This letter of seven very small pages came in an envelope addressed to the Psychiatrist-in-Charge of my hospital, from another state. I later discovered that it came from a woman who once lived near our hospital, she had relocated to the other state some months before she wrote. The first page of the letter does not open with any salutation or writer contact details, but goes straight into a report of her difficulties. It ends without a signature. It appears that the writer has a psychotic disorder. As she addressed the envelope to a psychiatrist, it is reasonable to assume that she had some degree of insight into the nature of her difficulties. As she did not give her identity or any information which would enable contact to be made, it is reasonable to expect her thinking was disorganization, in other words, that she had abnormality of the form of thought.

On page one, the patient starts by saying that a pain is causing her a lot of anguish. She says that some people are hurting her and that she is being tortured. Initially it is unclear whether she is writing about physical or emotional pain. On page three, however, she writes that she has burning on the feet, back, leg and face. On page five she writes that the pain is on the back of her head and the area for baby making. On page six she writes that she has sharp pain in the neck and head which makes her feel sick. On page seven she writes of getting voices and pain in the night. She writes, on page five that she is given pain to make her jump. In view of these additional details it is reasonable to assume that this patient is experiencing hallucinations in the form of physical pain. Such hallucinations, called somatic hallucinations, are rare.

There is mention of the voices, indicating auditory hallucinations, on pages one, two, three and seven.

On page two the patient states that voices are telling her to cut her vaginal area with broken glass and go up and down and around and around on a machine in a torture chamber. She also states that the voices scream at her. These are command hallucinations. Because of this patient's level of distress, she is at some risk of complying with these commands and causing herself serious harm.

Also on page one the patient writes that a person or persons are putting negative words on her body and in her room. It is not clear what this means. It could be that she had an abnormality in the form of her thought so that she was not transmitting a clear message, or that she was communicating depressed mood or some other form of distress. However, on page six she states that they are printing negative words on the walls and food, and on page seven, she states that these negative words have been put outside and inside the windows and doors. These statements strongly suggest that the patient had the visual hallucination of printed words. This is most unusual.

She describes her suffering as anguish, torment and torture. This theme continues on page three, where she writes that she wants to give up, on page four, where she states she cannot tolerate her situation any longer, and on page five, where she writes she wants a way out. She is distressed. Distress is appropriate when people are living in distressing worlds, and is common among those people who suffer threat and horror as features of their psychotic disorder.

On page two, the patient states that there is some kind of black and grey devil in the air. This is a visual hallucination. Visual hallucinations are probably not uncommon in schizophrenia, but they are less common than auditory hallucinations. When they do occur, patients often describe them as indistinct grey-black shapes, as here.

On page three, the patient states that the voices echo. It is not clear what is meant here. It may be that the voices sound as if they are in an empty room, or it may be that one voice will say something, which is then repeated by a second voice. The patient may be experiencing what is technically called thought echo. In this symptom, after a patient has a thought, such as, "Where did I put my keys", voices echo, or verbalize that thought.

On page four, the patient writes that "they" are trying to control her and take away her freedom, and that she is being monitored by a machine. On page five she complains that she wants to know who is causing her symptoms. On page six she states that she is controlled by something or someone, that they are watching every move she makes, that they are trying to make her do something, and that they are trying to make her into another kind of person. On page seven she writes of her freedom is being restricted. These are paranoid delusions.

On page five, the patient states "the area for baby making", where she is experiencing pain, needs an operation. This is a secondary delusion, secondary to the hallucination of pain.

In summary, there is evidence of abnormality of the form of thought, auditory hallucinations, including command hallucinations, pain hallucinations, visual hallucinations [certainly of a devil, probably also of printed words] and delusions of persecution and secondary delusions. It is known that this patient was hospitalized and treated for schizophrenia, and that she made an excellent recovery. There is some evidence that stress, substance abuse, birth complications, season of birth, nutrition and exposure to viruses and toxins may have a role in causing schizophrenia in genetically vulnerable people. Current thinking is that in every case, many factors are involved, perhaps a different group of factors in different cases.

Schizophrenia was once thought of as a purely “psychological” problem. That is, schizophrenia was conceptualized as a system of bad habits or maladjustments made by people with normal brains in difficult circumstances. Modern brain imaging and investigations, however, have shown abnormalities in brain structure and function in schizophrenia. These findings are statistically significant, when the results of groups of people with schizophrenia are added together. But, at the moment, there is no single physical abnormality that can be measured and used to make the diagnosis of schizophrenia in a particular individual. It is anticipated that diagnostic tests for schizophrenia will become available in the future.

In the early stages, the most common features of this disorder are acute attacks of psychosis, with hallucinations, delusions and some types of abnormal form of thought. These are termed the positive symptoms, that is, these symptoms are in addition to ordinary mental life. In the early years there may be a number acute attacks, but generally, these become less frequent or cease. Sometimes present at the first illness episode, but becoming more obvious over time, are loss of drive, loss of emotions, loss of energy, social withdrawal and self neglect. These are termed the negative symptoms, and represent a reduction in the ordinary mental life and ability to function.

In 1952 two French psychiatrists, Jean Delay and Pierre Deniker, reported that chlorpromazine, a drug developed for other purposes, had beneficial effects on many of the symptoms of schizophrenia. This was a most important breakthrough, to that point the only treatment of schizophrenia and manic depressive psychosis had been sedation.

The brain is composed of neurons which are long thin cells, joined end to end at junction boxes called synapses. Signals pass along neurons as electrical impulses, when they reach the end of the first neuron, a chemical messenger [called a neurotransmitter] is released. It passes across the tiny gap in the synapse to reach special receptors on the second neuron. The snug fitting of a neurotransmitter into the appropriate receptor on the other side starts an electrical current which then passes along the length of the second neuron. And so the process continues. In the human brain, there are probably two hundred different types of neurotransmitters, each with matching receptors.

It was found that chlorpromazine, and the similar drugs which soon followed, work by blocking the receptors for the neurotransmitter called dopamine. Recently developed drugs have less side-effects, and in addition to blocking certain dopamine receptors, they also block some receptors for the neurotransmitter called serotonin. These represent small advances. There has been no fundamental change in the drug treatment of schizophrenia for half a century.

To the present time, the drugs available for use in schizophrenia are effective almost exclusively in the treatment of positive symptoms, the delusions and hallucinations and some abnormalities of the form of thought. In many ways, the negative symptoms, the loss of drive and emotions, the social withdrawal and self-neglect, are the more disabling. It seems that some of the newer anti-psychotic drugs have a minor effect on negative symptoms. As with the diagnostic test, it is hoped that much improved drug treatment for the negative symptoms will be discovered in the not too distant future.

As mentioned, Kraepelin considered the prognosis of schizophrenia to be progressively down hill. It now appears that the prognosis may be somewhat brighter. Whereas once people with schizophrenia were generally cared for by long term institutionalization in mental hospitals, the vast majority are now able to live independently, albeit in most cases, with some community based professional support. It appears that not all those with schizophrenia have a chronic condition, there is evidence that some people have one or a couple of acute attacks, and make a good and sustained recovery.

CASE DRAMATIZATION

Sam Jones was thirty years of age. On leaving school he started a science degree, but he became psychotic, went to hospital and did not return to university. He had married and fathered one child, however, he was now divorced and did not see his child. He lived alone in a flat. A year ago, on a rehabilitation program, he had commenced an arts degree. He had ceased his medication, he had recently ceased attending classes and was neglecting his personal hygiene. He had been placed on a legal order and brought into hospital by community based mental health workers.

Sam had, in the past, taken large amounts of cannabis and alcohol, and uncertain amounts of amphetamine and LSD.

“I want to go home” and “I don’t want to be here” he said on the day of admission to the psychiatric staff.

He was malodorous, his clothes were stained with perspiration and food. He moved slowly. He mumbled and it was difficult to know which words he was saying. Those which could be understood were rarely connected to form meaningful sentences. The next day, in response to the question, “Why did they bring you into hospital, Mr. Jones?”

After a long delay he answered, “They made me come.”

He could not give an account of what he had been doing over recent days.

“I want to go” was the only clear message the staff received.

He moved awkwardly, with his head turned to one side, as if he had a stiff neck. He denied delusions and hallucinations, but as communication was poor, it was impossible to be sure. The doctor noticed that Mr. Jones copied her movements. When she crossed her legs, he would cross his, when she leaned forward, he would lean forward. At first she thought he was trying to mock her or somehow give offence. But he was distant, difficult to engage, and did not appear to have any interest in her reactions. She concluded that he was not trying to be offensive. Premeditatedly, she scratched her nose. Sam scratched his.

“Why did you scratch your nose just then,” she asked.

“Why did you scratch your nose just then,” he replied.

It was difficult to make a diagnosis. The form of thought was disordered and he was not caring for himself. He had used illegal drugs in the past; the present clinical picture could perhaps be a drug induced disorder. However, he had a history of schizophrenia and this seemed the most likely.

Later that day Sam stopped speaking. He sat smoking. Then he was found sitting motionless, the cigarette he had been smoking had burned through between his fingers; the butt had fallen down inside his half closed hand. There were deep burns and blisters on the adjoining sides of his index and middle fingers. He did not complain and showed no distress. He did not answer when he was asked why he had let his fingers get burnt. In contrast, the staff were greatly distressed, expressing a sense of having failed in their duty to protect their patient. But this was a busy ward and there had been no signal, no noise or movement, to raise the alarm.

Over the next day Sam only spoke on four occasions, usually to ask for a cigarette. He ate and drank nothing. His right hand was dressed and bandaged. In spite of staff being alert to the potential problem, he burned the index and middle fingers of his left hand in the same way.

Sam was suffering from catatonia. This is now an uncommon condition which can accompany schizophrenia or severe depression, in which motor or movement abnormalities are prominent. It can present in different ways. Over the last 30 years at least, the most common presentation has been much like Sam’s: under activity, graceless movement, sometimes with unconscious mimicking of the movements and words of others, often ending in a mute state, unresponsive to questions, and with cessation of eating and drinking.

In the past, the presentations of catatonia were often bizarre. Sometimes patients movements were the opposite of nearby people, for example, standing up the moment the doctor sits down, and then sitting down the moment the doctor stands up. There are amusing descriptions of encounters in which the patient put his hand out to the doctor, when the doctor extended his, to shake hands, the patient withdrew his hand, the doctor then withdrew his, at which point the patient extended his again. Waxy flexibility is a term applied to a now rare sign of catatonia. In this situation the patient's body and limbs could be moved, like warm wax, into odd positions, such as standing on one leg with the arms out from the side, and the patient would remain in that position until moved again.

There are two possible explanations as to why catatonia is not seen as commonly and in such severe forms as it was in the past. First, schizophrenia may have changed over time, and second, now that psychiatric treatment is more readily available, people are treated earlier, than formerly, that is, before their condition becomes so severe.

ECT is an effective treatment of catatonia. When the patient ceases eating and drinking, there is danger to life and an urgent treatment is necessary. This is usually ECT, even after the first treatment, eating and drinking commonly recommence. This was the case with Sam. He had a course of ECT and was commenced on the latest antipsychotic medicine which had less side effects than those which he had stopped taking. The number of university subjects he was attempting was halved, to reduce his stress, and he returned to his arts studies.

CASE REPORT

Daniel Cumerford was an Australian child movie star (Illustration 6.2). He was happy, good looking, enthusiastic and successful. In his second movie, in 1982 he played a leading role in the motion picture adaptation of the comic strip *The Story of Ginger Meggs*. Two years later he was diagnosed with schizophrenia and a further three years later, he was dead.

As a child Daniel was bright, artistic and had a lot of friends. He played soccer and he followed rugby league. He had supportive and encouraging parents and grandparents.

By 16 years of age, Daniel's life and future had changed. He became isolative and his behaviour was odd. He would stare at ordinary things like pieces of paper for long periods. He was diagnosed with schizophrenia.

Perhaps these ordinary objects which absorbed Daniel's interest held special meaning for him, or perhaps



Illustration 6.2 Daniel Cumerford was an Australian child movie star. In 1982 he played a leading role in the *Ginger Meggs*. He developed schizophrenia and died a violent death on Christmas Eve, 1987. "Some young men get hit by a car and get brain damage", said his mother, Lesley Armstrong. "My son got hit by schizophrenia."

he was experiencing heightened or changed perception. Heightened perception is when objects appeared especially bright or unique in some way, changed perception is when objects appear to change in shape or colour while they are being watched. Individuals are engaged in such observations, are is difficult to interest them in conversation or other activities.

Daniel began to take marijuana and LSD and to sniff glue, which made his symptoms worse.

He talked of suicide. On Christmas Eve 1987, he kissed his mother, Lesley Armstrong, said “Goodbye” and “I love you”. Later that night he was killed on a train track. While Lesley thinks Daniel did not commit suicide, it remains a possibility.

Schizophrenia takes many forms. Some people are predominantly troubled by positive symptoms, for others, the negative symptoms are the more disabling. Perhaps the most common is a combination of both positive and negative symptoms. The vast majority of people with schizophrenia experience at least one acute attack of positive symptoms. In rare cases, no acute attack occurs, but the negative symptoms gradually appear. This condition has been termed simple schizophrenia. Other presentations include catatonia, as described in the above case. There is currently a great amount of interest and research in the field. In recent years there have been great steps forward in our understanding of schizophrenia, in the near future advances in diagnostic and treatment methods are anticipated.

Sane AUSTRALIA

Sane AUSTRALIA (www.sane.org) is a leading non-government organization which works for the benefit of people with mental health disorders. It was formerly SCHIZOPHRENIA AUSTRALIA, and had a narrower focus.

Sane AUSTRALIA produces literature for patients, carers and the general public, raises money and lobbies governments on behalf of the mentally ill. To quantify the problem of schizophrenia, in 2002, Sane AUSTRALIA commissioned the accounting firm Access Economics to produce a report – Schizophrenia: Costs. Findings included that the real financial costs of illness totalled \$ 1.85 billion in 2001, about 0.3% of GDP and nearly \$50 000 on average for each of more than 37 000 Australians with the illness.

Direct health system costs were \$661 million in 2001. The additional costs being born by the individuals, carers, employers and government agencies outside of health.

The report details these the large outlays, but states that further cost-effective interventions are necessary in the form of early intervention programs, improved medications, rehabilitation programs, suicide prevention programs and extensive supported accommodation, if the shortcoming in mental health services are to be addressed and people with schizophrenia are to become participating members of the community.

Extensive shortcoming in the services provided to those with mental disorders have been identified by the Sane AUSTRALIA Mental Health Report. This report reveals that Australia spends only 6.5% of the national health budget on mental health services while the UK spends 10% and both New Zealand and Canada spend 11%. Shortcomings in services have also been detailed by The Australian (A special report, 29/4/2002), the Ombudsman of South Australia, the Editor of the Melbourne Age (22/9/2002), the Inquiry into mental health services in New South Wales, Select Committee on Mental Health (9/12/2002), and the Report of the Australian Capital Territory Health and Complaints Commissioner (14/12/02).

CHAPTER 7

MOOD DISORDERS

In the previous chapters we saw how abnormalities of thought and perception lead to certain clinical pictures or syndromes. In this chapter we will see how abnormalities in mood, both pathological depression and elation, (“path”, from the Greek word for disease) may also present as mental illness.

DEPRESSION

A depression in a cake, a field or any other surface, is a low area. Sometimes such depressions, as in the case of polished floorboards bearing hammer marks, are the result of being pushed down or struck with force. In economics, depression refers to the loss of vigor and trading in the marketplace and declining productivity.

When applied to human emotions, the term depression is interchangeable with sadness. We have all experienced periods of sadness or depression. These are usually the result of personal loss such as death of a relative or even a pet, or other unsatisfactory events, such as missing out on selection for a sports team or a job. Every time a grand-final is decided, a not inconsiderable proportion of the community is sad.

Depressions which are predictable, brief and of mild to moderate depth are normal responses. Depression may, however, present as a medical disorder. In these pathological depressions it may not be possible to identify a trigger and the depression may last for months or years. In pathological depression the central issue is not laziness, weak will, an attempt to gain sympathy or bad thinking habits, but abnormality in the structure and function of the brain. Viewed in this way, expecting the patient to explain why he is depressed and to pull himself together, makes as little sense as expecting the febrile patient to explain why he is hot and to lower his temperature by an act of will.

There is a gray zone between normal and pathological depression. It is sometimes difficult for doctors to determine where the episode of depression being experienced by a particular individual is located on a spectrum extending from normal depression through the gray zone and on to pathological depression. People whose distress is not immediately recognizable as pathological depression often have difficulty convincing their family, insurance company or even themselves, that they are genuinely ill and in need special help.

Depressive disorder is a cause of great personal suffering and may end in suicide. It leads to disability and loss of productivity. It is common. Full recovery is possible, but many follow a chronic or relapsing in course. Thus, depressive disorder is a large and costly public health problem.



Illustration 7.1. Image of painting by depressed man. This grey and black picture was painted by a man with a history of depressive disorder. There is no sign of happiness or energy. He suicided three days before his next appointment with his psychiatrist.

Courtesy of the Cunningham Dax Collection.

It is unfortunate that this condition has been called “depression”, as this name suggests that feeling sad is the only symptom. While sadness is usually a prominent symptom, the syndrome of pathological depression is a constellation of many symptoms.

Psychiatric disorders are classified according to sets of criteria. The Diagnostic and Statistical Manual of Mental Disorders, currently in the fourth edition (DSM-IV), is published by the American Psychiatric Association. It provides a list of symptoms for pathological depression, which in this publication is termed major depressive episode. The two main symptoms of depression are a persistent feeling of sadness and a loss of interest and pleasure in activities (Illustration 7.1). For the diagnosis to be made, at least one of these symptoms must be present for at least two weeks. In addition at least four of the following symptoms must also be present:

significant weight loss or gain

insomnia or increased sleep

agitation (worrying and physical restlessness) or retardation (slowed thinking and moving)

fatigue or loss of energy

feelings of worthlessness or inappropriate guilt

diminished ability to concentrate or indecisiveness

thoughts of death or suicide.

A note of caution: cook book type lists make the diagnostic process seem simple. Such impressions, however, are misleading and ignore the fact that there are many medical conditions that mimic depression. Thus, the diagnosis of mental disorders is a technical process that requires extensive, special training.

Symptoms are woven into clinical pictures. A typically depressed person will demonstrate disturbances in bodily functions and thinking in addition to sadness and the inability to experience delight. Disturbances in bodily functions are called “vegetative” symptoms and they include changes in appetite, libido, sleep patterns and energy. Characteristically there is weight loss and inability to sleep through the night, although the opposite, weight gain and excessive sleepiness, may occur. An especially common sleep problem is early morning awakening and an inability to return to sleep after waking. There may be loss of interest in sexual activity, and inability to have erections or to reach orgasm. There may be unexplained fatigue and disturbances of movement, with less or more movement than normal. When there is less movement, the face is expressionless, there is less use of the hands during conversation, and the patient is slow in walking, sitting and standing. The thoughts of depressed people are likely to be negative and to there may be a sense of hopelessness for the present and the future. There may be changes in the content of thinking with much guilt and self-loathing. Worries, real or imagined, become preoccupations. Slowness in thinking and difficulty with concentration further erode the ability to perform usual activities. Recurrent thoughts of death may lead to plans for suicide.

These symptoms may fall differently, creating different clinical pictures. One patient may be agitated and unable to sit still, another may be almost immobile. One may have depressed mood, constipation and inability to concentrate, while another may complain of inability to experience pleasure rather than depressed mood, headache and loss of energy. This suggests that depressive disorder may be a range of conditions which are grouped together because, as yet, we lack the knowledge and tools to reliably separate them. Once, any lump which grew in or on a patient was called “a growth”, now we understand and have the tools to differentiate lumps, from malignant tumor to benign cyst.

When a depressive disorder episode is identified, we can proceed to the next step. Generally speaking, these episodes occur in two psychiatric disorders, depressive disorder (also termed major depressive disorder and unipolar depression) and bipolar disorder. In depressive disorder, only depressive episodes occur. In bipolar disorder, in addition to depressive episodes, manic episodes or “highs” also occur.

The prevalence of depressive disorder is twice as common in females (about 6% in females, 3% in males). The average age of onset is in the mid-20s. Some people have isolated episodes, others have clusters of episodes and still others have increasingly frequent episodes as they grow older. While some episodes resolve spontaneously over a period of months, episodes may become chronic and fail to resolve, even with the best treatment. The clinical course of depression is not as favorable as was once believed. In fact, at one year follow up, only 40% of patients are symptom free, 20% have some residual symptoms, and the final 40% still have depressive disorder. About 15% of people with either depressive disorder or bipolar disorder die by suicide.

Psychological factors were considered to be the most likely cause of depression until advanced genetic and biological studies provided evidence of subtle brain abnormalities. Today, most psychiatrists believe that a combination of genetic, biological and environmental factors contribute to the illness and that the weight of these factors may be different for different individual cases and for different stages and episodes of the illness.

The importance of genetic factors in depressive disorder has been recognized for many years by both doctors and their patients, who can often name their relatives who suffer from the same illness. Genetic studies done in many countries looking both at whole families and sets of twins point to the inheritance of a vulnerability to depression. Brothers, sisters and parents of depressed individuals are two to three times more likely to develop depression than other individuals. Identical twins, whether reared together or apart, show a high rate of concordance for depression (concordance is the likelihood, if one individual has a dis-

order, or the related individual also having that disorder). If reared together, the concordance rate is 76%, reared apart the concordance is 67%.

Genes have their effects by influencing the physical structure and function of organs, in this case, the brain. Thus, the genetic studies which have proven the importance of genetic factors in depressive disorder, simultaneously provide evidence for the physical/structural basis of this disorder.

Modern post mortem studies have consistently shown abnormalities in the brains of people who have suffered depressive disorder. To the naked eye, the brain looks to be of normal shape and size. The abnormalities are revealed only when the size of certain structures is measured and when the cells are examined under the microscope. The size of many structures within the brain are reduced. The density, or number of brain cells in a given volume, and the size of particular cells, are both reduced.

Images of the living brain provide confirming evidence. Basically, two types of images are currently available, those which show the physical structure of organs, and those which show how well a particular organ is working. The physical structure of organs is particularly well shown using magnetic resonance imaging (MRI) techniques. There are some differences from one study to the next, but these are due to differences in diagnostic criteria, apparatus and technical methods. As mentioned, generally, MRIs in depressive disorder suggest reduction in certain brain structures.

The imaging studies of the function of the brain are of two types, blood flow studies and glucose metabolism (sugar consumption) studies. These are closely related. The amount of blood flow to a particular region of the brain is an accurate measure of the amount of activity going on in that region. The brain obtains energy almost exclusively from glucose, thus the amount of glucose being metabolized is a direct measure of the amount of activity going on in any brain region. As with the structural studies, there are some differences from one study to the next, which are due to differences in diagnostic criteria and technical issues. Nevertheless, decreases in blood flow and metabolism in particular brain areas have been demonstrated, and these are consistent with the post mortem and structural imaging findings.

Study of the biology of the brain emphasizes the role of two vital sets of chemicals, neurotransmitters and hormones. The brain, our body's command center, communicates its orders through chemical messengers called neurotransmitters as we have seen in Chapter One. Deficiencies of neurotransmitters, like serotonin and noradrenalin, are thought to underlie the symptoms of depression. Hormones, secreted by organs called glands, travel through the blood and regulate many of the body's physical activities. The brain controls the master gland, the pituitary gland, which in turn controls the secretions of hormones from many other glands. The brain uses some of the same neurotransmitters that are linked to depression to regulate the body's hormones. Thus, alterations in the regulation of both neurotransmitters and hormones are biological features of depression.

Distressing early life experiences also predispose people to depression. Recent stressful events may be important in triggering episodes. Triggering events are particularly important for early episodes. Such events are often less important in the second and third episodes. When the course is of multiple episodes, relapses often occur in the absence of identifiable stressful trigger events.

Much about depressive disorder remains unknown. Speculation continues regarding the triggering factors. Comparisons have been drawn between the hibernation of lower animals and the slow movement and withdrawal of people with depressive disorder. Comparisons have also been drawn between jet lag and the fatigue and sleeping difficulties of people with depressive disorder. Hibernation is a state triggered by changes in the environmental stimuli, such as day length and temperature, which impact on complex biological or body clocks. Jet lag is a state triggered by the artificial disruption of similar environmental stimuli. While not the complete answer, it is probable that in some individuals, on some occasions, depressive disorder may be triggered by the disruption of biological clocks. It is uncertain at the moment, whether research on biological clocks will provide useful treatment options for people with depressive disorders.

A range of treatments are available. For sadness which is a reaction to loss, psychotherapy has a place. Psychotherapy also has a place, if not as the sole treatment, as a component in a treatment of depressive disorder. Antidepressant medication is a central plank of most approaches to treatment. These have vari-

ous modes of action, but they all increase the availability of one or both of the neurotransmitters serotonin and noradrenalin.

Another highly effective treatment is electroconvulsive (ECT). Transcranial magnetic stimulation (TMS) has shown promise, but is not yet a widely accepted in the treatment of depressive disorder.

CASE DRAMATIZATION

Jessica Walker was 47 years of age and married to John, aged 49. She was a cleaner at a nearby school and he was a light truck driver. They had three children, all of whom had left home. They had three grandchildren. Mrs. Walker had a long history of depressive disorder and Mr. Walker had an arthritic knee from a football injury.

She sat on the sofa in the living room. When she was well, she had “worry lines” at the outer corners of her eyes, but for the past couple of weeks her face had sagged and her worry lines had almost disappeared. Her mouth had dropped at the corners. However, there was some tension in her face, her eyebrows were drawn toward each other. There was almost no movement of her face. When she spoke there was no smile, even at the mention of the grandchildren.

She spoke briefly in response to questions. Her voice was low and quiet and there was no change in pitch or melody in her words. She did not start conversations or make spontaneous comments. She sat slumped forwards, her back was bowed and shoulders drooped, she looked at the floor. Her hands did not leave her lap when she talked.

When she went to bed she went to sleep, but she woke in the early hours of the morning, and she was unable get back to sleep. She had no appetite for food or making love. She put food in her mouth, because that is the responsible thing to do, but she had even lost her appetite for her favourites: Atlantic salmon and white wine. She could not concentrate to follow books or television. She read and re-read the first paragraph of the newspaper, in an unsuccessful effort to spark interest in the outside world. Even with re-reading, she could not follow the thread of what was written. Her thinking was slow. She sometimes appeared rude, forgetting questions before she could work out the answers and get them said.

Her general practitioner sat on the other end of the sofa,

“How long have you been like this Mrs. Walker? You should have called me sooner.”

“A week, about...” She did not shrug.

“Tell me, how are you feeling?”

“I don’t have any feelings...that’s the thing.”

“But, do you feel depressed, again?”

“I did.....I have no feelings.....nothing.”

Mr. Walker told the doctor that his wife had been crying a week ago, but she had stopped.

“You should be in hospital, Mrs. Walker, where we can take care of you.”

“I’m constipated,” she replied.

“I’m sorry to hear that. How about you come into hospital for a while?”

After a ten second pause, she said, “It wouldn’t do any good”.

“Well if you say at home, will you be safe? You won’t try to hurt yourself, or anything?” the doctor asked.

“No” she replied, and after another ten second pause, “I’m already dead”.

In summary, the patient was slumped, she spoke in a low, quiet voice, she did not move her hands when speaking and her face was long and immobile. She described depressed mood, loss of the ability to experience pleasure, sleep disturbance, loss of appetite, inability to concentrate, constipation, and she believed that she was dead.

Mrs. Walker stated that she had felt depressed but that she now had no feelings and her husband stated that she had been crying a week ago, but that this had stopped. Patients with depressive disorder sometimes state that they are too sad to cry. Such statements are taken as an indication of worsening or progression toward the more severe end of the depression spectrum. It is not uncommon to hear people who do not have a depressive disorder, but who are in distress, sometimes following the death of a loved one, say that they can't cry, but they wish they could because then they would feel better. Probably, this group wants to cry because this is a means of releasing tension, which is different from passing through a tearful stage as pathological depression deepens.

Constipation is not mentioned in the DSM-IV diagnostic system, but is, nevertheless, a marker of severe depression. Large parts of the nervous system are under active, and it is believed that coordinated movements of the bowel are decreased. Unfortunately, most antidepressant medications also cause constipation, which reduces the value of this symptom in diagnostic process or as a marker of clinical change.

Mrs. Walker stated that she was already dead. It is difficult to believe that a person who is talking to you, believes that he or she is dead. This is an example of a nihilistic delusion. These are delusions that part of the individual, the entire individual or other parts of the world are dead or do not exist. They can occur with a range of psychotic disorders, but they occur most commonly in severe depressive disorder. Psychotic features lead to the designation of psychotic depression.

Mrs. Walker had severe/psychotic depressive disorder. She had no appetite and was eating and drinking little. She was psychotic, believing she was already dead. She was at risk of self injury or suicide. She had a long history of depressive disorder. In the past, when she deteriorated to this state, antidepressant medication had not been sufficient to produce a remission, and she had always required ECT. On this occasion, Mrs. Walker was admitted to hospital and observed. She was commenced on the latest antidepressant medication, more in hope than conviction, and booked for ECT three days later. Happily, the new antidepressant was more effective than the old. She made good progress and did not require ECT. She left hospital three weeks later, and continued to take the new medication.

Depressive disorder is a major health problem and is not well understood. It is probably a group of related disorders which have yet to be disentangled. A biological basis has been proven. Social, cultural and psychological factors are also important. We do not yet have an objective test, and rely on clinical assessment in the diagnostic process. Current therapies are of some use, but advances in this field are eagerly awaited. As with many other psychiatric disorders, we have made a good start, but the end is not yet in sight.

BIPOLAR DISORDER

Bipolar disorder is a disorder characterized by two phases, depressed and mood elevated (manic) phases. To make the diagnosis, there must be a history of at least one manic phase. Untreated, these phases usually last months. For any given patient, swings in mood may occur about equally in both directions or predominantly in one direction. Alternatively, or both moods may even co-exist (Illustration 7.2).

The depressive phases of bipolar disorder are exactly those described under the heading of Depression.

The central feature of mania is a persistently elevated, expansive or irritable mood (Illustration 7.3). To satisfy the diagnostic criteria for a manic episode set by the Statistical Manual, fourth edition (DSM-IV), at least three of the following symptoms must also be present:

Polluted

My mind needs an enema.

Something clean to soothe the area

A bath or a shower at least

I'm dirty mentally and

I go rotten daily.

My emotions need airing.

I belong in the dirty linen trolley.

Lust

I want to get in a car and

Drive until the world caves in.

I want to be arrested for being alive.

I want to drink tequila for morning tea and

Wear nothing but purple.

I want a fabulous love affair

With no restrictions and

Ice cream that isn't fattening.

I want a best friend for every day of the year

And a house with windows in every wall.

I want a world without cigarette butts and garlic breath

And a street where people dance on a whim.

I want to understand one thing

Why socks go missing and knickers never do.

Illustration 7.2 This is a poem by a young poet who had suffered from bipolar disorder. "Polluted" describes a depressive phase. She is not saying so much that she feels sad but that she is dirty and ends by saying that she belongs in a dirty linen trolley. This is an expression of the low self-esteem that often accompanies severe depression. With further lowering of self-esteem one can understand how delusions of guilt might develop.

The poem, Lust, was written during a period of mild mood elevation. There is no flight of ideas with rhyming and disorganized thought. There is playfulness and great lust for life. One can understand how such mood would be pleasant and the temptation to resist treatment and "handle it" would be great.



Illustration 7.3. Image of painting by a manic woman. This picture was painted by a woman with mania. There are bright colors, bold dramatic style and many symbols including a jack-in-a-box, musical notes, a question mark and the symbol for pound Sterling. This is a happy painting. Compare with with Illustration 7.1. Courtesy of the Cunningham Dax Collection.



Illustration 7.4 This item was made by a reserved young geologist during an acute manic episode. She had been admitted to hospital but slipped away and went into a bank – where she was not a customer and was not known.

The source of the toy bears remains a mystery. She made this construction at a customer desk in the bank. She asked tellers for materials as she required them. She first asked for scissors and cut cardboard promotional material to form the components of the sign post. She asked for colored paper from which she cut the letters. She then asked for the use of a stapler and glue to complete the work. The “Hil” was composed of three layers of ever smaller letters, first pink, then white and finally very small black letters.

On completion this construction was carried by the patient as a greeting placard along the city streets to the hospital where she made a gift of it to her treating doctor. For this normally demure young person, carrying this object in this manner in public constituted disinhibited behavior.

- inflated self esteem or grandiosity
- decreased need for sleep
- more talkative than usual, difficult to stop
- flight of ideas or the experience that thoughts are racing
- distractible, attention easily drawn to irrelevant stimuli
- increased activity
- excessive involvement in pleasurable activities that have a high potential for painful consequences, such as sexual indiscretions and foolish business investments (Illustration 7.4).

Common sense suggests that from mood elevation, many of the other features of mania would naturally flow. After all, when we are feeling good, for any reason, we are more confident, more energetic, talk more and sleep less. Common sense might also suggest that the underpinning of mania is over activity of some region of the brain - there is evidence which supports but does not yet prove this to be the case. People in a manic phase often feel very well and want to be allowed to get on with their plans to make money, find the cure for cancer or give away valuable belongings. There is frequently flight of ideas, thus there is disorganization of thought and action, and in reality, positive results are not achieved. There may be frank delusions about abilities, often the patient believes he or she is held in high regard by high status or potent groups, such as the Royal Family, the CIA or the scientific community.

Feeling well and ebullient, usually, the last thing that patients with mania will accept is that they are unwell. Thus, there is lack of insight and naturally, these patients can be very uncooperative. This is particularly the case in the early years. As attacks tick by, many patients learn to accept the advice of trusted health professionals, even though it doesn't feel right.

Bipolar disorder occurs in around 1% of the population, equally commonly in men and women. About 12% of the young people who suffer recurrent depressive disorder will in time develop bipolar disorder. This is a recurrent disorder, 90% of those who suffer a first manic episode will suffer subsequent episodes. Episodes usually become more frequent with age. About 25% of patients continue to suffer troublesome symptoms between full episodes. The popular view is that in contrast to schizophrenia, bipolar disorder has a good prognosis, but this is by no means always the case. Bipolar disorder can be unresponsive, frequently relapsing, and disability may persist between acute episodes.

As with depressive disorder, about 15% of people with bipolar disorder die by suicide. There is proven genetic vulnerability and social stressors may play a role in triggering manic and depressive episodes, particularly in the early years. There is good evidence that sleep loss may trigger manic episodes. Work deadlines, for example, may trigger manic episodes, perhaps by increasing stress and disturbing sleep.

As manic patients often lack insight, are over active and frequently disorganized, this is a difficult population to study, at least with respect to brain imaging studies. As mentioned, there is some evidence that parts of the brain are over active during acute manic phases. During depressive phases, activity is reduced in some areas, in a manner similar to, but not exactly the same as, depressive disorder. Small structural abnormalities have been demonstrated.

Recently, a new imaging technology has been developed. Magnetic resonance spectroscopy (MRS) looks at neither the structure nor the function, but at the chemical components of organs. Evidence from MRS suggests that, in bipolar disorder, the chemical composition of various brain structures may be abnormal.

Manic episodes are treated by a range of medications aimed at returning the mood to normal levels, reducing activity and enabling sleep. Acute depressive episodes are managed as for depressive disorder, predominantly with drugs which increase the availability in synapses of the neurotransmitters serotonin and noradrenalin. Both manic and depressive phases may be treated with ECT, when other methods fail. Bipolar disorder is unique in psychiatry, it is the only condition for which we have prophylactic or preventative medication. Lithium carbonate and some of the antiepileptic medications have a prophylactic role. It is believed they stabilize nerve cell membranes so that they do not fire, or conduct impulses, so easily.

Bipolar disorder is characterized by phases of mood depression and mood elevation. The depressive episodes are similar to those of depressive disorder. The manic episodes are periods of over confidence and

activity, decreased need for sleep, poor judgement and risk taking. For people other than the patient, these episodes are often a great inconvenience, for the patient they are often physically, financially and socially damaging periods.

CASE DRAMATIZATION

Susan Logan was 47 years of age and the non-identical twin of Jessica Walker. She was currently single, having been married twice. She had four children; the elder two had left home, the younger two lived with their father. There were three grandchildren. Susan had trained as a florist three decades ago. She had a long history of mental illness and had only been able to find a job in a flower shop a few months ago.

The shop bought stock directly from growers so they opened at 7 am to accept deliveries and prepare product for sale. Susan was usually waiting on the doorstep from 6 am. The owners had talked between themselves about giving Susan a key, to save her waiting in the cold. In view of her history of admissions to psychiatric hospital, they decided, for their own protection, not to give her one, just yet.

“And besides, she doesn’t have to get here that early,” said the wife.

“At least she’s keen,” replied her husband.

“I’m fine,” said Susan. “I can go window-shopping, and not spend any money.”

They liked this odd character. Her clothes were bright and clashed and sometimes she wore lipstick that was too red, but she was cheerful and smiled at everybody. She talked loud and a lot, but she knew flowers.

“Now, Sir, how can I help you? My word, that’s a lovely tie. What did you have in mind? For a lady, was it?”

“No. I mean yes, it’s for my mother. She’s in hospital.”

“Oh, dear. That’s a shame. I am sorry. Some flowers will cheer her up, though. Not allergic, Sir, I hope, though? I’d like tulips, if I was in hospital. What do you think of these, Sir?”

She never sold anything white; never ‘Alba’ magnolias or ‘Polar Bear’ rhododendrons. She sold all the bright yellow tulips and red dahlias they could get.

Susan started getting higher. Every person who gets manic, every relative of a person who gets manic and every doctor who treats people who get manic, knows what getting higher means. Sadly, at the time, many patients don’t recognize the early warning signs. Of those who do recognize what is happening, many think they can “handle it”. This is not surprising, as one of the symptoms is heightened confidence. It has been likened to being drunk on your own brain chemicals. With experience and consequences as our teachers, most of us learn to handle alcohol; some don’t. Making judgement more difficult for people with bipolar disorder is that the high of mania may exceed the happiness of alcohol and the rush of other drugs.

Susan had too much energy. While the owners were at the bank, she decided to sweep the floor of the shop. It had been swept the night before, but there were some leaves on the floor and she thought they would sell more flowers if she smartened the place up. Between customers, she moved a few pots from one side of the shop to the other and swept behind them. But it was difficult and cramped. She started putting pots outside, along the window. She needed more space so she put some along the edge of the footpath as well. It was lovely, it made a very pretty pathway for people to walk through.

“You’re obstructing the footpath, madam,” said a grumpy Police officer. “You’ll have to put this stuff back inside.”

“Oh, Good morning Officer. Yes, of course. Here,” she said, swirling some paper around a large bunch of red tulips. “Please, take these for your wife.”

The tired, seen-it-all-before police officer was startled.

“I’m not...Look, get this stuff inside. That’s all.”

“Well you should be,” scolded Susan, “You’re a very attractive man.”

The hadn’t-quite-seen-it-all-before police officer made a hurried escape. Susan held the sides of her head. She knew that was going “too far”. She knew she was on the edge. She knew she had to come down. She went to her purse and took some medicine.

“You’ve got to help me!” she told her doctor a few days later. “I’ve got to keep this job. It’s the first job I’ve had longer than a week for twenty years. What’s wrong with you fucking psychiatrists? Why can’t you help people who come to you for help? I’m sorry, I didn’t mean that. You see I just can’t...I just go from feeling fine, well, sometimes I feel terrific, and the next minute I feel sad or crabby. I’m going to slap a customer. Or scream at the boss. I feel like laughing and crying at the same time. I’m on a roller coaster. You’ve got to help me. Don’t worry, I’ll be OK. No I won’t!”

Not all mania is elation and confidence. There can be a lot of irritability, wild fluctuations from one extreme to the other and a nasty, simultaneous mixture of happiness and sadness. If not present at the start, irritability and distress often appear later in the course of an episode. Mania is unpleasant for others, but it can also be a very unpleasant experience for the patient.

In developing countries there are two types of patients in psychiatric hospitals: those who suffer paranoid delusions and those who suffer mania. The paranoid individuals publicly accuse and from time to time attack their incorrectly identified accusers, while the manic individuals keep the village awake all night, disorganize events and exceed their authority. The common point is that paranoid and manic people can be a public nuisance. It is often the common good, or common convenience, rather than concern for the well being of the sufferer, which leads to hospitalization. In well resourced, developed countries, patients with depression (major and other types) fill a substantial proportion of psychiatric ward beds. Not so in developing countries; individuals with major depression cause few problems. From time to time they hang themselves, but most of the time they sit quietly by themselves, and suffer in silence. Depressive disorder and mania are, in many ways opposites, different sides of the same coin. Over activity is much more socially disruptive than under activity, and the social consequences for people with mania are more severe.

Jessica Walker suffered major depression. In spite of a long history she was still married to her first husband and she had been able to keep her job at the local school. In contrast, Susan Logan, her non-identical twin, suffered bipolar disorder and was twice divorced and had been unemployed for many years. She was not caring for her younger children. There are many factors which contribute to divorce and unemployment, but these social disruptions are particularly common among people with mania; their condition may lead to them being extruded from society.

Susan had been prescribed lithium carbonate as a treatment for her mania, a number of times in the past. She had commenced, but had always discontinued within a few weeks. This time she continued. Her thyroid stopped working, a not uncommon side-effect. Instead of ceasing the lithium carbonate, she accepted the recommendation to commence on thyroid hormone replacement. It was a bother taking tablets, she hated “being dependent” on medication, but she gained good control of her mood. Her relationship with the grumpy Police officer flowered.

The mood disorders are common, serious disorders which cause great suffering and disability and may end in suicide. Genetic vulnerability, distressing early life events and current stress are important factors. The available treatments are generally effective, but far from perfect. Mania may cause social disruption and disharmony, but it is unique among psychiatric disorders, as prophylactic treatment (lithium carbonate and some anti-epileptic medications) is available.

CHAPTER 8

COMPULSORY ADMISSION AND TREATMENT

Some healthy people are uneasy when talking to a psychiatrist. It is as if they are afraid that the psychiatrist might suddenly and inexplicably go crazy him or herself, and lock them up in a cruel place, with no avenue for appeal, forcing them to live among frightening, dangerous mad people for the rest of their lives. Central to such a notion would have to be that psychiatrists are at best ignorant and at worst sadistic, and that they possess unbridled legal powers. Nobody could be so irrational, or could they?

Some people are concerned about the legal power of psychiatrists to admit patients to hospital and treat them without their consent. Others are concerned that psychiatrists irresponsibly release dangerous, mad people from hospital, who then attack members of the public. Thus the public simultaneously holds two opposing views - that patients should have the right to refuse treatment, that patients have the right to receive treatment. Rather than wielding unbridled power, the psychiatrist is frequently pinned powerlessly between opposing responsibilities.

Compulsory admission and treatment is a complex area, a web of many questions and opposing views. This chapter presents the general principles.

Some of the practical details of the laws dealing with compulsory hospital admission and treatment differ slightly from one jurisdiction to the next, but the principles are generally similar. The laws of many jurisdictions have recently been modified to bring them into strict alignment with the document, Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, which was adopted by the United Nations in 1991.

In all jurisdictions there are laws which empower psychiatrists to admit patients to hospital and treat them, without their consent. However, these legal powers are strictly limited and supervised.

The fundamental human right to autonomy, that is, the right of the individual to make decisions about where and how to live and what actions or treatment to accept from others, is respected and in all mental health legislation. However, there are other matters which may need to be taken into account, including the need to protect the patient from the consequences of mental disorder, and to protect others from the patient.

Laws allow individuals to be admitted to hospital and treated without their consent only when that individual is suffering a mental disorder and as a consequence of that disorder, represents a danger to him or herself or others. Many parts of this statement have precise meaning, all of which have been debated in court. In some jurisdictions the word danger is replaced by the phrase, risk to health. The terms danger and risk to health can be interpreted differently, in some jurisdictions they mean immediate risk to life and in others they are interpreted more liberally and may be taken to mean simply that the existing mental disorder will worsen.

What is meant by “mental disorder”? This differs from one jurisdiction to another. Universally, the major psychoses such as schizophrenia, are included. In all jurisdictions eccentricity, ethnicity and the holding minority political views are expressly excluded. In the vast majority of jurisdictions personality disorder has also been expressly excluded, but this is a complex issue, and we will need to return to the current debate.

It is commonly stated that the mental disorder must be of a nature or degree which makes it appropriate for the individual to receive treatment in a hospital. This appears at first to be simple repetition, as if the patient is a danger to self or others, that degree of mental disorder must be serious and treatment could be justified. But important aspect here is the mention of treatment. The main purpose of this process is to provide treatment to the patient. But what if there is no effective treatment? This is another issue to which we will return.

For the purpose of this chapter, mental disorder can mean a psychotic disorder in which there is impairment of the ability to think (in earlier chapters, called disorder of the form of thought) and beliefs which are clearly wrong and held in spite of abundant evidence to the contrary (earlier called disorder of the content of thought).

The law tolerates behaviour which is irrational or socially deviant. It tolerates self-destructive behaviour, where this is not driven by mental disorder, and suicide is no longer illegal. In particular, homosexuality and political affiliation are not grounds for the diagnosis of mental disorder.

There is no doubt that hospitalization has been a means of dealing with political dissidents in the USSR and elsewhere, and Hollywood sometimes portrays compulsory hospitalization as a means of disposing of unwanted spouses or obtaining money from eccentric aunts or uncles. However, such use of compulsory hospitalization is illegal, and if it does occur, which I doubt, it must be extremely rare in western countries.

The law which allows involuntary admission also allows involuntary treatment, but strongly limited treatment. The only treatment that is legally allowed, is the standard treatment for the mental disorder which led to hospitalisation.

Mental health law can not be used to sanction the treatment of other conditions. When considering other conditions, a breast cancer for example, generally speaking, the autonomy of the individual is respected, and the patient has the right to refuse treatment. The fact that the treatment is considered by others to be in the best interest of the patient is not sufficient.

The mental health laws state that a patient may be suffering from a mental disorder to the extent of representing a danger to themselves or others, but still capable of making informed decisions in other aspects of their lives.

However, that may not be the end of the matter. If the mental disorder renders the patient unable to fully understand the nature of the second condition and the consequences of not treating the second condition, it is considered that the patient is not competent to refuse treatment. Under these rare circumstances it is possible to legally treat a patient without their consent, for a condition other than their existing mental disorder. An example is a woman with a malignant breast lump who is hospitalised with hallucinations and delusions. If the hallucinations are of the police telling her to dye her hair and the delusion is that she is the reincarnation of Lady Diana, but she has a clear understanding of the medical opinion regarding the nature and consequences of not treating her breast lump, her desire for no treatment will be respected. On the other hand, if the lady hears voices telling her she is to be the mother of a new species and her delusion is that semen came from outer space to and the lump in her breast, which is a womb in which they are growing, and she is unable to understand the medical explanation of her lump, she would probably be treated against her will for both her mental disorder, and her breast lump.

This situation does occur from time to time in general hospitals. It calls for a special psychiatric examination to determine whether the patient is capable of making an informed decision. Only when the patient is clearly not competent to refuse treatment, is such involuntary treatment performed. In so doing, the intention is to protect patients against the effects of their mental disorder and to exercise the principle that the patient has a right to treatment.

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The question of whether patients can be force fed illustrates these issues. Individuals may refuse food for various reasons: 1) the political prisoner on a hunger strike for political purposes, 2) the patient with anorexia nervosa, a mental disorder in which there is the relentless pursuance of thinness, and 3) the psychotic individual who has the delusion that all food is poisoned and who is hearing God's voice instructing him or her not to eat or drink. The outcome of court hearings depends on the details of local laws and the details of the particular cases, however, the following are possible outcomes.

The individual who is refusing food for political purposes does not have a mental disorder and therefore cannot be involuntarily admitted to a hospital. This individual is fully aware of the nature of his/her behaviour and the consequences of not eating. Ordinarily, such an individual would not be force fed.

The patient suffering anorexia nervosa has a mental disorder and is a danger to him or herself. This indicates that admission to hospital without consent would be legally possible. However, the patient understands the potential consequences of not eating, and this raises the possibility that force feeding may not be legal. Nevertheless, in the cases which have reached court, force feeding has been allowed. It has been accepted that force feeding is a treatment of the anorexia nervosa, the mental disorder from which sprang the need for compulsory hospitalization and treatment.

The case of the psychotic individual who has abnormal form and content of thought and who is hearing God's voice instructing not to eat or drink, presents another set of issues. In this case compulsory admission to hospital could be legally achieved. But, it may not be possible to successfully argue that force feeding is an accepted treatment for the particular form of psychosis. However, with abnormal form and content of thought and evidence of what reasonable people would consider to be hallucinations, the case could be made, and would probably succeed, that the patient was not competent to make the decision to refuse treatment. Accordingly, it would probably be legal to force feed this individual.

To this point we have considered patients who have a mental disorder who represent a danger to themselves. Patients can also be admitted to hospital and treated without their consent, when they represent a danger to others.

Society has the expectation that psychiatrists will protect the public from those with mental disorders. In tandem with the rise in the rights of the individual to freedom, which has occurred around the world, there has been an increase in the expectation that the public should be protected from people with mental disorder. Obviously, if the rights of one group (the public) are to be increased, the rights of the other group (those with mental disorders) will be further infringed.

Many psychiatrists are uncomfortable with the role of the public protector, seeing themselves as healers of the sick rather than bodyguards of the healthy. They refuse to be, as they have been unjustifiably designated in the past, agents of social control. Nevertheless, psychiatrists to some extent, perform some public safety role.

Psychiatrists also point out that the prediction of violence is difficult and that prediction with certainty is impossible. It is like predicting the weather, it is relatively easy in the very short term, but much more difficult in the long term. If a person is red faced, pacing, punching walls, shouting, invading the personal space of others and verbally expressing the intention to injure or kill, violence in the near future may be predicted with some degree of certainty. But predicting events in the future is far more problematic – after all, circumstances can drastically change by chance – one could win a fortune or have one's spouse struck and killed by a police car – the life trajectory of even the most stable individual can take surprising turns, triggering both predictable and unpredictable responses.

The mental health laws are particularly difficult to interpret in the case of psychopathic and other types of personality disorder. The central feature of psychopathic personality disorder is disregard for and violation of the rights of others. Some authorities have argued that the psychopathic personality disorder represents a delay in the development of the conscience, in the way that others may have delayed development of intellectual abilities. There is a failure to conform to accepted social norms and illegal behaviour and imprisonment are common features. There may be deceitfulness, impulsivity, irritability and irresponsibility.

Frequently, there is predatory and exploitative behaviour, and lack of remorse. People with psychopathic personality disorder are not psychotic, they are aware of their actions and the potential consequences, and are competent to make decisions.

Many psychiatrists argue that psychopathic personality disorder is not a true psychiatric disorder, but simply socially unacceptable behaviour. They caution against the medicalisation of criminal activity. However, psychopathic personality disorder has been described in psychiatric textbooks (in various guises) for a hundred years and it is currently listed in the two main diagnostic systems, the Diagnostic and Statistical Manual and the International Classification of Disease. Therefore, by convention at least, psychopathic personality disorder is an established mental disorder.

There is no doubt that people with a psychopathic personality disorder frequently represent a danger to others. Sexual predators, serial killers, and most career criminals, satisfy the diagnostic criteria for psychopathic personality disorder.

Thus, the two main planks for compulsory hospital admission, that an individual has a mental disorder and represents a danger either to self or others, appear to be satisfied. This would mean that the management of individuals with psychopathic personality disorder is the responsibility of the mental health system rather than the justice system.

The vast majority of psychiatrists will not accept responsibility for the management of psychopathic people. This resistance has many facets, one being that while theoretically a psychiatric diagnosis, it is unlike other mental disorders (as mentioned, there is a clear understanding of the nature and consequences of actions) and is better classified as a problem of illegal or maladaptive behaviour.

However, the strongest argument against the compulsory hospitalization of people with psychopathic personality disorder under mental health law, is not that this is not a mental disorder. Rather, it is because there is no effective treatment. As the reason for compulsory hospitalisation is the cure or alleviation of the existing mental disorder, if there is no treatment, there is no justification for admission for psychiatric care.

The doubt about the status of psychopathic personality disorder as a true mental disorder and the absence of effective treatment places this "condition" in a special category. The refusal of psychiatrists to be involved in the management of people with psychopathic personality is not universal, however, and the regulations touching on this issue vary from one jurisdiction to another.

There has been much recent heated discussion about placing people with psychopathic personality disorder who have been identified as dangerous in psychiatric hospital for long periods, for the protection of the general public.

A summary of the standard view of psychiatrists is that, 1) if individuals are aware of the nature and consequences of their actions they should receive any legal consequences, 2) there is no point placing people in psychiatric hospital if there is no treatment for their condition.

Those who favour placing people psychopathic personality disorder who are considered dangerous to others in psychiatric hospital make three counter points, 1) that people who have not committed an unpunished crime cannot be placed in goal, 2) in other fields, doctors do not turn away from people just because they have no effective treatments (for example, in terminal illnesses doctors do their best to help), and 3) in other fields, doctors do not turn away from people for who do not have a disease (for example, obesity is not a disease, but doctors attempt to provide assistance,

The rejoinder to the third point is that colour blindness and dyslexia are reported in medical textbooks, but medicine does not take responsibility for them. If a child is found to have dyslexia the education department is required to provide special teaching, if an employee is found to be colour blind the employer is required to provide duties which will not place the employee or others at risk.

The United States of America is an example to the rest of the world regarding the freedom and rights of the individual. It was unexpected, therefore, when in 1997 the US Supreme Court ruled that states have the legal right to confine potentially dangerous sex offenders who do not have a psychiatric diagnosis

other than personality disorder in psychiatric hospitals. The case was *Kansas v. Hendricks*. Over the subsequent four years 16 states introduced similar legislation. The *New York Times* stated that in January 2002 there were there were 1, 200 sex offenders being held in psychiatric hospitals under these new laws.

In the 2002 case of *Kansas v. Crane*, Michael Crane was about to complete his four-year term in prison for sexually assaulting a shop worker. He had 18 previous arrests, some of which included sexual assault. Shortly before the end of his term he was diagnosed with exhibitionism and psychopathic personality disorder. This information was presented at a state initiated civil commitment procedure. A jury agreed that Crane was a sexually violent predator and should be confined to a state psychiatric hospital. The US Supreme Court later supported this finding.

The American Psychiatric Association strongly opposes the use of psychiatric hospitals to hold psychopathic people believed to be a danger to the public who have not treatable disorder. Nevertheless, at the time of writing, Michael Crane remains confined in one.

Britain is also famous for its justice system. However, similar moves are also underway on this side of the Atlantic. There have been two drafts of a new mental health bill. In June 2002 the Minister for Health Jacqui Smith stated, "The bill introduces a single definition of mental disorder. This means that personality disordered people will no longer be excluded from compulsory treatment on the grounds that they are untreatable, provided they meet the criteria for compulsion. This will ensure better treatment for dangerous mentally disordered patients and better protection for the public."

The Mental Health Alliance, a group of over 50 voluntary organizations, and the Royal College of Psychiatrists have expressed the view that the draft bill is deeply flawed and unethical. But there seems little doubt that Britain will soon have laws like those in the USA in which people who are responsible for their actions and for whom there is no treatment will be locked in psychiatric hospitals because one or more "experts" believes them to be dangerous.

As mentioned, even the experts are unable to predict violence with certainty. Alec Buchanan and Morven Leese (2001) recently scientifically examined the evidence and concluded that, due to the uncertainty of prediction, six people would have to be detained to prevent one violent act. This is very sobering, given that one of the bulwarks of British justice is that it is better for a ten guilty men to escape than one innocent man be punished.

The management of people with personality disorder who are considered to be dangerous continues to present a challenge to societies around the world.

CASE DRAMATIZATION

The large majority of career criminals satisfy the diagnostic criteria for psychopathic personality disorder. In the case of many, the diagnosis can be made with reasonable confidence even without a benefit of a psychiatric interview, the list of their illegal activities usually gives sufficient evidence. This is particularly the case with violent criminals.

Alphonso Capone was born in Naples in 1898. He went to New York where he was a well established gangster before he turned 20 years of age. At 22 years he went to Chicago and during the Prohibition years he was the head of a gang which controlled gambling, vice and illegal alcohol. He was responsible for many brutal murders but was able to avoid arrest by bribing and intimidating the police. He was eventually convicted on charges of tax evasion. He was released from prison because he was suffering from chronic syphilis and died at 49 years of age, in 1947.

There is evidence to indicate that Al Capone was dangerous, that he disregarded and violated the rights of others, that he repeatedly performed acts which were grounds for arrest, that he was deceitful, aggressive and remorseless. Capone had others do most of the "wet work" (killing) on his behalf. It is unclear



Illustration 8.1 Victor Lustig in his heyday. He was a confidence trickster who was arrested 48 times for deception and related offences, but convicted only once. He even tricked Al Capone out of money. He was a man who had a disregard for the rights of others and lived a non-violent predatory life.

Recently, attempts have been made to keep sexual predators in custody indefinitely, for the protection of others. When people have not been convicted, or have completed their sentences, they have no place in a prison. When people do not have a treatable mental disorder they have no place in a hospital. Nevertheless, in the USA, such people are being consigned to hospitals. Similar arrangements are being considered for the UK. It is unlikely that non-violent confidence tricksters will be included in the target group.

whether the plans for the long term custody of dangerous people with psychopathic disorder include those people who direct others to perform brutal acts, or only those who do the brutal acts themselves.

There are also charming, non-violent persons with psychopathic personality disorder. Such individuals represent a danger to social and financial lives of others.

Victor Lustig was born in 1890, the son of the Mayor of Hostinne in Bohemia. He was educated locally but then sent to Paris to complete his education. He soon began to masquerade as a 'Count' and lived by gambling. After the first world war he moved to the USA (Illustration 8.1).

In Kansas, wearing a monocle and claiming to have recently sold his family heirlooms he cashed in two stacks of government bonds for \$50 000. Later, when the bonds were counted it was found that they were two stacks of paper with a government bond on the top and bottom of each. He was apprehended by a private detective but persuaded the duped banker that his reputation would be destroyed if the story came out. The furious banker agreed not only to drop the charges, but to pay Lustig \$1000 for distress and inconvenience.

After a racecourse swindle he moved to Paris. He read that the French Government was thinking of scrapping the Eiffel Tower due to the high maintenance costs. He posed as Deputy Director of the Ministère des Postes et des Télégraphes and forged letters to five scrap metal dealers. He selected as dupe, a man who obviously desired social acceptance. This man became suspicious, however, so Lustig demanded a huge bribe, which convinced the dupe that the deal was genuine. Lustig took the bribe and left France.

In Miami he told a young actress that he was a successful Broadway producer and she accompanied him to parties. He let it be known that he was preparing a new musical. A millionaire who dreamed of becoming the toast of Broadway gave Lustig \$34 000 backing, and never saw him again.

In California Lustig convinced a millionaire who was having business difficulties that he had a box which printed \$100 bills. The Count sold the box for \$25 000 and when the purchaser discovered he had been tricked he was unable to go to the police.

Here, the current and the above case interlock. Lustig set out to sting Al Capone. Lustig had himself introduced to Capone in Chicago. He told Capone he planned a Wall Street scam, saying that he would double everyone's money in 50 days. Capone gave him \$50 000 and told him to double it in 60 days or he would be dead. It was the challenge that led Lustig to approach Capone, in fact, he had no Wall Street plan. Lustig disappeared and returned in 60 days. When he was summoned to Capone, he hung his head and apologized and said his plan had not worked. Capone was furious, thinking that his money had been lost.

Lustig then, unexpectedly, handed over Capone's money. It was all there. Capone was pleased and thinking Lustig was down on his luck, gave him \$5 000 to help him get back on his feet.

That was the high point of Lustig's career. He had been arrested 47 times but he had always escaped conviction because his victims had been too ashamed to testify against him. He was arrested for counterfeiting in 1935 and sent to Alcatraz, where Capone was also incarcerated. He died in jail 11 years later, at the age of 57.

Again, there can be no doubt that Lustig disregarded and violated the rights of others. He was deceitful, irresponsible and lacked remorse. He satisfied the diagnostic criteria of psychopathic personality disorder, but he was different from Capone, as he was never involved in violence. There can be no doubt that this man represented a danger to the social and financial lives of others. It is unclear whether the plans for the long term custody of dangerous people with psychopathic disorder in psychiatric hospitals include such non-violent individuals.

THE REVIEW PROCESS

Compulsory hospitalization and treatment is subject to close scrutiny. There is a host of bodies willing to examine complaints against individual doctors. Every state or region has a medical registration council. This body is willing to hear complaints and when serious and substantiated, and will de-register or strike the doctor off the register, making it illegal for him or her to practice medicine (Illustration 8.2). Every hospital and state health department has an ethics committee which is willing to hear complaints. All specialist medical groups such as the surgeons, pathologists or psychiatrists have national colleges which confer specialist qualifications, and these colleges are willing to hear complaints. The courts of law are willing to hear criminal charges brought by the police and civil charges brought by civilians. In addition, each geographical region has a Health Ombudsman or Health Complaints Commissioner who is employed by the state to pursue complaints against doctors. The duties of these officers include establishing a high public profile and producing easy to follow instruction brochures so that lack of knowledge or inconvenience cannot prevent the lodging of complaints. Arrangements have now passed beyond the clearing away of obstructions to the active encouragement of complaints, as articulated by Robert Hughes in "The Culture of Complaint".

Doctor struck off for sex with patient

Illustration 8.2. This headline appeared in *The Weekend Australian* in December, 2001. Similar articles frequently appear in major newspapers around the world. This was a typical story. A female patient consulted a male doctor on a professional matter and a sexual relationship developed which lasted for a few months. The New South Wales Medical Tribunal considered that the doctor had abused his position of power and influence over the patient and that the affair had a deleterious effect on the patient's health and well-being. The Tribunal decided that to protect the community, maintain standards and keep the public's confidence in the profession, the doctor should be struck off the register. To be struck off means to be de-registered and unable to earn a living by practicing medicine.

If a patient has a grievance and makes a complaint against a doctor to the registering authority, that body is obligated to investigate and take appropriate action. De-registration is a possible outcome. Doctors are also exposed to criminal and civil action, and a host of complaints procedures and ethics committees, depending on local arrangements.

Pecuniary interests and the pursuit of publicity are frequently more important than the pursuit of justice in some proceedings. If one's livelihood and self view depends on the hearing of complaints, it is natural, but not natural justice, that one will ferret out every possible complaint.

All branches of medicine, not just psychiatry, are being battered by legal action. It is an excellent way to make a quick buck. The modern aphorism, "shit happens," (meaning accidents happen and sometimes no one is to blame) applies to every endeavor, except medicine. This is not to argue that patient's rights should not be at forefront of social and legal agendas, but that there should still be room for common sense. As a consequence of frequency of legal actions against doctors, insurance premiums in some fields are so high that doctors can no longer take the risks and are leaving those fields. The clearest example is obstetrics. In some locations which were once well supplied with obstetricians, there is now not a single one in practice. There are two alternatives, either all these obstetricians were negligent or incompetent and it is a good thing for public health that they have left the field, or the methods of complaint have been unbridled and the findings of "investigated" complaints have been unreasonable.

The mental health laws which deal with compulsory hospitalization and treatment provides at least two additional avenues of appeal or review. First, there is an independent review body which must be notified of all compulsory admissions, all leave given while on legal orders, all information withheld from patients and sundry other events. This body arranges for automatic reviews of all cases of compulsory hospitalization, within a set time. The organ of review is usually a Tribunal (at least three members) which reports back to the organizing body. Patients can apply to this body to have their case reviewed without delay. Second, there is another body, independent of the Tribunal which known by various names, but most commonly, Official Visitors.

The powers of these bodies are vague and vary from one jurisdiction to another. One advertisement for members of a Mental Health Review Tribunal gives the duties as "review the situation of persons with a mental illness within the framework of the Mental Health Act, and cognate legislation, and make appropriate determinations and recommendations" (Illustration 8.3). An advertisement for Official Visitors gives the duties as "...inspect approved hospitals...Assess the adequacy of the facilities and standards of care available to people with mental illnesses. Respond to referrals as allocated, and investigate any complaints and/or suspected breaches of the Mental Health Act which may have occurred and to respond accordingly" (Illustration 8.4). Depending on the jurisdiction, both the Tribunal and the Official Visitors may discharge patients from hospital.

While these arrangements may protect some patients, they damage others, and they come at a high financial cost. It should be understood that the Principles for the Protection of Persons with Mental Illness and

NSW HEALTH
Better Health Good Health Care

MENTAL HEALTH REVIEW TRIBUNAL PART-TIME MEMBERS

Applications are invited for part-time appointment as a Member of the Mental Health Review Tribunal in the following categories: lawyer, psychiatrist and "other suitably qualified persons".

QUALIFICATIONS:
Lawyers must be admitted as a barrister or a solicitor of the Supreme Court of New South Wales. Psychiatrists must be Fellows of the Royal Australian and New Zealand College of Psychiatrists or equivalent. "Other suitably qualified or interested persons" should possess qualifications or experience rendering them suitable to be appointed as members of the Tribunal.

DUTIES:
To sit on Tribunal panels and review the situation of persons with a mental illness within the framework of the New South Wales Mental Health Act 1990, and cognate legislation, and make appropriate determinations and recommendations.

SESSIONAL RATE:
Lawyer and psychiatrist members: \$572 per day or \$285 per half day.
Members with other qualifications or experience: \$436 per day or \$217 per half day.

Illustration 8.3 Mental Health Review Tribunals are one of the many organs which watch over the care of people of people involuntarily admitted to hospital. They have vague duty statements such as "review the situation of persons with mental illness within the framework of the Mental Health Act, and cognate legislation, and make appropriate determinations and recommendations". The vagueness indicates the lack of a specific role.

The remuneration offered in this case is up to four times the average national wage.

the Improvement of Mental Health Care which was adopted by the United Nations in 1991 were designed to protect the rights of people in the USSR, Algeria and other repressive regimes, not the progressive western democracies where human dignity is respected and patient care is a matter of professional pride. The problem with establishing regulations is that while they drag up the quality of care in facilities with low standards, they drag down the quality of care in facilities with high standards.

The patients who are compulsorily admitted to hospitals have severe mental disorders. Most have difficulty with logical thinking and many have paranoid delusions. The various mental health acts dictate steps which clinicians must take, these include providing patients with printed information about the meaning of the act and the purpose of the automatic reviews and the structure and modus operandi of the Tribunal hearings. However, many very sick patients simply cannot understand and are frightened by either or both the printed information or the Tribunal hearings. Paranoid individuals may be made worse by these events, believing that they are being judged and even processed for execution rather than protected. It is not uncommon that patients require additional involuntary medication and involuntary confinement in secure quarters after Tribunal hearings.

These acts also demand a costly bureaucracy. There must be a salaried president and office staff to keep records and arrange hearings (which universally involve at least three paid members) and office space, telephone, computing and faxing facilities. One advertisement gives the daily sitting fees for Tribunal members with legal or medical qualifications as \$ Aus.572 per day, and for members without these qualifications, \$ Aus.436 – the larger amount being equivalent of four times the average national wage (Illustration 8.3).

Costs of another dimension occur at the ward. Clinical staff are required to fill out forms, fax forms to authorities, inform patients about the act and the hearings, record why potentially damaging material has been withheld, and attend lengthy hearings. All of this reduces the time clinical staff have for clinical work. Staff build trusting relationships with patients. With paranoid patients trusting relationships are built by avoiding the topic of whether or not staff "believe" the patient's delusions. At automatic, compulsory hearings, at which patients are present, staff members have to state and be questioned by the tribunal members on whether or not the patient is, in fact, deluded, thereby destroy fragile, valuable relationships. Automatic reviews of mental health orders reduce the clinical services which are available to patients and may destroy patient-staff relationships. This is a disservice rather than a service to patients.

In the typical advertisement for Tribunal members statements are made such as "The State Government is committed to ensuring that membership of statutory boards and committees reflect the broader community." As well as legally and medically qualified people they seek "other suitably qualified persons". The duties are vague and include making "appropriate determinations and recommendations". What are these Tribunals and Official Visitors really for? Are they to check out whether the appropriate forms have been

filled out and signed in the proper order? A single office assistant could perform that function and alert hospital officials to any oversights? Are they to check on the psychiatrist's diagnosis? The psychiatrist has made a diagnosis after assessing the patient and extensive discussion with nursing staff, friends and relatives. After reading the chapters on disorders of thought and perception, the reader will have some idea of the complexity of the psychiatric examination. These are only two of the many aspects of the psychiatric diagnostic process. Is the lawyer or other non-medical member of the Tribunal in a position to challenge the diagnosis of the psychiatrist?

Mental Health Review Tribunals and Official Visitors are expensive, damaging options. They have been erected to solve problems which do not exist in modern western psychiatry. They appear to be based on the notion that psychiatrists and psychiatric nurses must be watched or they will fake diagnoses and exploit sick patients. They are a nonsense which is tolerated because of post-modernist thinking that there are no experts and every body's opinion is as good as the next person. There needs to be a review mechanism so that people cannot be hospitalized and treated without consent with insufficient justification. Mental Health Review Tribunals and Official Visitors performs that function, but less expensive and damaging and more sensible alternatives are sorely needed.

Expression of Interest Official Visitors and Co-ordinator, Official Visitors

The Official Visitors Scheme is established under the Mental Health Act 1996, which is soon to be proclaimed. Expressions of interest are now being sought from persons interested in becoming Official Visitors and/or the Co-ordinator of the Official Visitors scheme in accordance with the Act.

Official Visitors are appointed by the Governor for a period of up to three (3) years. A person is not eligible to be appointed as an official visitor if they hold an office in the Department of Health and Human Services, if they have an interest in a contract with the Crown or a hospital that is an approved hospital under the Mental Health Act 1996, or they have a financial interest in an approved hospital.

Official Visitors

Key Functions

As a member of a panel, inspect approved hospitals (where people with mental illnesses may be involuntarily detained and treated) as requested by the co-ordinator of official visitors. Assess the adequacy of the facilities and standards of care available to people with mental illnesses. Respond to referrals as allocated, and investigate any complaints and/or suspected breaches of the Mental Health Act which may have occurred and to respond accordingly.

Remuneration

An hourly rate will be paid for visits to approved hospitals, plus travelling and other reasonable expenses. Payments will normally be made on a monthly basis.

Illustration 8.4 This is a newspaper advertisement for Official Visitors. This copy, the only one to hand, has been defaced by being underlined in a few places by an incredulous doctor (not the current author).

There were no essential qualifications for these Official Visitors. It was not essential for Official Visitors to have even a rudimentary knowledge of mental health issues. This is consistent with the notion that such bodies should be non-discriminatory and should reflect the general community. That sounds very fair and reasonable.

But how are members of the general public going to perform the "Key Functions"? How is a member of the general public going to access the "adequacy...of the standards of care"? By what criteria does a member of the general public "inspect" an approved hospital? Do they use the criteria that are used by professional hospital accreditation committees? If not, why not?

ECT is an aspect of care. Are the official visitors able to say what is not enough and too much ECT? Do they have an opinion on whether it should be applied unilaterally or bilaterally?

Opponents of the Official Visitors arrangements ask, if Official Visitors are appointed for psychiatric wards, why are they not also appointed to cardiac or orthopedic wards? The answer proffered answer is that only in psychiatric wards are patients involuntarily detained. Because patients are only involuntarily detained on the psychiatric wards. That may be so. But would Official Visitors be comfortable giving an opinion on the standard of care in the cardiac or orthopedic wards? If not, why not? Is psychiatry easier than cardiology and orthopedics? Apparently so. Apparently members of the general public are capable of assessing the standards of care of psychiatric wards.

Proponents of the official visitors movement explain, "Oh, no, we don't come to look at medical and nursing standards!" What standards do they come to inspect, then? If not to inspect medical and nursing standards, they can only be coming to make sure patients are not being treated inhumanely, to make sure they are being fed and not bashed or sexually exploited.

Psychiatric patients are cared for by nurses, doctors, social workers, psychologists, occupational therapists, all with professional training and codes of ethics. There are also receptionists, the people who bring and take away the mail and the meals, the people who fix the lights and the cleaners, not to mention patient support groups. If there was inhumane treatment it would soon get out and the police and registration bodies would soon be on the job. Official visitors are paid "an hourly rate...plus travelling and other reasonable expenses" to perform a nonsense job; better to pay an extra nurse who will do a useful job.

CASE DRAMATIZATIONS

The following vignettes represent 40% of a group of patients whose cases were automatically reviewed by a Mental Health Review Tribunal. They are taken directly from a letter which sought changes to a Mental Health Act.

Mr. LM. This man was calm and progressing well before he was advised that his case was to be reviewed by a Tribunal. He was given this information in a professional and sensitive manner. He became very paranoid and aggressive. He had to be overpowered and given medication by injection to return him to equanimity. This destructive outcome arose not because of the events at the hearing, but because this psychotic man could not understand that the hearing was to protect him. He found the prospect of a hearing to be a threat of attack/interrogation.

Ms ATL. When told of the Tribunal hearing, she packed her bags and insisted on leaving. She became irrational and could only focus on her rights and that staff were bound to respect her rights. She screamed and was physically aggressive to staff who tried to stop her. Staff had to lock the doors of the ward and finally, she was placed in the High Dependency Unit. This was a consequence of being given a document outlining patients' rights and the composition and method of operation of the Tribunal.

Ms SLM. When told about the impending Tribunal hearing, this patient felt very threatened and wanted a range of people to come to her protection. On her request a priest was called. She became distressed, angry and aggressive toward staff. She was given additional oral medication.

Ms MMcG. This patient was recovering well and taking clozapine. When she was given information about her order and that a Tribunal hearing would follow, she became preoccupied with her rights. She subsequently refused clozapine, deteriorated, and was given additional medication. Finally she had to be transferred from the psychiatric ward of a general hospital to the Maximum Security Ward of a Psychiatric Hospital.

Ms HC. This patient came before the Tribunal for a second time. The Tribunal heard from this insightful patient that she did not believe that she had schizophrenia. The Tribunal heard that the patient had been diagnosed as suffering from schizophrenia by three hospital psychiatrists and four registrars in psychiatry. In the presence of the patient the Tribunal asked whether a further opinion could be obtained and suggested the opinion of a general practitioner might be sought. This was a nonsensical suggestion which damaged the patient's view of the medical staff.

The patient was worried about confidentiality. She did want to reveal her thoughts to a non-clinical person. When asked about her beliefs by a Tribunal member she answered "Why should I tell you.? You are not my doctor", and steadfastly refused to give further information. She was subsequently excessively concerned that the Tribunal knew about her private life and thoughts.

Mr. SR. This paranoid man was extremely agitated at the prospect of appearing before the Tribunal. He was distressed and his psychosis was made worse by the hearing. (Dr P had to firmly state that he believed Mr. SR was a danger to others – a view which Mr. SR hotly denied.) After the hearing the patient required a large amount of medication which he would otherwise not have required.

Ms MC. This psychotic female was distressed by the events of the Tribunal Hearing. Her recovery and discharge were delayed by the process.

Ms IJ. In the High Dependency Unit, this young person was perplexed and immobile (as a result of catatonic schizophrenia). This was explained to the Tribunal and this is how she presented. After the interview a Tribunal member stated that "She doesn't look anything like you described." This was wrong, the patient presented exactly as she had been described. The problem was that the Tribunal member could not understand the description.

The patient was unable to understand the hearing and her condition immediately deteriorated. She had to be given additional medication and her recovery was delayed by the Tribunal hearing.

Ms EMT. This young paranoid person was up and showered and reasonably settled before the Tribunal hearing. The nursing report states that at the hearing the patient “totally lost control, paranoid, accusing, delusional, frustrated and angry, stating over and over again how she needed and must get out today. Could not sit still, sitting on the floor, pacing, charging around the room and crouching in the corner of the room sobbing.”

The patient’s condition deteriorated after she left the Tribunal hearing and she needed to be placed in the High Dependency unit and given additional sedation.

Buchanan A, Lesse M. Detention of people with dangerous severe personality disorders: a systematic review. *British Journal of Psychiatry* 2001, 358, 1955-1159.

CHAPTER 9

MADNESS IN COURT

The public gets angry when a criminal act has been performed and a defendant's lawyer raises the topic of mental disorder. There is a feeling that something unfair is happening, a bad person is cheating, a guilty person is avoiding punishment. The media, knowing what's good for business, provide comprehensive coverage, and feed the fire.

When John Hinckley shot President Ronald Reagan, but was found not guilty by reason of insanity (NGBRI), the public was outraged. The trial brought psychiatry and the laws that allow psychiatric opinion into the court to close scrutiny. "The psychiatrists spun sticky webs of pseudo-scientific jargon, and in these webs the concept of justice, like a moth, fluttered feebly and was trapped," wrote one commentator. The legal reaction included a new and tougher law governing the insanity defence, the Comprehensive Crime Control Act of 1984 (USA).

The interface between psychiatry and the law is complex. The relevant laws differ from one jurisdiction to the next, and in any particular jurisdiction, there may be a number of overlapping laws. The aim of this chapter is to outline some basic principles.

FITNESS TO PLEAD

As much as we don't want guilty people avoiding punishment, most would agree, it would be unfair to try and potentially punish people, if they were unable, through mental incapacity, to defend themselves in court (Illustration 9.1). Such a person is said to be unfit to plead. Opinions may be obtained from psychiatrists, but it is important to be aware that the final decision on fitness to plead (also termed, competency) is made by the court.

The legal process may be complicated, but the psychiatric criteria for fitness to plead are straightforward. The important issue is not the nature or severity of any disorder, but the ability of the individual to function in court. The Competency to Stand Trial Instrument, which is widely used in the USA, indicates 13 different mental functions which should be assessed. The criteria of fitness to plead differ from one jurisdiction to another, but in all, the defendant must have the ability, 1) to understand the charge and possible penalties, 2) to understand the court proceedings, and 3) to give instructions to the defending lawyer.

In most cases, when an individual is unfit to plead, the crime is not serious. People who are unfit to plead have severe mental disorders, therefore, they have not been able to plan or execute devious, secret activities. The offences often involve damage to property or minor assault.

What happens to people who are unfit to plead varies, but this is not a route by which the guilty escape justice. If the defendant is unfit to plead because of a treatable condition, such as schizophrenia, the ap-

Apology after mad killer recaptured

By MATTHEW FRANKLIN and PAULA DONEMAN in Brisbane

QUEENSLAND Premier Peter Beattie has admitted his Government mishandled the treatment of criminally insane killer Claude John Gabriel and publicly apologised to his victim's mother.

Gabriel, 26, returned to Brisbane yesterday, six months after absconding while on leave from Brisbane's John Oxley hospital, fleeing first to his parents' home in Victoria then to Italy, Greece and Singapore.

Gabriel stabbed 17-year-old Janaya Clarke to death in a frenzied attack on the Gold Coast in November 1998 but was judged mentally unfit to stand trial for her killing.

He was detained in Auckland three weeks ago and left early yesterday, closely escorted on an Air New Zealand flight by four police and a psychiatric nurse.

He is now back at John Oxley Hospital in secure custody.

Gabriel's return came after a lengthy legal stand-off which ended late last week when his family volunteered to return him to Brisbane.

Mr Beattie yesterday expressed disgust at a call by the Gabriel family for Janaya's mother, Robyn Clarke, to join them in legal action against the Victorian Government for failing to help Gabriel.

"It is an outrageous thing to suggest," Mr Beattie said.

"It causes extra pain

to the victim's mother and she is the one who has really been damaged by all this."

Gabriel's parents will face a Brisbane court later this month charged with aiding his escape.

Mr Beattie said he was relieved Gabriel was back in custody but angry that his escape had caused pain for Mrs Clarke.

"The Queensland Government could have handled this a lot better," Mr Beattie said.

"We could have ensured he didn't abscond in the first place."

He said the Gabriel family's call for him to be transferred to Victoria would not be possible until at least July because the Victorian Government had yet to finalise legislation allowing such transfers.



GAME OVER: Criminally insane killer Claude Gabriel returns to Brisbane and custody yesterday.

Image of Claude Gabriel

Illustration 9.1. Claude Gabriel, described here as a "mad killer", stabbed a 17 year old female to death in 1998 and was still unfit to plead in 2002.

This report illustrates an additional problem in the provision of psychiatric care. Gabriel, who was being held in a psychiatric hospital under the Queensland mental health act, fled to another Australian state and then to other countries. There was great difficulty retrieving him. At the moment, the mental health act of one jurisdiction is not enforceable in another. This is unlike the situation with serious criminals who are relatively easily passed between countries that have reciprocal arrangements. As Gabriel had been unfit to plead, he had not been convicted and thus the mechanisms that exist for criminals could not be applied. Currently, regulations are being considered which may enable the mental health acts of some jurisdictions to be enforceable in others.

appropriate treatment can be offered and when the patient gains the ability to plead, the case can be heard. This may mean that the patient spends months in a prison hospital before a verdict is reached. In the case of a guilty verdict, the time spent in the prison hospital before the case is heard may, or may not, be subtracted from any prison sentence. This means that the time spent in custody may be significantly lengthened by the inability to plead.

Some people who have been charged but are unfit to plead do not gain the ability to plead. Depending on local laws, such people may remain in prison or some form of mental health facility for extensive periods, even years. In some instances people on minor charges are eventually rehabilitated into the community without ever gaining the ability to plead, in which case the charges are dropped.

In the case of serious charges, people who are not fit and remain unfit to plead, may remain in a prison hospital indefinitely.

Difficult moral questions arise when the individuals on serious charges, who are unfit to plead, refuse medication that will potentially render them fit to plead. Most would agree, it would be in the best interests of these people for them accept medication, become able to plead, and have the matter resolved court. It could happen that they are found not guilty and walk free from the court. Even if they receive a sentence, the time they will spend in custody will be short, relative to the time they will spend in custody, if they remain unfit to plead indefinitely.

One view is that it would be better to force these people to accept a trial of medication, rather than allow them to languish in custody. However, as mentioned in an earlier chapter, the principal of autonomy is strongly protected. Just because a person is not fit to plead does not mean that person is not fit to decide

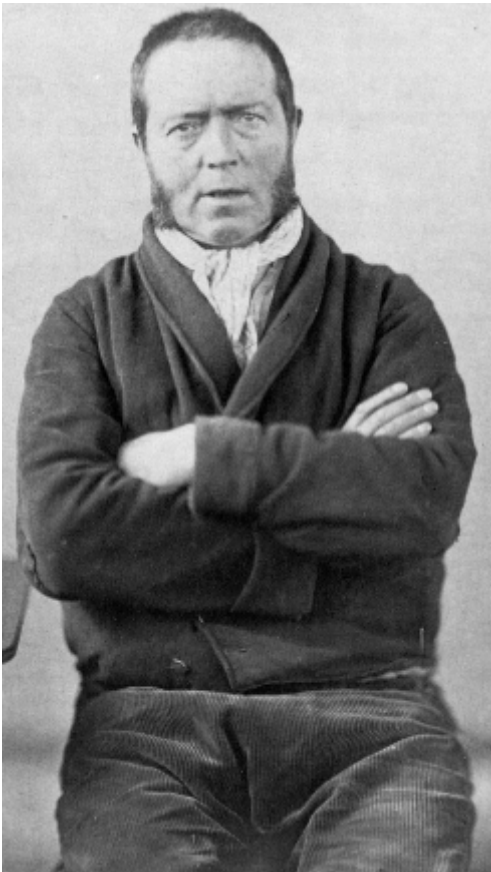


Illustration 9.2 Daniel McNaughton suffered a paranoid disorder. In 1843, in England, he attempted to assassinate the Prime Minister of England, Sir Robert Peel. He shot and killed William Drummond, Sir Robert's secretary by mistake. He was found not guilty by reason of insanity. The subsequent public outrage led to the generation of the "McNaughton rules" which articulate the principles of the insanity defence.

whether or not he or she will take medication. The stage is set then, for the principle of autonomy to delay release from custody.

CRIMINAL RESPONSIBILITY

It is rare for psychiatrists to raise the ire of the public on this issue of fitness to plead, as it is rare that a person accused of a serious crime, particularly when there is evidence of premeditation, is considered unfit to plead. More commonly, the public gets annoyed when psychiatrists get involved in the issue of criminal responsibility. However, if we look at the basic arguments, most can accept that it is fair and proper for courts to consider the topic of responsibility, and that psychiatrists can make a legitimate contribution to this consideration.

For a person to be found guilty of a crime, two basic elements need to be satisfied. Obviously, a prohibited act must have been performed. This is called *actus reus*, or the guilty act. There must also be the necessary state of mind or intention to perform the act. This is called *mens rea*, of the guilty mind.

Mens rea is categorized as specific and general intent. Specific intent means that the act was performed to achieve a particular outcome. For example, in murder, the intention must be to kill, not simply to strike in anger. If specific intent cannot be established, the charge becomes the less serious one, for example, murder becomes manslaughter. General intent may be presumed from the performance of the act. It can be used to argue that the defendant should have been conscious of his/her actions at the time of the offence, and to prosecute carelessness.

THE INSANITY DEFENCE

This defence is available in most but not all jurisdictions. It embodies important principles. It depends on a claim of the absence of a guilty mind, that is, the defendant was not responsible for his/her actions because he/she was insane at the time.

If successful, this defence leads to acquittal with the determination being NGBRI. Importantly, it does not lead to the defendant walking free from court, instead, the individual is sent to a prison hospital or similar mental health facility, for treatment and continuous assessment.

There is no universally accepted, definition of legal insanity. One set of principles emerged following the trial of Daniel McNaughton in 1843 in England (Illustration 9.2). McNaughton had planned to kill the Prime Minister, Sir Robert Peel. By mistake, he shot and killed William Drummond, Sir Robert's secretary. McNaughton had acted in response to paranoid delusions. He was found NGBRI. Queen Victoria, Sir Robert, the press and the public found this verdict difficult to accept. As a way forward, the House of Lords summoned the 15 Chief Justices of England to Parliament and asked them questions about the laws of England, as they related to the insanity defence.

The response of these Chief Justices have become known as the McNaughton rules of insanity:

“To establish a defence on the ground of insanity, it must be clearly proved that at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing wrong.”

Thus the accused must prove there was a disease of the mind, that there was a defect of reason, and then, one of the following, 1) that the nature of the act is not known, or 2) that he/she lacked knowledge that what he/she was doing was wrong.

Interestingly, strictly applied, McNaughton would have failed the test which bears his name. There is no doubt McNaughton had a severe mental disorder. But it cannot be argued that he did not know the nature of the act. He aimed and fired a pistol at the man he planned and intended to kill. At that moment, did he know that killing was against the law, that is, wrong? Almost certainly.

When psychiatrists hired by the prosecution and the defence give opinions to the court, it is usually about the mental state of the defendant at the time of the offence. It is difficult to be sure about the mental state of another person at another time. It is not surprising that opinions differ. Nor is it surprising that prosecution and defence lawyers seek opinions that support their cases. While there may be some “hired guns”, that is, psychiatrists who will slant their opinions to advantage the case of those who are hiring them, this is unethical and uncommon practice. It is important to remember that opinions are put before the court, and that the court decides which opinions to accept and which to reject.

Release from prison hospital or similar mental health facility usually requires a recommendation from a mental health review committee. It is one thing for a Parole Board to have recommended the release of a mentally healthy prisoner who re-offends. From the public perspective, it is quite another for a person who had been found NGBRI to be released and re-offend. The public considers such individuals to be dangerous and unpredictable and expects any assessing committees to be particularly cautious. And so they are. Thus, contrary to public opinion, patients found NGBRI usually spend longer in custody than those who are found guilty and serve their sentence in the ordinary manner.

Some legal advice is that even when the individual has a mental disorder and good grounds for the insanity defence, that this option not be taken, and instead, the plea of not guilty be made. This is because, in the worst case scenario, a guilty verdict, the individual will receive a finite sentence, and as there is a mental disorder, he or she will likely be managed in the prison hospital, anyway. This should mean the individual would receive the same medical treatment and a definite date of release, sooner rather than later, at the will of a potentially capricious committee.

Such legal advice is less common where capital punishment is available. In these jurisdictions the diminished capacity defence, which will be discussed below, may be claimed.

GUILTY BUT MENTALLY ILL

In some jurisdictions the NGBRI verdict has been withdrawn and replaced with guilty but mentally ill (GBMI), while in others, the NGBRI verdict has been retained and GBMI has become an additional option. In these latter jurisdictions, under the insanity plea, the verdict may be, not guilty, NGBRI, GBMI, or guilty.

When the GBMI verdict is reached, the court must impose a sentence. While this verdict might suggest the convicted person will receive treatment for mental illness, such treatment is not mandatory, and appropriate services are unavailable in many prisons. It has been said that GBMI plea is little different from a guilty plea, and that a GBMI verdict is little different from a finding of “guilty but suffering lumbago”.

The GBMI verdict was introduced with the hope that it would overcome some of the difficulties of the NGBRI verdict. If, for example, instead of pleading NGBRI, the individual pleaded GBMI, there would be no need for lengthy court battles with processions of psychiatrists presenting opposing views, and less opportunity for the media to whip itself into frenzy. Also, in jurisdictions lacking alternative facilities, with a GBMI finding, there would no longer be the problem of holding a person who has been found not guilty (on the grounds of insanity) in prison. The person would be guilty and thus could, quite properly, be managed in a prison hospital.

There is no evidence that GBMI mitigates the sentence, and as stated, it does not ensure that treatment will be provided. Thus, in spite of the early hopes, this option has not significantly improved the management of this special group of patients.

DIMINISHED RESPONSIBILITY

Diminished responsibility may be a defence to the charge of murder. If this defence is successful, the accused is found guilty of the lesser charge of manslaughter. Diminished responsibility depends on the notion of a halfway stage between full and absent responsibility. It is based on a definition of mental abnormality which is wider than that of the M'Naughton Rules. The Homicide Act 1957 (England) states:

“where a person kills or is party to a killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being party to the killing.”

The important pieces are that 1) at the time of the crime the accused was suffering from an “abnormality of the mind”, and 2) that the abnormality of mind substantially impaired mental responsibility.

For the purpose of this act an authority defined “abnormality of the mind” very widely, as “a state of mind so different from that of an ordinary human being’s that the reasonable man would term it abnormal”.

When a person who is charged with murder makes this reduced responsibility defence, he or she is pleading not guilty to murder, but guilty to manslaughter. If this plea is accepted by the prosecution and the judge, there is no trial, but a sentence for manslaughter is passed. This may include a period of custody with or without compulsory treatment.

If this plea is not accepted by the prosecution or the judge, a trial is held. The evidence is presented and the jury decides whether at the time of the crime the accused was suffering from an abnormality of the

mind and if so, whether this substantially diminished his/her responsibility. The possible outcomes are guilty of manslaughter or guilty of murder, with a more lenient sentence being associated with the former.

The diminished responsibility defence has been successful based on “emotional immaturity”, “mental instability”, “psychopathic personality”, “reactive depressed state”, “mixed emotions of depression, disappointment and exasperation” and “premenstrual tension”. As mentioned, abnormality of the mind has been broadly defined.

Many regard diminished responsibility to be a better law than NGBRI and GBMI. A penalty is paid, but an appropriate one.

ALCOHOL AND DRUGS

Alcohol and drugs raise interesting issues. On first principles, if an individual was so intoxicated as to be unable to form intent, or not to know the nature of his/her actions, one might expect the guilty mind would be absent and the insanity defence could be successfully pleaded. Unlike mental illness and mental retardation, however, intoxication is usually a result of one’s own actions.

As mentioned above, *mens rea* is categorized as specific and general intent, and general intent has the individual responsible for damage that results from negligence and recklessness. Self induced intoxication with alcohol and drugs may form a partial defence. It may be accepted by the court that intoxication made the defendant incapable of forming a specific intent crime such as premeditated murder. Thus intoxication is not sufficient for the plea of NGBRI, but may satisfy the requirements for diminished responsibility.

Interestingly, as opposed to acute intoxication, where chronic alcohol abuse has caused an organic brain disorder such as alcoholic dementia, alcoholic hallucinosis or delirium tremens (DTs), NGBRI can be upheld.

It is ironic that the individual who has been irresponsible many times (taken so much alcohol, over so many years, as to cause brain damage) has the option of NGBRI, but the individual who has been irresponsible once (getting drunk once) does not.

AUTOMATISM

Clearly, for conviction of a crime there must be the performance of a prohibited physical act (*actus reus*). This physical act must have been conscious and volitional.

An act performed by a person’s body, independent of the person’s mind, is for legal purposes an automatic act or automatism. A defence claiming that the act was performed involuntarily is called the “automatism defence”. An example would be person stung by a bee while driving, who involuntarily drives off the road and kills a pedestrian.

This defence is rare, but it attracts media attention. It has been successful when acts have been performed while sleepwalking, during post head injury periods, and during hypoglycaemia (low blood sugar) and epileptic seizure.

Epilepsy has been used as a defence, and it has been successful. However, most often, it is poorly substantiated and unsuccessful.

Other medical conditions have also been proposed. In 1978 Dan White killed two people at City Hall in San Francisco. In what became known as the “Twinkie Defence”, the defence claimed White had eaten many “Twinkies” before the killings, and a consequent high blood sugar had produced a state of temporary insanity. The jury accepted this argument and returned a verdict of manslaughter, rather than murder. The public outrage over this case led to the repeal of the diminished capacity defence in California.



Illustration 9.3 a & b. On July 6, 2000, Daniel Ruda (27 years of age) and his wife Manuela (23 years of age) invited their friend Frank Hackert (33 years of age) to their flat in Witten (Germany) for drinks. The Rudas then performed the premeditated sacrificial murder of Hackert. They hit him on the head with a hammer, stabbed him 66 times, cut a pentagram on his chest, put his body in one of many coffins in the flat and took his car for a week-long drive that ended at a police road-block.

The Rudas were involved in the occult. They conceived the plan on June 6 and decided to act on the sixth day of the next month, thus yielding the number 666 (the Devil's number). In court they said they killed because this was the only way for them to get into Hell. Daniel was described as an aggressive loner and Manuela said that she had exchanged sex for a sample of men's blood, which she then drank. They said that they could not be held accountable for the killing because Satan had ordered them to do it, and a command from him could not be ignored.

During the trial the Rudas poked out their tongues, made insulting gestures and statements to the judge, the parents of their victim, the journalists and witnesses.

At first sight, this case appears to manifest the "madness" of psychosis. However, there were no true delusions or hallucinations. The couple knew the nature and the consequences of their act. They were diagnosed as having severe personality disorder. Daniel was sentenced to 15 years and Manuela to 13 years in a forensic hospital.

The prosecution had argued that the couple were culpable and had sought prison sentences.

THE GERMAN SYSTEM

In the German forensic system there are three findings of interest: culpable (blameworthy), reduced culpability and not culpable. There is a close relationship between each finding and a psychiatric diagnostic group, and each finding has a relatively standard sentence structure. People without a psychiatric diagnosis are culpable and are sentenced in the usual manner.

Those found to have reduced culpability are often people with severe personality disorder. They often receive a reduced sentence, for example, murder may attract 15 years rather than life in custody. This may be served in jail or in a forensic hospital, or some years in one of these, and the remainder in the other type of institution. In the forensic hospital, treatment is provided (Illustration 9.3).

Those found to be not culpable are usually people with psychotic disorders, such as schizophrenia. These offenders always deployed to forensic hospital, and treatment is provided. They do not receive a fixed sentence but are reviewed annually. The length of time spent in the hospital depends on response to treatment. Thus, one year, or the remainder of the life may be spent in this form of custody.

PAST, PRESENT AND FUTURE

It is difficult to discuss madness in court. The medical and legal models are different, they have different goals, different values and the respective practitioners have different ways of thinking. It is interesting that the McNaughton rules have influenced this field for more than one an a half centuries, and the GBMI verdict, which was ushered in with optimism and confidence, has met with less than universal applause. We will, no doubt, produce better models in the future. This will require practitioners from both sides of the gap to cooperate in the generation of new concepts.

A new initiative in the US will hopefully show the way forward. A federal Mental Health Courts Program is to be funded. The aim is to keep people who have severe mental illness and commit minor offences from being incarcerated in prisons and instead, to direct them to comprehensive treatment. It is expected up to 100 courts will be established. They will be staffed by judges, social workers, probation officers and others, and will supervise cases and have a role in treatment.

This is a difficult field to grasp, as the laws and even principles differ from one jurisdiction to the next. The above paragraphs are a general taste. As has already been said, the role of the psychiatrist in court is to provide expert advice, and while the media work at making the psychiatrists look silly for having apparently contradictory opinions, it is the court which decides which opinion, if any, is accepted.

CASE REPORT

In 1983 human body parts were found in a sewage processing plant in Hobart, capital city of the state of Tasmania, Australia. Subsequently, Dr Rory Jack Thompson, an American-born research oceanographer, aged 41 years, employed by the Commonwealth Scientific and Industrial Research Organisation (CSIRO) was charged with the murder of his estranged American-born wife, Maureen Ellen Thompson (Illustration 9.4).

Dr Thompson had come to Australia in 1974 at the age of 32. He had a distinguished and sustained research career.

In 1984 Dr Thompson told the court he had killed his wife to “stop her stealing” the children. Dr and Mrs. Thompson were living apart at the time of the killing and their two children, aged eight and five years, were staying with Dr Thompson. He told the court that one night preceding the killing he had rehearsed his actions by dressing in disguise and driving to his wife’s house to check the timing. On the night of the killing he put the children to bed, then dressed in a wig and skirt, so that if seen he would not be identified, and drove across the city to his wife’s home. He killed her with a club made from the leg of a table and dismembered her body with a meat cleaver and hacksaw. He said he had flushed 90% of her body pieces down the toilet and buried the remainder, including her head, in a shallow grave in nearby



Illustration 9.4 Dr Rory Jack Thompson fabricated an alibi, disguised himself as a woman, killed his wife, dismembered her body and flushed most of it down the toilet in Hobart, Australia. He was found to be not guilty by reason of insanity. The local Mental Health Review Tribunal three times recommended his release from prison, but subsequent governments refused. After 17 years, Dr Thompson hung himself with a shoelace, in prison.

bush-land.

It was revealed in court that, some months before her death, Mrs. Thompson had notified the Police and a state Domestic Violence Committee that her husband had been violent in the home and she feared for her life.

Dr Thompson pleaded not guilty to murder and said he had been mentally ill, he had not been aware that his actions were wrong and that he had been acting under an irresistible impulse. He was found NGBRI and committed to the Risdon Prison Hospital in Hobart, under a mental health order.

It was difficult for those not engaged in the court proceedings to accept this decision. Dr Thompson had taken care to dispose of his wife's body and to escape detection. Thus there appeared to be ample evidence that he knew what he was doing and that what he was wrong, at least in the eyes of the public. He had planned and even rehearsed the killing, thus, there appeared to be little evidence that the killing was the result of an irresistible impulse.

Some have speculated that Dr Thompson was found NGBRI because of the grotesque nature of his acts. It has been speculated that the jury wanted to see Dr Thompson as different from themselves, or that they found his acts so repulsive that they concluded, in spite of evidence to the contrary, that he "must" have been mad.

Whether or not NGBRI was the most appropriate verdict, this was the verdict achieved. Dr Thompson had killed and performed the grotesque acts of dismemberment and disposal of most of his victim's body via a toilet. He was found not guilty, which meant that he was not in need of punishment, but he was found to be insane, which meant that he was in need of treatment. His release from custody, one would therefore expect, would depend not on the expiration of a finite sentence, but on a Mental Health Review Tribunal forming the opinion that he was not longer insane and no longer a danger to the public, and on this opinion being accepted by the Tasmanian Government of the day. Thus, the scene was set for a long and sorry chapter.

In 1990, after seven years in prison, Dr Thompson (now 48 years of age) applied to be considered for release by the Tasmanian Mental Health Review Tribunal. The Tribunal formed the opinion that Dr Thompson did not have a mental disorder and did not represent a danger to the public and recommended to the Tasmanian Government that he be released. This recommendation was hardly surprising as Dr Thompson had been a productive scientist before his arrest, he had never manifested the symptoms of a clinical mental disorder, and while he had represented a grievous danger to Mrs. Thompson, there had never been evidence that he was a danger to anyone else.

Some months later, in early 1991, the Tasmanian Government (a Labour government) rejected this recommendation, stating that it was not convinced that Dr Thompson no longer posed a danger to the public. This caused public unrest. A psychiatrist who had been a member of the Mental Health Review Tribunal made a public statement and resigned. He made the point that Governments appoint expert tribunals because they need advice and if Governments are not going to accept the expert advice they seek, Tribunals are a waste of time and money.

Many believed that the Government rejected the Mental Health Review Tribunal for political purposes. There is no doubt that the release of Dr Thompson would have been unpopular among the voters. A spokesperson for the Tasmanian Women's Action Group said that Dr Thompson "should be locked away for life". A spokesperson for the Hobart Women's Shelter said, "He should never be let out" and that the consideration of release "shows how little value Tasmanian society puts on the lives of women". The office of the psychiatrist member of the Tribunal who resigned was picketed.

A spokesperson stated that the Government had made this decision "on the basis of evidence given to it", suggesting that the Government had additional information. Rather than calm the debate, this added fuel to the fire. Some did not believe there was additional information and the Tasmanian Bar Association stated that if there was such information, it should have been given to Dr Thompson so that he could refute it.

In 1992 Dr Thompson made another appeal to the Mental Health Review Tribunal and another recommendation for release went to the Tasmanian Government. On this occasion it was revealed that the Government had sought the opinions of Mrs. Thompson's family regarding release. While this may have been appropriate if punishment was being considered, it was not immediately clear what insights the family might have to offer on treatment. As it happened, Dr Thompson had been writing to his children, who were with their mother's family. It was said that some of his letters were inappropriate and the decision had been made not to pass some on to them. One of the children feared for their life if Dr Thompson was released. This may have been the source of the additional information hinted at by Government spokesperson.

Contacted by a Tasmanian newspaper one member of Mrs. Thompson's family said of Dr Thompson, "He should have been put to death". The concept that Dr Thompson was NGBRI was not unanimously embraced.

In 1993 Dr Thompson again appealed to the Mental Health Review Tribunal. Again the recommendation was made that he be released. Again, the Tasmanian government (now Liberal) refused the recommendation. This refusal was supported by a range of groups including the Council for Civil Liberties, which stated that if necessary the Government should pass a new law to keep Dr Thompson behind bars. A spokesperson for the Council said that Dr Thompson's release would be "an insult to the memory of his wife", and went on to say that Dr Thompson should not have been found not guilty.

In 1993 Dr Thompson published his autobiography. In describing the killing he wrote, "She grabbed the stick and hit me on the forehead; it hurt, but not hugely; my thought was "Great; now I will have a bruise for evidence". He also drew attention that people are killed in war and housewives dismember chicken in preparing meals. "So, why the carrying on as if I had done something beyond the realm of human behavior?"

In 1994 Dr Thompson applied to the Full Court of the Supreme Court of Tasmania for breach of habeas corpus, but this failed.

In 1999 while outside the prison on a work gang, Dr Thompson (now 57 years of age) escaped, but was recaptured within hours. He began to despair that he would ever be released. Later that year he hung himself with a shoe lace, in prison.

The case of Dr Thompson illustrates some of the problems with NGBRI. This is not an easy way out of a difficult position. There is no finite sentence and release depends not only on the opinion of a Metal Health Review Board, but on Governments, who have a range of issues to consider. But there is another lesson to be learned from this story. In this case the NGBRI defence was offered and this verdict was reached, but the public never thought it was right. This made release unlikely. It is considered by some, a perverse form of justice, that Dr Thompson who probably never suffered a mental disorder, was able to manipulate a system such that he was found not guilty; but that the trick he played, the claim of mental disorder (insanity in legal terms) back-fired, preventing his released from prison.

CASE SPECULATION

In mid-2003, 40 year old David Mark Robinson, who lived in Melbourne, boarded a commercial aircraft bound for Launceston, Tasmania. During the flight, it is alleged that he attempted to hijack the aircraft, as a means of causing it to crash. He was armed with two sharpened wooden stakes. He was physically prevented from reaching the cockpit by two brave cabin staff and a small number of passengers. One cabin staff member received repeated stab wounds to the head and another received a powerful blow to the face. Within days, the newspapers reported that Mr Robinson had been taken from prison to a high security psychiatric hospital.

Few details had been published at the time of writing. Mr Robinson was born in England, where his parents still reside. His father has terminal cancer. Mr Robinson is described as an unemployed computer

analyst. He had been married, but this ended eight years previously. He had enjoyed a romantic relationship with a female who lived in Launceston, but this had been terminated in recent times. Mr Robinson's parents and all those who know him indicated that such behaviour was out of character and unexpected. A neighbour stated that she had about weekly discussions with Mr Robinson on spiritual matters. She stated that he held strong beliefs, "but they were pretty standard Christian beliefs".

Whether Mr Robinson was insane or not may be argued in court. Certain features suggest he may have been. The motive is unclear. There is no evidence that Mr Robinson was seeking religious martyrdom. To launch an attack on a plane bound for Launceston seems odd. This is not a prominent or nationally symbolic city, and predictably, the plane was less than half full.

It is unlikely a coincidence that Mr Robinson's recently terminated romantic relationship was with a person living in that city. If his plan was, as stated in the newspaper, to crash the plane in the city of his former lover, does that tell us anything? It does not. He could be acting out of simple anger and resentment, or he could be acting on a delusional belief. The fact that his friends thought that this behaviour was out of character, however, counts against anger and resentment, and by reduction, suggests a delusional explanation.

The point was laboured in the press that Mr Robinson had been stressed by the end of his romantic relationship and his father's terminal cancer. But this does not help with the discussion of whether or not Mr Robinson was responsible for his actions. One can be highly stressed, but still responsible for one's actions. On the other hand, stressors can tip a vulnerable person into a psychosis which could render one not responsible.

Mr Robinson armed himself with two wooden stakes. This raises interesting questions. Wood is not detected by metal detectors, and these instruments proved sufficient to inflict serious injuries. Thus, there may have been the intention to avoid detection and premeditated his actions. This could suggest that Mr Robinson was aware of the nature of the acts he was going to perform and that these acts are considered to be wrong. This line of argument might weaken the insanity defence.

On the other hand, wooden stakes are uncommon weapons with a particular sub-cultural function. In literature, at least, a wooden stake through the heart is the only way to kill vampires, and associated supernatural beings. Therefore, the choice of wooden stakes may indicate a fully responsible, or a deluded, insane perpetrator. We will have to wait for further details before approaching a conclusion.

Thompson R J. *Mad Scientist*. Southern Holdings. Huonville, Australia. 1993. ISBN 094908929X

CHAPTER 10

MADNESS IN THE COMMUNITY

The cause of mental disorder remains uncertain, but evidence indicates that genetic vulnerability, early life experiences and recent stresses are important factors, in at least some cases. At a cellular level, pathological changes in the amount of chemical messengers which pass from one nerve cell to the next have been proposed, along with or as well as other abnormalities. The symptoms of mental disorders include abnormalities of thinking, perceiving and feeling. In response to stress and the frightening experience of these symptoms, patients may develop secondary problems such as conflict with families, suicidal behaviour and drug or alcohol abuse.

The management of mental disorders requires a many pronged approach. A trusting patient-doctor relationship is essential. On this foundation the patient's symptoms can be fully explored, a diagnosis reached and a treatment program commenced. An explanation of the symptoms and advice on the most productive way to conceptualize them is provided. This may take the form of psychotherapy. For the last fifty years, medicines have been available which have helped to correct the underlying chemical messenger abnormalities with beneficial effects on some of the symptoms in 60-80% of patients. Medication alone is rarely sufficient.

Patients with severe mental disorders may need periods in hospital to reduce stress, receive assistance with self care, restore eating and sleeping habits, for protection from self-destructive behaviour, for special investigations, to participate in intensive group therapy, relaxation and exercise programs, and to receive electroconvulsive therapy and other advanced treatments. Those who have lost skills and are unable to care for themselves may need longer periods in hospital and the services of a range of other health professionals such as social workers and occupational therapists.

In the past, main treatment components were hospital care, support, encouragement, and skills training. Sometimes, all efforts were ineffective and patient and staff could only wait for the disease to run its course and for a natural remission to occur. Modern medication and services accelerate the recovery process and in many cases, hospitalization is not necessary.

For more than a century, until the mid-twentieth century, psychiatric care was provided not in out-patient settings or in the psychiatric wards of general hospitals, but in mental asylums (Illustration 10.1). Then came changes, the asylums were closed and patients were managed "in the community". The thinking leading to the change and the quality of the care currently provided are issues for debate. The "deinstitutionalization" of psychiatry has had many benefits. Questions remain, have we thrown the baby out with the bath-water? Can the full range of psychiatric services be provided outside hospital? Some psychiatric beds continue to be needed and they are hard to find, has the psychiatric bed reduction gone too far?

In April 2002 The Australian newspaper conducted "A special report" and found "Deinstitutionalisation – the policy of shifting people for psychiatric hospitals into the community – has failed many of the people it was designed to help, leaving them homeless, destitute and desperate". In the December 2002 Victorian state elections the Labour Party election policy included the opening of an additional 100 psychiatric beds

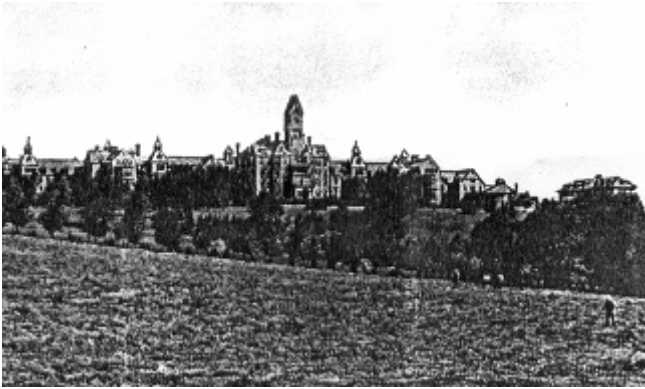


Illustration 10.1. The Worcester State Hospital, MA, USA; circa 1910. This imposing sandstone building is typical of the asylums that were built outside most major cities in many parts of the Western world. They were generous in architectural proportions and had large numbers of beds, but were never properly funded or staffed.

Photograph courtesy of Jeffrey L Geller, MD.

in that state. That party retained government. Also in that month The Select Committee Inquiry Into Mental Health Services In New South Wales recommended “more long-term and supported accommodation mental health beds be provided”. Also in that month the Australian Capital Territory Health and Community Complaints Commissioner recommended the establishment of “a range of medium and long term housing options associated with clinical support for people with mental health disability”.

To follow the debate we need the history. The details differ from one country to another, but generally, in the Western world, the seventeenth and eighteenth centuries saw the rural poor leave the land and move to the industrialized cities. The cities became overcrowded and people lost the support structures of their rural communities. These were turbulent times, with social problems, crime, unemployment, poverty and possibly mental illness, increasing. Governments responded by building new institutions: prisons, workhouses, poor houses and asylums.

In England the Vagrancy Act of 1774 made the first governmental distinction between lunatics and paupers. At about this time some private ‘madhouses’ were established for those who could afford to pay for care. The County Asylum Act of 1808 provided for the building of public mental hospitals in every county. But little happened until the Lunatics Act of 1845 required each county to build an asylum, marking the beginning of institutional care for the mentally disordered.

The lack of order and morality of the cities and the stress of family life were regarded as damaging factors, which could lead to mental disorder. Asylums would remove patients from these circumstances, and return patients to the lost country serenity; there would even be the opportunity for meaningful work in the fields. Simultaneously, patients were purposefully, removed from stressful family situations.

Most will agree that asylums were built with the intention of providing care for those with mental disorders. Some may argue that they were built to hide away the mentally disordered, for the convenience of the non-mentally disordered. There is little evidence that this was part of the initial intention, but as time went on, unmarried mothers and others with social difficulties were given asylum. Most will also agree that asylums provided food, shelter from the elements and physical safety, and the best treatments of the day. There are no credible claims to the contrary, the intention of establishing the asylums was to provide these good things for needy patients with mentally disorders.

Commenced with good intentions, the asylums were never properly resourced or financed. They quickly become overcrowded. In relatively isolated areas, it was difficult to attract adequate numbers of well trained staff. While not designed for this purpose, the asylums allowed the mentally disordered to be removed from public places, thus tolerance decreased and the stigma of mental disorder consequently increased.

Claims are made that the asylums began to exist for the benefit of the staff rather than the patients. Staff received wages for their work, but claims are made that some stole food and other goods that were purchased for the benefit of patients. Further, there were claims that the daily routines of the asylums were

organized for staff convenience rather than patient needs. There were also occasional claims of staff physically mistreating patients.

Asylums were intended to supply all the needs of patients for long, in some cases, indefinite periods. To supply all the needs for a person is an enormous undertaking, and for whatever reason, these institutions became very large, sometimes with more than one thousand patients. Thus, the task was large but of low status, the resources were short and the whole operation was performed outside public scrutiny. It would have been a miracle if there had not been some misappropriations by staff and some maltreatment of difficult patients. There were frequent scandals followed by public inquiries and temporary improvements.

Mental hospitals, as the asylums became known, provided a range of services including acute admission and assessment, secure care, long-term care and rehabilitation. Most hospitals had at least ten wards so that patients could receive services according to their level of function.

Before the 1950s, all those who required acute psychiatric admission went to the mental hospital. Admission did not automatically mean long term treatment and a large proportion were discharged after a few weeks of treatment. Secure wards were available to those who, due to mental disorder, were dangerous to themselves or others. Long-term wards were available to those people who were damaged by their mental disorder such that they were unable to attend to their own nutritional needs and hygiene, access services in the community and manage their own medication. Some patients gradually recovered on long term wards over months or years, others remained indefinitely. Rehabilitation wards taught the budgeting and domestic and self care skills which had been lost, enabling damaged patients to return to independent living outside the hospital.

Mental Hospitals were most numerous and cared for the greatest number of patients, shortly after the Second World War. Then came the deinstitutionalization of psychiatry. This process is almost complete in many parts of the world. In England and Wales in 1975 there were 130 psychiatric hospitals, most containing many hundreds of patients. In 2001 only 14 remained, with fewer than 200 in each, representing a closure of 95% of the 1975 mental hospital beds. In the USA from 1960 to the late 1990s, the mental health beds were cut by more than 90%. In New South Wales [Australia] mental health beds have been cut to the point that public psychiatrists claim to be unable to provide appropriate treatment and have threatened industrial action (ABC, 2004).

These numbers do not tell the whole story. As the mental hospitals began to close, acute psychiatry wards began to open in general hospitals, thus a small proportion of the psychiatric hospital beds were, in effect, not closed, but transferred to the general hospitals. These general hospital psychiatric beds are, however, exclusively acute or short stay beds. As the mental hospitals closed, some longer term beds were created outside the hospital. These were in a range of group homes, some were supplied with twenty-four hour staff support, most were supplied with telephone numbers and visiting staff. Because of the differences from one region to the next, it is impossible to make an exact statement of what proportion and in what form the mental hospital beds were replaced. However, in all regions, the number of beds with any type of professional support is much lower than during the old mental hospital system.

Many factors led to the demise of the mental hospitals. The repeated scandals and inquiries raised serious doubts about the system. Postmodernist thinkers rejected the notion of expertise as the exclusive province of the experts and egalitarianism fostered the view that everyone had valuable ideas. After the Second World War came a wave of anti-totalitarianism, and criticism of “total institutions”, which included mental hospitals and prisons. During this time “social justice” was being formulated and the right of the individual to self-determination and dignity became important issues. In the 1960’s a philosophy of love, freedom, tolerance and antiauthoritarianism became fashionable. The anti-psychiatry movement began to emerge in Britain. Thomas Szasz published his popular but destructive book *The Myth of Mental Illness* in 1960. The sociologists hypothesized that mental disorders could be accounted for by medical labeling of deviant or unusual behavior. Sociologist Erving Goffman published his book, “*Asylums*”, in 1961, which forcefully drew attention to the lack of autonomy and dignity he believed mental hospital patients suffered. With the development of effective antipsychotic drugs in the 1950’s and 60’s it became possible to offer care for seriously mentally disordered patients in the community. Interestingly, the features which

were thought to be advantageous when the asylums were built, the removal of patients from the cities and their families of origin, were among those considered to be the least desirable by the new reformers.

“Institutional neurosis” or the “institutionalization” of individuals was conceptualized and widely advertised. As mentioned earlier, in the 1890’s Kraepelin had described dementia praecox, a disorder with onset in adolescence and early adulthood. A prominent feature was episodes of acute madness, but the term “dementia” was coined to describe a loss of drive and energy, loss of direction in thinking, apathy, social withdrawal and an inability to attend to personal needs, feeding and hygiene (more recently termed “negative symptoms”). In the mid-twentieth century it was noted that inmates of goals and prisoner of war camps, who had no personal belongings and no autonomy and were subject to the will of others, eventually lost their sense of personal identity and became apathetic and submissive. In 1959 Russell Barton published “Institutional Neurosis” in which he described social withdrawal, apathy and inability to perform self-care among mental hospital patients. Suddenly, the original descriptions of Kraepelin were forgotten and it was assumed that this syndrome was caused by mental hospital treatment rather than the mental disorder which brought the patients to the mental hospital in the first place.

The negative symptoms have been well described in patients who have never been near a mental hospital. There is some evidence to suggest that the negative symptoms of schizophrenia may be compounded by institutional care which lacked humanity and stimulation. This was the exception, however, as most mental hospitals did not lack humanity and stimulation. Nevertheless, the belief that mental hospitals were responsible for the symptoms of mental illness was accepted by planners and decision makers and was a large nail in the coffin of the mental hospitals.

The biggest nail, however, is rarely talked about. That is, cost. Total institutions are extremely expensive to operate. From time to time we hear how expensive it is to keep a single prisoner in custody. In this regard to cost, mental hospital patients were no different. While prisons require 24 hour prison officers, mental hospitals required 24 hour medical and nursing staff. There was the cost of providing meals three times each day, cleaning, linen service, light and heating, every day of the year. Mental hospitals were large enough to require carpenters and repair staff. They were surrounded by gardens and needed gardeners, they were away from population centers and had to employ drivers and delivery people. As well, each employed a body of administrative staff. If patients are placed “in the community”, at least most of these costs, go away.

Clinicians demonstrated that certain patients with mental disorders could be managed outside mental hospitals, and further, there was reason to believe that for some, independent living could be very beneficial. This was the justification for completely closing the vast majority, and drastic “downsizing” of the remainder of these expensive facilities.

The promise was universally made that all the money saved would be redirected into community based care, but nowhere has this been demonstrated. In December 2002, Dr Brian Pezzutti, of the New South Wales Legislative Council stated, “It is almost 20 years since the Richmond Report (which recommended deinstitutionalisation) and the community sector is still yet to see the resources they were promised.”

Ironically, experienced clinicians now claim that providing good quality care in the community can be more expensive than institutional care. While the salaries of carpenters and gardeners are saved, and the cost of meals, cleaning and linen is shifted back to the patient, the cost of the large number of clinical staff travelling from residence to residence and having to go looking for patients, plus the cost of cars, telephones and the computerization of information consumes any savings.

In Australia, the National Mental Health Strategy which commenced in 1992 was the prominent force in the closure of the mental hospitals. It states, “In the past, the more severely affected people were isolated and treated in psychiatric institutions, and had little opportunity to decide how and where they wished to live their lives...People in psychiatric hospitals were also denied the opportunity to participate in the life of the community”. This stuff must have been written by people who have never had to care for severely mentally ill people who desperately needed asylum. It is true that severely mentally ill people were “isolated” by being in mental hospitals, but they were already isolated, having already been rejected by the community. It is true that they were “denied the opportunity to participate in the life of the community”,



Illustration 10.2 “Many mentally disordered people have been ‘returned to the community’ as part of a policy of reducing the number of mental-hospital patients. Hundreds of thousands of these people have become hopeless derelicts in the large cities.”

This illustration and legend come from, Robertson I. *Sociology*, Third Edition, 1987. Worth Publishers, Inc. New York.

but this denial was put in place, not by the hospital, but by the community. It is not true that these patients “had little opportunity to decide how and where they wished to live their lives”. Most were not on legal orders and were able to choose, and they chose the comfort, familiarity and “community” of the hospital. On this point the National Mental Health Strategy might have come with a footnote to chronic, severely psychotic patients: *We know what is best for you, we know better than you do, and better than those running the mental hospitals.

There is now a debate about whether community psychiatry had failed. The word community is now redundant. There is no institutional psychiatry anymore. The question has become, has psychiatry failed the community.

“Quietly but steadily, jails and prisons are replacing public mental hospitals as the primary purveyors of public psychiatric services for individuals with serious mental illness in the United States”, wrote Dr E. Fuller Torrey (1993), a world figure in psychiatry. He estimated that in 1993 there were 162 822 individuals with serious mental disorders in US jails and prisons or on parole, which was twice the number of patients in state mental hospitals. He gave as the main reason for this situation, that there were insufficient public psychiatric services to which the mentally ill could be diverted.

“Deinstitutionalization of seriously mentally ill individuals has been the largest failed social experiment in twentieth-century America”, he wrote. He ended by saying that the problem was not that these patients could not live in the community, but that they had not been provided with appropriate support (Illustration 10.2).

Dr Povl Munk-Jorgensen (1999), writing in Denmark, described 230% increase in the number of mentally disordered individuals under the supervision of the Department of Probation and Parole and a reduction of almost 60% in the number of psychiatric hospital beds over the period 1980-97. He believes that deinstitutionalization has advantages but that replacement services have not been able to protect mentally disordered people from committing minor crimes, which lead to them entering the penal system.

Similar reductions in mental hospital beds and increases in the proportion of individuals with mental disorders in the penal system have also been reported in Canada and many other parts of the Western world. This is a form of “transinstitutionalization”, the phenomenon of people moving from one type of institution to another, as a result of administrative rather than real change.

The number of homeless people in Great Britain doubled during the 1980’s and 30-50% of the homeless have significant mental disorder. Deinstitutionalization has been identified as one of the factors contributing to the rise in homelessness (Scott, 1993). And editorial in the *Medical Journal of Australia* (McGorry, 2003) stated, “Many (people with schizophrenia) live in poverty in substandard housing, having little to occupy their time and trying their best to cope, often with the aid of harmful amounts of legal and illegal

drugs. The plight of family members is also serious and all too often leads to frustration and despair.” One such relative is Chairman of the Australian Competition and Consumer Commission, Professor Allan Fels, who has a 31 year old daughter with schizophrenia. He was reported in *The Australian* (Yallop, 2003) as saying, “Deinstitutionalisation has failed because it has not been matched by the level of services required”.

In the field of social matters, it is often impossible to be certain which factors have led to a particular outcome. In addition to deinstitutionalization, many of the attitudes and policies which made deinstitutionalization inevitable, have worked to shape our current psychiatric services. As stated above, the Western world is now relatively free of mental hospitals. The important issue is not antecedents, but what is the quality of the currently available services.

Dr Julian Leff (2001) makes the point that, “when basic needs are satisfied, a new level of need becomes apparent”. For this reason, optimal psychiatric services will never be achieved, for when the aspired to optimal level is achieved, it is possible to see another, just beyond. There are a number of areas of public psychiatry that need attention.

Rehabilitation of those with mental disorders involves the teaching of budgeting and domestic and self care skills, and can be well provided in the mental hospitals. A ward can be designated, programs can be developed and patients and staff are readily available. This is much more difficult without the hospital base. Dr Leff and others identify rehabilitation as a service which needs attention in this new age of mental disorder care.

It is a widely believed that additional long-term and acute beds are required. Long-term beds can be made available in many forms, group homes with individual bedrooms and common living spaces are acceptable to most patients and are more economical than single isolated units. These can be supported by resident carers or visiting professionals, depending on the average disability of the patients. Such arrangements are a blend of the best of both worlds, some of the economy of size of the old mental hospitals, but with size limited and based on more normal living style.

Acute beds are currently, also in short supply in most countries. A “scandal” broke in Adelaide, the capital city of South Australia, in later 2001. It was revealed that acute psychiatric patients were being shackled to beds and supervised by security staff in Emergency Medicine Departments and general wards of major teaching hospitals for up to several days, while awaiting acute psychiatric ward beds. This also occurs in Brisbane, the capital city of Queensland and Melbourne, the capital city of Victoria.

In a recent report, “Mental Health Services for People in Crisis”, the Auditor General of Victoria (2002) stated, “people in psychiatric crisis faced difficulty assessing acute psychiatric beds due to increasing demand pressure and static bed numbers in some regions”.

When details of the Adelaide events were reported in the national newspaper, a host of bodies declared that they would investigate, including Eugene Biganovsky, the state Ombudsman. It is hoped that the planners and the purse-string holders, rather than the clinicians who are doing the best they can with inadequate resources, will be found accountable.

SERVICE PROBLEM

Southern Tasmania has a population of 250 000. Hobart is the state capital. The Royal Hobart Hospital is the major teaching hospital and has had an acute psychiatric unit for 30 years. The Royal Derwent Hospital was a mental hospital in a rural setting, 40 kilometers from the capital. The Royal Hobart Hospital did not have a secure ward; all manageable patients were admitted, but dangerous and destructive patients were sent on to the secure ward at the mental hospital, to be returned to the Royal Hobart Hospital, after they had settled.

The Royal Derwent Hospital was being slowly wound down and the decision was made to build a secure ward at the Royal Hobart Hospital, so that it could deal with all acute admissions. The political decision was made and announced with great public trumpeting that the Royal Derwent Hospital would close on particular day in late 2000. The problem was that the building of the replacement secure ward had not commenced and completion was not expected for a further nine months. When the difficulties of this situation were raised, ineffectual and impractical solutions were suggested.

There was no alternative and staff at the Royal Hobart Hospital simply had to manage all dangerous and destructive patients as best they could, on the open ward.

An acute inpatient unit which must accept all acute psychiatric patients needs a secure unit. To close the acute secure unit of a geographical region is like closing the cardiac care unit of that region. In similar circumstances, management would not close a cardiac care unit, the outcry from those people who survived heart attacks would be deafening. But dangerous, destructive and insightful psychiatric patients are not going to effectively complain that they were denied the benefits of a secure unit.

For those nine months it was necessary to make extensive use of intravenous and intramuscular injections, and to have security guards on the general psychiatry ward around the clock for up to a week at a time. Doors were broken, holes were punched in the walls and staff were assaulted. Eventually, the new secure unit opened. Perhaps management breathed a sigh of relief, pleased to have got through without a major assault or a newspaper expose. What passed unappreciated was the damage to staff morale and staff confidence in management.

CASE DRAMATIZATION

Lin Chin's Chinese ancestors came to Australia during a gold-rush over a century ago. Her parents own a large and successful market garden business. They are extending into the commercialization of Australian native plants.

Lin attended an exclusive private girls school. She was good at all academic subjects and took additional classes in gymnastics and music. She was an avid reader and had many friends.

She was admitted to the psychiatric ward of a private hospital at the age of 16 years. For many months she had been acting strangely. She had filled her cello with the feathers from a feather pillow. She seemed to believe that wizards and witches and various other fictional characters from the Harry Potter books were living in her cello.

Doctor: "Well, about the Harry Potter characters, which of them do you think might be living in your cello?"

Lin: "They're not."

Doctor (rubbing her forehead): "Oh, I'm sorry, I thought you said Harry Potter characters were living in your cello?"

Lin (giggling): "They're trying to."

Doctor (relieved to be on the right track at last): "So, which characters are trying to live in your cello?"

Lin: (twisting in her chair to look behind): "Hagrid was."

Doctor (uncertain and wanting to clarify): "Lin, when you say 'Hagrid was', do you mean Hagrid was living in your cello, or Hagrid was wanting to live in your cello?"

Lin (smiling): "I don't know."

During the admission interview she seemed to indicate that she played the cello on some occasions, but that a Harry Potter character played it on others.

Doctor: "I see. Well, when you are playing, your fingers would be pressing on the strings. But when Dumbledore is playing, whose fingers are pressing on the strings?"

Lin (looking confused): "Wha?"

Doctor: "Lin, when Dumbledore is playing your cello, are your fingers pressing on the strings?"

Lin (looking defensive): "Of course, that's how you play it."

Doctor: "OK. When Dumbledore is playing your cello. Your fingers are pressing on the strings. Is Dumbledore making you press on the strings?"

Lin (confidently): "He wouldn't do that."

Doctor: "I see. Well, how does Dumbledore play your cello?"

Lin (smiling): "He could be."

Lin was suffering what is now called hebephrenic or disorganized schizophrenia. The onset is usually in adolescence, there is disorder of the form of thought and behavior is disorganized. There may be delusions, but these are poorly formed and vary from moment to moment. The patient is often smiling, unconcerned about his or her condition and described as shallow or fatuous. Such patients may not be able to care for themselves, wandering aimlessly and neglecting self-care.

Lin did not want to be at school. When she was taken there, she was disruptive and had to be removed. She was not able to occupy herself alone at home. She tried to cook but set the house on fire, she would wander off and before long, drifted into the company of the drug sub-culture. It was feared that as she had access to some money and valuable belongings, and she was a naïve female, she was at risk of financial and sexual exploitation.

In the past she would have been managed in a mental hospital long-term or rehabilitation ward where with structure and support she would gradually recover or at least stabilize and develop some independence. As there was no mental hospital, she spent most of a year in a general hospital psychiatric ward in a series of long admissions. This was not ideal, the rapid turnover of acutely disturbed patients was distressing, and the general hospital bed was expensive.

Attempts were made by the mental health service to provide structure and purpose by suggesting community based activities. But Lin, with fleeting delusions, disorganization and lacking insight, did not want to attend the suggested activities. Even if she set out with the intention of co-operating and attending a particular activity, she would get diverted and end up wandering the streets. When asked what she would like to do, she could not give a cogent answer and her answer differed with each asking.

In the end, Lin's mother had to leave work and function as a private nurse. While this can be justified as the family has a responsibility toward members and the state should not be expected to provide services which are the responsibility of family, Lin's mother had a different view. She had enjoyed her position in the company, but she did not enjoy looking after her daughter. She pointed out that she had created employment, that when she left the company, it was necessary to terminate a secretary and three gardeners who had been working on the projects that she had devised, implemented and supervised.

CASE DRAMATIZATION

In 1985 Mr. Jan Petrov appeared to be about 50 years of age. He had lived in the long-term ward of a mental hospital for 12 years. He was born in Estonia. His records showed that he had been living and working in an unskilled capacity in a small city in Australia for about ten years before admission to the mental hospital. On admission he had claimed he owned vacant land in that city, it was unclear whether this was a delusion. He could not provide details and searches of records did not support his claim, although, due to the vague nature of his claim, it difficult to be sure the correct records had been searched.

Few details were available of the clinical picture when Mr. Petrov was admitted. He had been a vagrant and living in shelters for at least a number of years, and was referred by welfare workers and police who believed he was acting “strangely” and neglecting him-self. There was a history of alcohol abuse and two convictions for drunk and disorderly behaviour. The records showed the admitting staff suspected but were not certain of the presence of delusions or hallucinations. The admission diagnosis was wide open, it was thought he was either alcoholic, schizophrenic or an itinerant seeking a bed and food.

Mr. Petrov spoke little to others, but muttered to himself. He had a strong accent, and apparently, rudimentary English. He mumbled answers and seemed to have disorder of the form of thought. When he did speak to others, it was difficult to understand what he meant, and presumably his accent, limited English, poor diction, and disordered form of thought all played a part.

It was impossible to form an opinion about his intelligence, but he had travelled from one side of the world to the other and has worked for some years, which indicated at least near average intelligence.

Mr. Petrov was of average build and had a full head of hair. He had no teeth and appeared to be grinning much of the time. It was uncertain whether his apparent grin was due to the absence of his teeth. When not encouraged into staff structured activities such as occupational therapy, he sat immobile on a garden bench outside the ward, looking at a pleasant country view.

Mr. Petrov was a passive man. He did not appear to have paranoid delusions and was never aggressive. He was friendly insofar as he answered greetings, but he initiated little interaction and formed no warm interpersonal bonds. He did not wash unless the staff insisted. He did not change his clothes or buy clothes. He did not make his bed until he was directed to do so, and when he did, he pulled up the top cover, leaving the sheets crumpled beneath. He was interested in food insofar as he always waited in the dining room at meal times and he ate rapidly. He chewed with his mouth open. If he coughed while eating he did not cover his mouth and food flew out onto the table. He did not help with food preparation or serving and he did not help with clearing the table or washing the dishes, without being encouraged so to do.

During his dozen years in the mental hospital two attempts had been made to prepare Mr. Petrov for return to the community. His skills had been assessed and plans had been made to retrain him in the areas of daily living in which he was most lacking. Both attempts failed. It was believed Mr. Petrov did not want to leave hospital, that he was not participating in the rehabilitation process and therefore it was pointless persisting.

The decision was made that this mental hospital would be closed, so every patient had to be assessed and appropriate disposal determined. Patients were to be prepared, as well as possible.

Mr. Petrov's records were again reviewed and he was interviewed. His muttering suggested that he was hallucinating, and he certainly lacked initiative, energy and interest in others. This suggested schizophrenia with some positive and many negative symptoms. Schizophrenia was considered the most likely. Alcoholic hallucinosis along with the apathy of alcoholic dementia was an alternative, which could not be excluded. It was noted that Mr. Petrov had not sought alcohol in over a decade, although he appeared to grin when the topic was mentioned. There was no denying alcohol had caused some problems prior to his admission, so alcohol abuse would remain on the potential problem list. He had limited communication skills. It was considered that Mr. Petrov, with apparently no friends or family, no trade or professional training, and with limited local language was unwilling to leave his relatively comfortable hospital life, and that he had sabotaged previous rehabilitation attempts. It was not possible to form a strong opinion on personality and motivation, as apparent deficits would be consistent with the negative symptom of schizophrenia, which were believed to be present. When asked, as part of the disposal process, he answered that he did not want to leave.

Mr. Petrov was given twelve months instruction, guidance, example and encouragement to help him master basic personal budgeting, hygiene and food preparation. As the mental hospital was closing, he would have to leave. As he had shown little interest or aptitude in learning budgeting or food preparation, he was moved into a boarding house where at least he would be fed twice a day, he would get clean linen and the rubbish bin in his room would be emptied once a week. This was a boarding house in the private sector which catered predominantly for people living on government pensions who had low levels of function.

Nevertheless, Mr. Petrov was immediately unpopular because he chewed with his mouth open and when he coughed, food came out on the table. When he walked into the communal TV lounge, he would change the channel without asking those who were already watching. Other viewers threatened violence, but nothing happened. Not because Mr. Petrov made belligerent counter-responses, his lack of concern about what others said or thought was unnerving.

Community based mental health workers made efforts to support Mr. Petrov. They visited second daily and arranged for the boarding house proprietor to remind Mr. Petrov to take his medication.

Mr. Petrov started drinking alcohol. He brought it back to the boarding house, which was against the rules. He drank all his money and was threatened with eviction when he could not pay his board. The mental health workers arranged for Mr. Petrov's money to be handled by the Public Trustee, so that his board came directly out of his fortnightly pension and then the remainder was released to him, half each week. He stopped drinking, but soon took a dislike to the boarding house and left. He slept on the streets.

He was taken to a shelter for homeless men. After a week or so the operators thought Mr. Petrov was physically and mentally disordered and took him to the local general hospital. He was found to be malnourished but not physically sick, and was admitted to the psychiatric ward. It was concluded that he suffered chronic paranoid schizophrenia with prominent negative symptoms. His medication was changed and he was discharged back to the shelter. He took alcohol back to the shelter and was threatened with expulsion. He agreed not to take alcohol back to the shelter again and stopped drinking for three months.

He then became clearly paranoid and left the shelter and was not seen for a month. Then, while drunk, he staggered into the path of a car and received a head injury. He was admitted to the general hospital neurosurgery ward and was found to be unable to speak and paralyzed on the right side. When his condition had stabilized he was physically rehabilitated but could not walk very well and was discharged to a long term facility for the physically disabled.

It was ironic that the absence of long term supported psychiatric care was the path to long term care. The absence of psychiatric care was an important factor contributing to Mr. Petrov's physical injuries. In the end he did receive long term supported care – the justification being physical rather than psychiatric disability.

The deinstitutionalization movement believed that people like Mr. Petrov were robbed of their identity and dignity by the mental hospital and that discharge would lead to a new sense of autonomy, dignity and fulfillment.

Dr Torrey and Mary Zdanowicz (1998), however, have another view. In *The Wall Street Journal* they estimated that 1 000 homicides are committed each year throughout the USA by seriously mentally ill people who have no stable residence and are therefore not taking appropriate medication. They state, "Their victims should still be alive. The tragedy is that the mentally ill are a threat to society because society has failed them".

Dr Jeffrey Geller (2000), a leader in public-sector psychiatry, has explored the meanings of the word "community", finding the most satisfactory to be "a social group sharing common characteristics, circumstances, and/or interests, perceived or perceiving itself as distinct in some respect from the larger society in which it exists". He argues that in the mental hospitals the seriously mentally disordered had "a" community, but since they have been discharged into "the" community many now have no community. For many patients deinstitutionalization has destroyed their community and we have a mental health system, which Dr Geller claims "is looking more like the one we had in the 18th century".

CONCLUSION

Mental disorders may seriously impair the patient's ability to function in a productive and independent manner. A couple of centuries ago, as a means of providing care for people with mental disorders who were destitute, asylums or mental hospitals, were established. These provided total care for patients on an, if necessary, indefinite basis. The asylums were never properly funded and were misused, insofar as they cared for a range of socially disadvantaged people. This is probably gilding the lily somewhat, as some patients were probably neglected in these large facilities and lost a sense of dignity and autonomy. Also, there was probably some pilfering and abuse of patients by staff. Over recent decades these hospitals have been closed.

There were arguments in favor and against closure, and there have been both beneficial and deleterious consequences. I am biased and have mainly presented examples of deleterious consequences.

Scientific papers appear in the psychiatric journals asking "has community psychiatry failed?" There is no asylum psychiatry anymore, so the adjective "community" should be dropped, and instead, the question should become, "has psychiatry failed the community?" Of course, psychiatry can only properly serve, if properly resourced. There is evidence that comprehensive, integrated psychiatric services are yet to be provided. However, we should also heed Dr Leff's caution, "when basic needs are satisfied, a new level of need becomes apparent". It is easy to underestimate and I am probably guilty of some underestimation of the progress made by closing the asylums. The better outcome would have been achieved if the worst aspects of the asylums had been corrected and the best retained.

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CHAPTER 11

MADNESS AND GENIUS

The belief has persisted for thousands of years, that genius and mental disorder are linked. “No great genius was ever without a tincture of madness,” wrote Aristotle (422-384 BC). He may not have been the first to make this connection. He believed both genius and madness were the result of an excess of bodily black bile. What he really meant is impossible to determine, as there was no clear definition of the term which has been translated as madness, and as already stated, we have no clear definition for the word madness. He did not write at length on the subject.

Nor is there a widely accepted definition of the term genius, and there are very few studies of the mental health of geniuses. There are, however, some important studies of the mental health of creative and world-famous figures from a range of fields.

Those with mental disorders and geniuses or world-famous figure are different from average people. Thus, these two groups are similar insofar as they are different. But are these groups very similar to the point that they are a single group, or are they only the same only insofar as they are different from the average?

People with mental disorders featuring abnormal forms of thought, make unusual statements. They make unusual connections between ideas. Sometimes their statements sound like lateral thinking. That is, they sound clever, they sound as if the patient is purposefully attempting to approach an idea or problem in a new, from a new perspective or in a creative manner. Unfortunately, this is not the case. The patient with disorder of the form of thought is making these unique associations by accident, slipping off one idea and landing on another. As thinking is disorganised, so behaviour is disorganized. People with this problem do not have formulate plans well, and they do not reach high goals. While such patients may, from time to time, appear to present an alternative answer, they usually produce very little.

For these reasons, contrary to popular opinion, few creative artists or important thinkers have suffered from schizophrenia. Vincent Van Gogh almost certainly did not have this condition. He was born in Holland in 1853. His extended family included art dealers and there was a family history of mental illness. He had a troubled work history and four significant relationships with women, all which ended, bringing him disappointment. At the age of 27 years, Van Gogh announced he would become an artist. He produced more than 800 paintings, mainly during the last seven years of his life. He shot himself to death at the age of 37.

It is well-known that Van Gogh cut part of his left ear off and presented it to a prostitute. This, along with his occasional statements that he thought he was being poisoned or persecuted by the police have been taken to indicate schizophrenia. This is unlikely as there was no evidence of negative symptoms, such as social withdrawal and loss of feelings, and he was extremely productive in his last seven years. An organic cause for some odd behavior is probable; he suffered gonorrhoea and syphilis, he was poorly nourished and drank large amounts of absinthe, an alcohol containing a neurotoxin which is known to cause psychotic symptoms. A mood disorder is also highly probable. There were periods when he experienced

the symptom of depressed mood, and episodes of excitement. He said, "I go like a steam engine at painting" and was prolific, suggesting a mania, and died by suicide, suggesting depression.

Visual art is an area of human activity with a tradition extending back to the cave drawings of prehistory. There are libraries full of art history and a large body of well argued concepts. Like many other forms of human endeavor, there is continuous progress and the activities at the leading edge may not be understood or valued by the average person.

In 1917 Marcel Duchamp placed a urinal in an art exhibition in USA, calling it "Fountain". He said this was art, because he said it was art. In 1961 Piero Manzoni defecated in 90 small cans, which he labeled, "Artist's shit". These sold for more than their weight in gold. In 1994 the Danish artist Christian Lemmerz put six dead pigs in a glass case so that visitors to the Ezbjerg Gallery could watch them decompose. The exhibit had to be cancelled because of the stench. In 2001 the prestigious and valuable Turner Prize, offered by the Tate Gallery, Britain, for contemporary art was won by Martin Creed whose exhibit was a bare room with a light which switched on and off. Interviewed about the meaning of his work, Creed said little more than that the light went on and off. In 2002 the valuable Paul Hamlyn Foundation Award was won by Ceal Floyer for "Rubbish Bag". This was a rubbish bag full of air. The artist stated that the intention is that the viewer wonders whether the bag is full of air or rubbish. In 2003 Tracy Emin sold an unmade bed and two suit cases to a London art gallery for three times the average annual wage. In the same year, the Trapholt Art Museum in Kolding, Denmark, presented an instillation of 10 food blenders with a goldfish in each, and invited visitors to turn them on. Some did so, and a charge of cruelty to animals was prosecuted. The artist, Marco Evaristi, stated the aim of his art was to provoke "ethical thought".

Art is based on work that has gone before, and new movements generally represent advances in the field. I do not understand what is being communicated by the works mentioned in the above paragraph, but that is presumably because of my ignorance of the field. If a person who belongs to a particular sect has a belief which is foreign to the treating psychiatrist, such as, God will arrive on earth tomorrow and he will have iridescent purple hair, before this belief is branded a delusion, the psychiatrist must ask other members of the sect. If the belief is shared by a group of people it cannot be classified as a delusion. Sect members are usually quite definite about whether a member is psychotic or not. The same can be applied to the field of visual art. While some contemporary art may appear to be the work of a psychotic person, if peers accept the work, it is probably not the work of a psychotic person. Art critics do not describe the above artists as psychotic. The rest of us must consider their advice seriously.

There is much anecdotal evidence to indicate that creative people are more often eccentric or more often have odd personality features than the non-creative population. Hans Christian Anderson, the Danish author of children's stories carried a coil of rope for fear of being caught in a hotel room fire. When the wife of the poet and painter Rossetti died, as a token of his love, he placed his unpublished manuscripts beside her in her coffin. Seven years later he dug up the coffin, dusted off his papers and published them. Sir Walter Scott had a salt cellar which was made from the fourth cervical vertebra of Charles I. James Joyce kept a tiny pair of doll's knickers in his pocket. Marcel Proust wrote most of his novels lying in bed. Rossini was completely bald and wore a wig. In exceptionally cold weather, however, he wore two or three wigs simultaneously. Beethoven had no interest in personal cleanliness and his friends had to take his dirty clothes away and wash them while he slept.

There is also anecdotal evidence that many great scientists have been eccentric. Sir Francis Galton, one of the most prolific scientists of all time regularly carried a brick wrapped in brown paper and tied with a piece of rope, so that he could stand on it to see over people's heads when he was in a crowd. Alexander Graham Bell kept his windows permanently covered to keep out the harmful rays of the moon. Sir Joseph Banks was described by his biographer as "a wild and eccentric character". Nicola Tesla, who gave his name to the unit of magnetism was celibate and said, "I don't think that you can name many great inventions that have been made by married men". Henry Cavendish, a great chemist and physicist, was exceptionally shy and would only ever eat mutton. He communicated with his servants by letter, if he met one by accident, they were dismissed. He had a second staircase built in his house so that he could avoid them more easily. J B S Haldane was one of the best known scientists of the twentieth century, at one time he did not remove his boots for three weeks. General Haig said of him that he was "the bravest and dirtiest

soldier in the army". Dr Paul Erdos was one of the most gifted mathematicians of all time, writing 1500 scientific papers. He lived as a homeless derelict, shunning material possessions because, "property is nuisance".

Professor Nancy Andreasen (1987) studied 30 living creative writers, thirty control individuals and the first-degree relatives of both groups. A specially designed structured interview addressed both creativity and mental health. The writers had substantially higher rate of mental illness, particularly mood disorders. The first-degree relatives of the writers also had a higher prevalence of mood disorder and creativity. These results suggested that creativity and mood disorder were in some way linked, and that genetic factors could be involved.

Dr Felix Post (1994) studied the biographies of 291 world famous men from the fields of science, thought, politics and art, looking for evidence of psychopathology. He concluded that they excelled not only by virtue of their abilities and originality, but also through their drive, perseverance, industry and attention to detail. He found that unusual personalities and minor mental disorders were more common among this group than among the general population. Of the more serious mental disorders depression and alcoholism and perhaps sexual disorders were more common than among the general population. This was most marked among the writers. His point is well taken, that while odd and different and more often depressed and alcoholic, these people were productive because of their positive characteristics and capacity for careful and sustained work.

Dr Arnold Ludwig (1994) studied the mental health of 59 living female writers and a control group, using a questionnaire and interview. He found higher rates of mental disorder among the writers. The most common were mood disorders, drug abuse, anxiety and eating disorders. While genetic links between creativity and mental disorder were suggested, it was also found that a higher proportion of writers had experienced sexual or physical abuse in childhood. Thus, environment rather than genetics may have been the important factor. Whatever the root of the mental disorders and unusual personality features, this psychopathology seemed to provide the basic ingredients and motivated the writing process. Further, writing appeared to provide a form of self therapy. Ludwig also made the point that personal strengths were evident and necessary for writing.

Dr Felix Post (1996), in his study of 291 world-famous men, had found an increased prevalence of psychopathology among writers. He set out to confirm those findings, and to seek causal factors, by looking at a group of 100 writers. The biography analysis method was again used, and poets, prose fiction writers and playwrights were compared. The findings were consistent with his earlier study with each group of writers showing a high prevalence of mood disorder, alcoholism, unusual personality features, sexual and marital problems. Overall, some form of mood disorder was present in 82% of writers, the prevalence increased from poets to prose writers to play writers. Overall, 75% of these writers had a family history of mental disorder.

Dr Post proposed a causal connection between literary creativity and proneness to depression and alcoholism. Mood disorder may be conceptualized as a particular sequence of brain cell activity. Unfortunate life events may result in increased activity in these cell circuits. In those who have inherited a predisposition, unfortunate life experiences may increase activity resulting in changes in cell activity and mood disorder.

Post postulated that the increased activity which can lead to mood disorder, might not only be precipitated by external events, but could also, perhaps, be caused by creative efforts, in particular, by verbal creative efforts. Thus, he postulates that creative effort is the cause of the increased prevalence of mood disorder and other psychopathology observed in creative people, particularly writers.

Other possible explanations are purely genetic. The possible mechanisms include that genes for psychopathology and creativity are close together on a chromosome and are thus inherited together, or that the same gene serves or underpins both creativity and psychopathology.

Opposing the view that the creative effort may cause psychopathology observed in writers (Post, 1996), is the view that creative effort may function as therapy (Ludwig, 1994). Artistic, particularly literary, creativity calls for knowledge of the self and an appreciation of the self in relation others and the environment. It is

Poet	Pulitzer Prize	Treated for Depressive Disorder	Treated for Mania	Committed Suicide
Hart Crane		+	+	+
Theodore Roethke	+	+	+	
Delmore Schwartz		+	+	
John Berryman	+	+	+	+
Randall Jarrell		+	+	+
Robert Lowell	+	+	+	
Anne Sexton	+	+	+	+
Sylvia Plath	+	+	?	+

Illustration 11.1 Professor Kay R Jamison extracted this information from the New Oxford Book of American Verse. Among the 36 poets included in that authoritative publication, eight had been treated for depressive disorder. Of this eight, at least seven (possibly all) had also been treated for mania, indicating bipolar disorder. Five had committed suicide. These prevalences are very much greater than would be found among 36 members of the general population, indicating a link between creative writing and mood disorder (Adapted from Jamison (1990).

conceivable therefore, that creative activity has therapeutic potential, particularly where there are distressing early life experiences and consequent low self-esteem.

When the above accounts are teased out, and supplemented by the work of other scientists, including that of Professor Kay R Jamison (Illustration 11.1), there is evidence that the reported mood disorder includes both depressive disorder and bipolar disorder. One can accept that the suffering experienced during episodes of depression may provide the individual with subject material write about, and the motivation to work during periods of remission.

But what of manic episodes? During manic episodes the individual has racing thoughts, many ideas, increased energy, decreased need of sleep, confidence and a willingness to take risks. As long as mania is only mild and does not cause the individual to become unable to think or function, or lack food intake and sleep to the point of collapse, it can be seen that mood elevation could be an advantage. If we consider two equally well trained and intelligent individuals, but one has increased energy, decreased need for sleep, more ideas and a willingness to take risks, it is clear which will be the more productive and longest remembered. The last seven years of Van Gogh’s life is a probable example. Spike Milligan, widely regarded as a “comic genius”, is a better example, as his bipolar disorder was more clearly apparent and quite well documented (Illustration 11.2).

With respect to unusual personality features, are we looking too deeply? It is not uncommon for people who are successful and enjoy the adulation of the masses to become flamboyant. In fact, flamboyance is a good means of drawing attention to oneself and one’s work. Flamboyance can be just good business sense. Further, if one has an absorbing idiosyncratic interest, such as painting or writing, is it surprising if one pays more attention to that issue, than to appearance, manners and more conventional issues?

Great things, perhaps even for talented individuals, can only be achieved through great focus and determination. Satirist John Clark wrote (2000) “Mahatma Gandhi. Joan of Arc. Thomas Edison. Emily Pankhurst. St Thomas Aquinas. Marie Curie. Copernicus. Boadicea. Socrates. Jane Austen. Alexander the Great. Florence Nightingale. Leonardo da Vinci. Eleanor Roosevelt. Who among them devoted their lives to obediently fitting in, doing what was expected of them, subjugating their own preferences, serving the will of others, meekly following the conventions of the day?”

POEMS OF SPIKE MILLIGAN

Manic Depression

*The Pain is too much
A thousand grim winters
grow in my head.
In my ears
the sound of the
coming dead.
All seasons
All sane
All living
All pain.
No opiate to lock still
my senses
Only left,
the body locked tenses.*

Hope

*Just when I had made my today
Secure with safe yesterdays
I see tomorrow coming with its pale
glass star called hope.
It shatters on impact
And falls like splinters of cruel rain
And I see the red oil of life
running from my wrists
onto tomorrow's headlines.*

2B or not 2B

*When I was small and five
I found a pencil sharpener alive!
He lay in lonely grasses
Looking for work.
I bought a pencil for him
He ate and ate until all that was
Left was a pile of wood dust.
It was the happiest pencil sharpener
I ever had.*

Illustration 11.2. Allen Terrence (Spike) Milligan (1918-2002) was born in India. He served in the Second World War during which he suffered "shellshock" (a term which covers a range of reactions to the stress of warfare). Subsequently he wrote comedy for all forms of media, the best known being *The Goon Show*. Spike changed the face of comedy in Britain and around the world. His influence is obvious in the Monty Python's *Flying Circus* scripts. He also influenced entertainers in other fields, including the Beatles. Toward the end of his life he remained active in comedy, but he was also became active in conservation.

Spike had well documented bipolar disorder (also known as manic depressive psychosis). There is clear evidence that mania underpinned some of his comedy.

"Manic Depression" (above) was written during a depressive episode in 1953/4, when Spike was in the Psychiatric Wing of St Luke's hospital. "Hope" (above) was written following a depression related suicide attempt by wrist cutting in 1971, in Woy Woy, Australia.

"2B or not 2B" (above) is a playful poem which may have been influenced by an episode of mood elation.

Reproduced by permission of Spike Milligan.

CASE REPORT

Les Murray is a world-famous poet, the winner of numerous awards including the T S Elliot Prize and the Queen's Medal (UK) and the Petrarch Prize (Germany), who was born and raised and has returned to Bunyah, a rural district in New South Wales, Australia.

At the time this book was written, Les had authored or edited over thirty books, mainly poetry, but some prose. In "Killing The Black Dog" he gives a personal account of suffering depression and anxiety and his self-treatment through writing poetry. He has also spoken on this topic on radio and television. The black dog was a term used by Winston Churchill when referring to his episodes of depressive disorder.

Les was born in 1938 and was an only child. Subsequent to his birth, his mother had a series of miscarriages. A miscarriage caused her death when her son was 12 years of age. The boy felt responsible for his mother's death, and was told this was the case on more than one occasion by his father. He came to fear sexual intimacy which he associated with fatal consequences.

In his mid-teens Les changed schools. "There, among neatly dressed town kids for the first time, I made all the wrong opening moves and promptly died for it. I came on as friendly, puppy-like, as well as a Brain and a show-off, and the unanimous verdict was that I must be reminded constantly that I was fat and ridiculous." He remained there until he completed school two years later. He had no friends, he was only once addressed by his first name and constant reference was made to his weight.

On leaving school Les had a variety of posts, working for a time as a translator of technical and scholarly texts at the Australian National University. He married Valerie Morelli at 24 years of age and they lived overseas for a year. Les completed his Bachelor of Arts at 31 years of age. He then worked in the Public Service before becoming a full-time writer.

On reflection, Les considers he has suffered depressed mood for much of his life. His first acute episode commenced when he was about 21 years of age and lasted more than two years. He experienced phases of mild mood elevation and moderate depression. In "Killing The Black Dog" he describes severe inanition. He self-treated with stimulants, which were readily available.

His second acute episode began at 50 years of age, following a conversation in which a woman "cheerfully recalled to me one of the nicknames she had bestowed on me thirty-odd years earlier". Within days he was experiencing pain in his hands and began weeping while driving his car. He could no longer tolerate the taste of tobacco and suffered indigestion. He was admitted to a cardiac ward with chest pains, which proved to be a panic attack. Subsequently he suffered many panic attacks, sometimes three or four in a day.

He experienced "sessions of bottomless misery". His thoughts were "like shredded mental kelp marinated in pure pain". He experienced early morning awakening, with "troubles and terrors ripping into you with a gusto allowed them by fatigue and the disappearance of proportion".

From his account Les suffered major depression and panic disorder. He obtained little benefit from the antidepressant medications, but some help for his panic disorder from an anti-anxiety medication. He got help from work, family and the support of other sufferers.

At this time, he found writing prose difficult, "when I was utterly depleted I concentrated my resources around my essential art form, poetry, because it was what I'd bet my life on." He embarked on an attempt at self-treatment, a talking cure rather than a chemical one. He talked to himself, using poetry. He sought through introspection, to understand himself and his illness, and repeat it "till I could 'hear' it and think straight about it". He concluded that the death of his mother was an important issue. He remembered that he had felt she had a growing dislike for him as her miscarriages continued, and that he had felt guilty for being born. He discovered he "had been furious at my father for sinking into broken-hearted grief when my mother died, a grief he had nourished and refused to give up till the day of his own death some forty-four years later".

Burning Want

by Les Murray

*From just on puberty, I lived in funeral:
mother dead of miscarriage, father trying to be dead,
we'd boil sweat-brown cloth; cows repossessed the garden.
Lovemaking brought death, was the unuttered principle.
I met a tall adopted girl some kids thought aloof,
but she was intelligent. Her poise of white-blonde hair
proved her no kin to the squat tanned couple who loved her.
Only now do I realise she was my first love.
But all my names were fat-names, at my new town school.
Between classes, kids did erocide*: destruction of sexual morale.
Mass refusal of unasked love; that works. Boys cheered as seventeen-
year-old girls came to me, then ran back whinnying ridicule.
The slender girl came up on holidays from the city
to my cousins' farm. She was friendly and sane.
Whispers giggles round us. A letter was written as from me
and she was there, in mid-term, instantly.
But I called people 'the humans' not knowing it was rage.
I learned things sidelong, taking my rifle for walks,
recited every scene of From Here to Eternity, burned paddocks
and soldiered back each Monday to that dawning Teen age.
She I admired, and almost relaxed from placating,
was gnawed by knowing what she came from, not who.
Showing off was my social skill, oddly never with her
but I dissembled feelings, till mine were unknown to me too
and I couldn't add my want to her shortfall of wantedness.
I had forty more years, with one dear remission,
of a white paralysis: she's attracted it's not real nothing is enough
she's mistaken she'll die go now! She'll tell any minute she'll laugh –
Whether other hands reached out to Marion, or didn't,
at nineteen in her training ward she had a fatal accident
alone, at night, they said, with a lethal injection
and was spared from seeing what my school did to the world.*

Illustration 11.3 Les Murray is a world-famous poet. He has suffered depressed mood for most of his life. He has suffered at least two acute, but sustained episodes. He used poetry to explore his memories and emotions in an attempt at self therapy. He was partially successful. *Burning Want* is an example of his exploration. See the text for more details.

* Les coined the term "erocide" to mean the deliberate destruction of a person's sexual morale.

Les faced everything he could dredge up. Important, helpful poems written during this process include "Burning Want" (Illustration 11.3) and "Head-Spider". He was better but he wasn't cured. "...I'd used my best Sunday punch on my illness, putting it under the burning glass of poetic analysis, and still hadn't defeated it".

Then at 58 years, Les was struck down with a very rare condition, a liver abscess. Part of his liver was surgically removed and he was unconscious for many days. There was an enormous expression of public love and concern in the form of letters and flowers from all over the world, and regular radio bulletins on his progress. Building on the growth he had achieved through his self-examination in poetry, this public response, when he finally regained consciousness, was the "affirmation I'd needed". His depression dissipated. In the five years since the liver abscess, Les has remained emotionally and physically well.

SUMMARY

The notion that madness and genius are somehow linked goes back to antiquity. The terms madness and genius are poorly defined, the only question which can be approached is whether there is any linkage between mental disorders and creativity or achievement of world-fame proportions.

Schizophrenia is a psychosis which is perhaps the archetype of pathological madness (as opposed to the madness of anger and madness of carefree fun). In schizophrenia thinking is disorganized and there is lack of drive. There is no evidence of increased prevalence of schizophrenia among the creative and famous.

There is some evidence of an increased prevalence of eccentricity and unusual personality features among the creative and famous. It is possible that there is a genetic explanation, but we should not lose sight of the fact that flamboyance is good advertising and may be used to draw attention to our work. Also, people with absorbing interests are going to pay more attention to them than to appearance and behaving in a conventional manner than the rest of us.

There is good evidence that mood disorder, alcoholism and sexual disorders are more common among creative people, particularly writers. It may be that there is a direct genetic explanation, meaning that the genes for certain psychopathology and creativity are located close together on the same chromosome and are therefore commonly inherited together, or that the same gene serves or underpins both psychopathology and creativity. The contrary explanation is that writers have, more often than members of the general population, experienced damaging early life experiences, which have stimulated both the psychopathology and the creativity. Rather than one of these explanations being correct and the other incorrect, it is possible that both genetic and environmental influences are important.

The suffering experienced during episodes of depression may provide the subject material and the motivation to write during periods of remission. During mild manic episodes the increased amount of thoughts and energy, the decreased need of sleep, the confidence and willingness to take risks, may increase productivity and success.

It is of interest that some writers use their craft as a form of therapy, "writing out" their pain. An apparently opposing view is that creative activity increases the activity of certain brain cell circuits and that in vulnerable individuals, this can lead to depression.

If madness means schizophrenia, there is no link between madness and increased creativity and productivity. There is a link between creative writing and depression and alcoholism, but the nature of this link remains to be determined.

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CHAPTER 12

SUICIDE

Why are we so distressed when we hear about a suicide? Everyday, on the news, we hear about death – car accidents, industrial accidents, fire, landslides, murder, assassination, war casualties, disease and starvation. We feel fleeting sympathy for this procession of unfortunate people and their unfortunate families. But we pause and feel more deeply when we hear of a suicide. Why is that? Is it because we can identify more closely, we can become that person for a moment? And if so, why? Is it because we have all been tempted at one time or another? Can we identify more closely with the person who has suicided than the hang glider who has crashed to death, because we know how it feels?

For some of us, the answers to those questions will be, yes. For others, the answer will be, no. One certainty about suicide – it's not a “one size fits all” issue. Suicide is complicated. All those who suicide are individuals with distinct histories and predicaments, and all those who study suicide have their own biases and agendas.

It is appropriate for me to declare my own history and bias. I have spent my professional life in state hospitals, admitting and treating severely mentally ill and socially dysfunctional patients. State hospitals have the authority to compulsorily detain mentally disordered patients, and accordingly, are seen by some to be responsible for all actions of all admitted patients. Some suicide, and some suicide in hospital, is inevitable. When this happens, police, coroners, families, newspapers, administrators and others, blame the hospital staff. These blamers don't consider the 5000 success stories, they focus, instead, on the occasional unfortunate, unavoidable event. My history then is of being blamed for (damaged by) the suicide of others, and my bias is toward the view that suicide is sometimes not preventable.

Laughter and suicide are actions that may be associated with a range of emotions and situations. Laughter may be associated with being tickled or, less commonly, the acute pain of barking the shin against a steel railing. Laughter may occur in situations of pleasure as when winning a large bet, or in situations of embarrassment, as when tripping over on a first date.

IS SUICIDE A FORM OF MADNESS?

Suicide may be the result of religious or political fervor – an individual giving his or her life to further the cause. In some circumstances, martyrdom is simultaneously achieved. Suicide bombing in the Israeli conflict and the crashing of planes on September 11 being recent examples. In the Second World War Japanese kamikaze pilots crashed their planes into enemy ships. In the 1960s many people self-immolated in Vietnam in protest against the war.

In late 1969, Jan Palach a 20 year old university student self-immolated in Wenceslas Square, Prague, in protest against the Soviet invasion of Czechoslovakia. Twenty five followed his example in the following

three months. A recent Czech assessment stated "...the memory of those who decided to put their death in the service of truth guided many Czechs through the hopeless decades of the Communist dictatorship. Their selfless act shaped the Czech conscience during the 20-year period between 1969 and 1989, and changed it forever".

In 1998, Thupten Ngodup a Buddhist monk of 50 years, self-immolated in New Delhi, in protest against the Chinese occupation of Tibet. In mid-2003 four Iranians self-immolated [three in Paris and one in London] in protest against the arrest, in France, of members of the opposition group, the People's Mujahideen.

Suicide, for a person with a terminal illness, may be a way of escaping a painful and undignified end. In 1983, Arthur Koestler, an internationally known writer, thinker and advocate of euthanasia of 78 years, suicided in London. He was suffering from Parkinson's disease and had let it be known that he would end his life when his symptoms became intolerable. (Some writers have used the term, rational suicide, in this type of situation.) In August 2002, Jo Shearer a 56 year old Adelaide woman committed suicide. A former journalist and war correspondent, she was not suffering a terminal illness, but intractable pain from a progressive spinal disease. A month before she died she gave a newspaper interview in which she detailed her intentions, on condition that the story would only be published after her death. In most countries, suicide is not illegal, however, it is illegal to assist someone to die (euthanasia). There is a strong call in many areas for euthanasia to be made legal for those suffering terminal or painful conditions.

Suicide, for the public figure who has been disgraced and lost fortune and future, may be a reasonable option. There are many examples. Mark Anthony and Cleopatra suicided in 30 BC, in Alexandria. Following the death of Julius Caesar, Mark Anthony and Octavius had controlled the Roman Empire. The bond was strengthened when Mark married Octavius' sister (Octavia). However, Mark rejected Octavia and Rome and for Cleopatra and Egypt. Octavius took an army to Egypt, crushed the forces of Anthony and Cleopatra in the Battle of Actium, and pursued them to Alexandria. Faced with defeat, disgrace and retribution, they took their own lives.

In 1987, 47 year old Budd Dwyer, a Treasurer of Pennsylvania was convicted in a bribery scandal. He called a press conference, declared his innocence and while the cameras were recording, pulled out a pistol and shot himself in the mouth (Illustration 12.1). In 1996, 56 year old Jeremy (Mike) Boorda, a prominent USA admiral, was being pursued by the media for wearing a medal to which he was not entitled. He shot



Illustration 12.1 a & b. In 1987, Bud Dwyer called a news conference and while the cameras were recording, he pulled out a 44-magnum pistol, put it in his mouth and shot himself in the head.

Dwyer was Treasurer of Pennsylvania and had been convicted of a bribery scandal. His political life was at an end. He may have been angry or experiencing other unpleasant emotions. There was, however, no evidence that this man was suffering from a psychiatric disorder.



Illustration 12.2. Vlado Stojiljkovic had been the head of the Serbian Police and was charged with crimes against humanity. Hours after the Yugoslav parliament adopted a law approving his extradition to the UN war crimes trial, in 2002, he walked in front of the parliament building, calmly took out a pistol and shot himself in the right temple.

An associate read Stojiljkovic's suicide note to the media. "With this act, as a deputy of the federal parliament, I express my protest against this puppet regime". It continued with criticisms of various political figures, and ended with, "The citizens of this patriot and patriots will know how to avenge my death".

As with Bud Dwyer, in Illustration 12.1, we do not have an accurate account of the man's state of mind at the time he shot himself. However, the setting of his actions and the words of his suicide note indicate that he was motivated, at least in part, by anger toward his political enemies.

himself in the head. In 1998, 37 year old Justin Fashanu, a prominent former Norwich City soccer hero, who was wanted in the USA for sexually molesting a 17 year old male, hanged himself from a London bridge. In 2002, Vlado Stojiljkovic who had been the head of the Serbian Police was to be extradited to face a UN trial for crimes against humanity. He walked in front of the parliament building and shot himself in the head. His suicide note was an angry attack on those who had voted for his extradition (Illustration 12.2).

Members of the public often believe that people who suicide must be suffering from a psychiatric disorder and that they are therefore not responsible for their actions. (The corollary is that any health service staff who have been in contact are the ones who are responsible.) Support for the belief that those who suicide are suffering from mental disorders comes from a research process called the "psychological autopsies". In this process, a group of experts who study suicide, select cases of completed suicide and examine all the information available about what the deceased said and did in the last weeks or months of their lives. These groups usually find at least half and in some studies nearly all the deceased suffered symptoms of mental disorder before they died.

It is reasonable to assume that, immediately before the act, all or almost all of those who suicide are feeling sad, angry and isolated. It is probable that the majority of those who suicide experience symptoms of mental disorders. But, having symptoms does not mean that one has a fully established and diagnosable mental disorder. No psychological autopsy has convincingly demonstrated that the majority of those who suicide have been suffering mental disorders such that they were not responsible for their actions.

There are many "psychological autopsies" done by journalists that indicate that suicide may occur in the absence of mental disorder. These are not true psychological autopsies, of course, as the journalists are not experts in suicide research. Nevertheless, when investigating suicides, journalists inquire about the state of mind, psychiatric history and past and recent life events. They are looking, particularly, for evidence of professional negligence or failure of the common man to support his neighbor, that is, signals to which others should have responded. They offer a reasonably comprehensive account of events by a sensible person trained in investigation and analytical thinking. In 1990, in Melbourne, 50 years old Floyd Podgornik, an apparently happy rags-to-riches millionaire property developer shot himself. In 1996, in France, 41 year old Amschel Rothschild, a successful pilot and rally car driver, farmer, banker and heir to a huge fortune, hung himself. In 1999, in London, 58 years old, David Edward Such, who legally changed to Lord Such and was known as Screaming Lord Such, hung himself. Such had been a star of rock and roll in the 1960's, he continued to live by making music in pubs and at concerts, but he was best known as a political satirist and prankster. Wearing outrageous clothes, he established the Monster Raving Loonie Party which he headed for 30 years, making him the longest serving political leader in Britain. The party slogan was, "Vote for insanity – you know it makes sense". His ex-wife, ex-de facto, current fiancée and 24 year old son were among his mourners. While it is probable that the above people who took their own lives felt sad, angry or isolated at the time of taking their lives, journalists could find no evidence of mental disorder. Further, all were apparently successful and had friends, and there were no warning signs to indicate impending suicide.

Suicide, like homicide, is a piece of behaviour that ends in death. The difference is the direction in which the violence is released. In homicide the perpetrator is held responsible, in suicide, others are held responsible. Homicide may be the result of anger, avarice, revenge, and less often, mental illness. Suicide may also be associated with a range of human emotions and occur in a range of circumstances.

HIGH AND LOW RISK

The concept of identifying groups of people according to the level of risk of suicide (low-risk and high-risk) opens further discussion of the topic and sets a basis for prevention strategies.

Researchers have been trying, for many decades, to find markers or factors which will predict suicide. If good markers could be found, people so identified would form high-risk groups. Such groups could receive special attention and treatment, with the reasonable expectation of preventing suicide.

The social characteristics of male sex, increasing age, widowhood, single or divorced state, childlessness, high standard of living, economic crisis, high alcohol consumption, broken home in childhood and the medical characteristics of a present mental illness, family history of mental illness and a history of previous suicidal behaviour were identified as important markers of suicide, by Stengel, in 1971. No new markers have emerged in the last couple of decades. Markers are regularly rediscovered and have recently been recast as three domains of risk factors which may contribute to suicide, 1) mental and behavioral disorder, 2) rootlessness and social withdrawal, and 3) chronic interpersonal problems. These rearrangements are of little help, they contain nothing new,

The problem is that the markers we have are not very good. Even if a person has many of these markers, this does not predict suicide with any degree of certainty. This is because the base risk of suicide is very low, and it can be multiplied five, 10, 20, or even more times, without the risk becoming very strongly predictive.

Let's put some numbers up to get the problem into perspective. Suicide rates are expressed as the number of deaths in one year which occur in 100 000 people. The United Kingdom has a suicide rate of around 15, Australia around 17, and Canada around 25. These are very small numbers compared to the population of 100 000 from which they come. Thus, in spite of all the media hyperbole when the suicide rate goes up a bit in one region, suicide is still a rare event. Where the annual rate of suicide is 20 per 100 000, each person has, in one year, a 0.02% chance of suicide. If the markers mentioned above were able to indicate those people who are 50 times more likely than the average person (they are not that good), then those people in the high-risk group would have a 1% chance of suicide. This means that to save one person, 100 people would need to be identified and treated for one year.

From 100 high-risk people, hopefully, one person would be saved, but statistically speaking, 99 others would be identified and treated who were not going to suicide. Thus, at the moment, because the markers are not specific, the high-risk approach is very inefficient.

A number of observations appear to support the high-risk approach to the prevention of suicide. One is that about 10% of people with major mental disorders, such as bipolar disorder and schizophrenia, will eventually suicide. It is proposed that this would be a good place to start. [This is somewhat naïve. Of course the clinicians involved in the treatment of such patients are aware of the increased risk in this population, they are experienced, and they do their best.] People with major mental disorders continue to suicide, not because the clinicians are not aware of the problem or not trying, but because suicide is impossible to predict, and major mental disorders, which often respond poorly to treatment, complicate all aspects of the patient's life. It needs to be kept in mind that this 10% is a life-time figure, so for 10% of patients, it will occur at some stage in the next 40 or 50 years. The other 90% will not suicide, and will not welcome unnecessary supervision and treatment.

It is also believed that about half of those who suicide will have visited a general practitioner (GP) in the month before death, so this too, is proposed as a good place to start. In recent years, in the Western

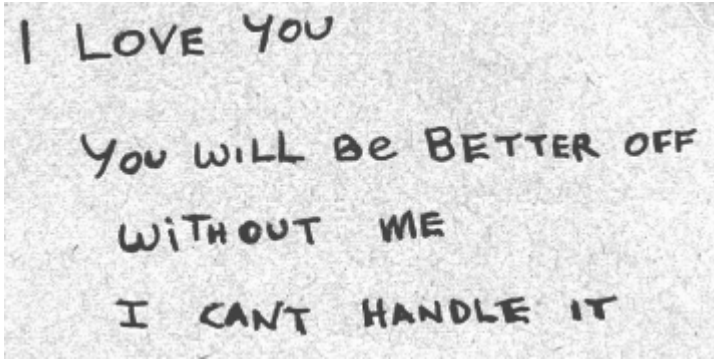


Illustration 12.3 This suicide note was left by a middle-aged man. He had taken overdoses of medication on half a dozen occasions and survived. He had a severe alcohol problem. He was living independently of, but in the same house as, his wife and children. He reported depressed mood and was being treated for depression. How much his depression was a primary condition, or secondary to his alcohol intake and the strained family relationships, was not clear. Nor was it clear whether he expected to survive this overdose, as he had the others.

The note suggests that the patient was suffering and that he had regrets. He was a man at long-term risk of suicide who was unable to find lasting satisfaction in life, in spite of the best efforts of mental health professionals.

world, GPs have responded to the need to increase awareness and skills in the field of mental health. This has included attention to suicidal risk and appropriate management. While valuable, these efforts are not going to solve the problem of suicide. As suicide is rare, it occurs only once in five years in a patient of an average GP. It is difficult to be completely prepared to deal with rare events. Also complicating the picture is that while people with emotional problems may present to the GP, they often deny them, presenting instead with physical problems.

While the treatment of high-risk populations may not reduce the suicide rate across the entire population, the question remains, does treatment of high-risk groups significantly change the risk for people in those groups. Does the treatment of high-risk groups change outcomes? Unfortunately, randomised controlled studies of intensive treatment of high-risk groups do not show that this approach saves lives (Appleby et al, 1999) (Illustration 12.3).

In response to budgetary constraints the criteria for psychiatric admission for the Fulton County, Georgia, USA, were changed in 1996. Admissions were halved. Admission was resisted for those with “personality disorders, chronic suicidal ideation, or long-standing patterns of self-injurious behaviour”. For the period 1997-1998 there was a slight fall in the suicide rate in that county. This led to the conclusion that “the availability of inpatient psychiatric services does not have an impact on the occurrence of suicide” (Garlow et al, 2002).

The other approach to the prevention of suicide is the public health model. This approach is appropriate for rare conditions, where there is low risk, but everyone in the population is at least at this level of risk. Looking at the numbers, for a population of 100 000 who are at a 0.02% risk, if 1000 people are removed because they are at high risk, 99 000 will remain in the low-risk group. From this 99 000, at 0.02% risk, using simple mathematics, 19.8 people will suicide, which is nearly the 20 which would be predicted from the original 100 000. Statisticians and epidemiologists would explode with outrage if they read this paragraph as it is inaccurate – it does not take into account that the risk for the low-risk group would fall when those in the high-risk group are taken out of the equation, and there are other omitted mathematical subtleties. These “ball-park” figures are presented, however, to illustrate that when the low risk group is large, even though the risk is small, it will produce many, if not most, of the suicides. In these circumstances, a whole of population, or public health approach is needed.

Huntingtons disease is a fatal neurological disorder which is transmitted by an identified gene. It occurs only in particular gene carrying families. In any community, the members of these families and the treating doctors know which families carry the gene. The diagnosis, treatment and prevention of Huntingtons disease is best suited to a high-risk approach. It is clear that the children of Huntingtons disease families are at high risk and the rest of the population is at no risk. It would be wasteful to screen the entire population for this disorder.

Motor vehicle accidents, by contrast, can happen to anyone. It may be argued that certain individuals are at greater risk, such as those with past driving convictions and people who take excessive alcohol. But because the whole community, even the little old lady who only drives to church, is at some risk, community wide measures are appropriate. These measures, which include speed limits, legal blood alcohol levels, compulsory seat belt wearing and technical improvements in roads and cars, have been shown to reduce accidents.

An interesting aside is that a high-risk approach to driving can be counter productive. Starting from the observation that young drivers were more commonly involved in accidents, driving education of school children was expected to reduce the number of accidents involving young people. The result was the opposite, the total number of accidents involving young people increased. The reason was that driver education resulted in more young people driving. While the new young drivers were better trained than the young drivers of the past, there were more of them, and while their risk was lower, the greater number on the roads resulted in a greater number of accidents. Prevention is not always a straightforward matter.

So what public health measures might be effective in reducing suicide? There is some evidence that reducing access to lethal means of suicide may be beneficial, however, this is not proven, and some substitution with new methods would seem likely (Lewis et al, 1997). In Fiji, paraquat, a highly lethal insecticide used in sugar cane farming is ingested by half the Fijian Indians who suicide. I was discussing the wisdom of regulating the supply of paraquat with a local psychiatrist. "But you can't make rope illegal", he said. The other half of the Fijian Indians who suicide, hang themselves.

In the UK poisonous domestic gas and barbiturates (sleeping medication which is fatal in overdose) were phased out and this was reflected in a decline in the suicide rate between 1963 and 1970. However, the rate rose again after the mid-1970s. Later, catalytic converters, which render car exhaust relatively harmless, became compulsory and this was at least partly responsible for a decrease in suicide incidence from 1990 to 1997. Reducing the availability of firearms and the substitution of drugs that are not dangerous in overdose, for older potentially fatal drugs, may be helpful, temporarily at least.

It is worth asking the questions, is suicide a disease, and is suicide a medical problem? Emile Durkheim (1897), a French sociologist, was an important pioneer in the study of suicide. He described "altruistic" suicide, in which the individual sacrifices his life for the good of the group. The religious and political suicides mentioned above fit this category. The larger part of his work, however, indicated that suicide was the result of a weakening of the links between the individual and the group to which he or she belongs. Suicide could be anticipated when there was decreased social integration, regulation and control, and increased isolation or oppression of the individual. His work stated that suicide was not a medical but a social matter.

More than a century later we are still discovering that the social characteristics of male sex, increasing age, widowhood, single or divorced state, high standard of living, economic crisis, high alcohol consumption and broken home in childhood are important markers of suicide. To these may be added the medical characteristics of presence of mental illness, family history of mental illness and a history of previous suicidal behaviour.

A most important risk factor is unemployment and national recession. This was demonstrated by increasing suicide rates during the Great Depression of the 1930s. More recent examples come from Japan which has been in recession. In the late 1990s, many Japanese businessmen suicided by leaping from skyscrapers. In 1998, 58 year old Takayuki Kamoshida, Director of the Bank of Japan hanged himself in his flat in Tokyo. In that year the total number of suicides for the country rose by 34.7% to 32 860. This increase

was believed to be a consequence of the worsening economic state of the country, and the national Japanese characteristic of measuring self-worth by income and employment status.

What are the implications of the finding that suicide rates are linked with levels of unemployment and the health of national economies? These issues are outside the sphere of influence of the medical profession. The same can be said for the current high rate of single parent families and unsatisfactory outcomes of the divorce process, by which children may be deprived of the benefit of contact with one parent. It is hoped that future social policies will produce more supportive and integrated communities.

Alcohol abuse is now cast as a social rather than a medical issue. An association between alcohol abuse and increased risk of suicide is well established. It is due, at least in part, to the destructive sociological consequences of alcohol abuse - interpersonal conflict, court appearances, unemployment and divorce. In addition, alcohol reduces the level of neurotransmitter activity in the brain, thereby causing depression. It has been noted that lowering the legal drinking age from 21 to 18 years of age increases the frequency of suicide in 18 to 21 year olds by 8% (Birckmayer et al, 1999). Social or other policies which reduce alcohol abuse can be expected to impact on the rate of suicide.

DIFFERENT COUNTRIES, TIMES AND RATES

We should look at how the decision is reached that suicide has occurred. Suicide is not a medical diagnosis. It is a legal finding, made by a coroner or magistrate. There is no blood test or x-ray that identifies cases of suicide, instead, there are opinions and judgements about the intentions and behaviour of persons who are not present.

The possible findings of a coroner's inquiry depend on the jurisdiction, but in general these are, death by natural causes, murder, suicide or misadventure (accident). In exceptional circumstances an open finding is made, which means that there was not enough information to form an opinion.

It is reasonable to believe that coroners and magistrates are disciplined, but mortal. They are aware of the sensitivities of the communities they serve, and it is not insulting to suggest that they may be influenced by changes in public attitude.

When the community attitude is that suicide is sinful and disgraceful, there is a tendency for coroners and magistrates, out of respect of the deceased and their surviving relatives, to find the cause of death to be other than suicide. Instead of suicide, the causes found may be accidental in the young and natural causes in the old. When, however, people begin to speak out publicly about the problem of suicide and the taboo is lessened, coroners and magistrates are more likely to make findings of suicide. Such changes in judicial practice have not been explored and are not taken into account when claims are made of increases in suicide rates.

The countries of the world can be ranked according to the details they provide regarding suicide rate. Over decades, there is a strong tendency for each country to report a relatively stable suicide rate and to retain the same position relative to other countries (La Vecchia et al, 1994).

In Europe, Hungary (41.85) and Finland (28.15) are always near the top and Italy (8.25) and Ireland (6.9) are always near the bottom of the scale. This raises interesting questions. Are these true differences in the rate of suicide, or are these differences artifacts generated by differences in the attitude of coroners and magistrates, or differences in the care with which these details are handled and publicized?

There is no doubt that in the Catholic countries of Italy and Ireland, suicide is considered sinful and brings disgrace on families. It is reasonable to assume that local coroners and magistrates would be influenced by these factors. But any differences between countries cannot be easily explained by religion - Hungary and Finland, which have very high rates, are also Catholic countries.

In Asian and Pacific countries there are also significant differences in the rate of suicide in different races occupying the same land. Striking differences have been demonstrated in Singapore between the Indians

(13.7) and Chinese (13.5) and the indigenous Malays (1) (Kua and Tsoi, 1985), and in Fiji between the Fijian Indians (19.5) and the Fijians (1.5) (Pridmore et al, 1996). From first hand experience, there are real differences in the rate of suicide of the Fijian Indians and Fijians. This is not due to an artifact of designation process or information handling. These races are different religiously, but also culturally and socially; which factors contribute to the difference in suicide rates is unknown.

The suicide rates of the countries of the world have remained relatively stable for decades (La Vecchia et al, 1994). From time to time authorities detect changes in rate in certain places or in certain age groups. In the 1990s, in Australia, attention was drawn to an increase in the suicide rate of young people. The increased media attention and public concern may have further inflated the figures through the process of coroners and magistrates becoming more aware and more “able” to make the finding of suicide. It is interesting that the overall suicide rate of the country did not rise, as there was a simultaneous reduction in suicide rate of the old. This reduction was not the result of any specific suicide prevention program aimed at a high-risk group, instead, it seems to have been the result of improved health and social services available to the old. This is consistent with the view that reducing isolation, distress and difficulties across the community will have a beneficial effect on the suicide rate.

CREEPING CUSTODIALISM

Dr Martyn Patfield (2000) has drawn attention to an alarming situation. He points out that patients who suicide are frequently sad, despairing and alienated, but that when they come into hospital they are placed in rooms which will intensify rather than reduce these feelings. In recent years hospitals in which suicide has occurred have been attacked by the courts. This has led to the rooms, in which potentially suicidal patients are nursed, being stripped of all manner of furnishings and finishings: opening windows have been replaced with Perspex with holes, beds have been replaced by mattresses on the floor, pictures and even door handles have been removed. Anything that could be used as a suspension point or for cutting, anything which could be used to cause any form of injury has been expunged.

We are now practicing defensive medicine. First, we take steps to protect ourselves, and from a safe position, we then try to care for the patient. We have a “duty of care” toward patients, but this has been taken, by the courts, to mean “duty to protect”.

Patfield states that caring for patients means treating them, and the best treatment for those feeling loss and alienation is provided in a familiar and warm, rather than sterile environments. Caring also, of course, involves the thoughtful management of risk. The law is not helping these people, but making matters worse.

MURDER-SUICIDE

Murder followed by suicide has not been extensively studied. The only available reports come via the newspapers.

After looking at these for some years, they appear to be of two main types, those in which strangers are murdered and those in which family members are killed.

When strangers are killed, there appears to be two main subtypes. The first is when the act is “altruistic”, that is, for the good of the group, members of the opposing group are murdered. The second is when isolated individuals who are poorly integrated express anger and resentment toward society.

There is no need for examples of the first sub-type, these are now common in terrorist attacks. In the second sub-group, in 1996, Thomas Hamilton murdered 16 children, in Scotland. Hamilton is characteristic

of this group. He had no successful adult interpersonal relationships. He had been involved in scouting, but had been expelled from the movement. He had expressed anger toward others.

When family members are killed, there also appears to be two main sub-types. In the first there is mental illness. The evidence suggests that most of the mentally ill people involved in murder-suicide kill their relatives to “save” them from a worse fate. It seems that they intend to kill themselves to escape, and as an act of kindness they kill relatives rather than leave them to suffer. In 1992, Brian Schlaepfer killed six relatives, in New Zealand. He suffered depression.

In the second sub-group are those who kill family members in an expression of anger. In most instances the anger is about the loss of children, and the children are “taken” from the hated custodial spouse. In 1985, in Sydney, Sergio Gianfrancesco shot his estranged wife and three children. A Family Court ruling had denied him access to his children.

The perpetrators of murder-suicide who kill strangers may have odd personalities, but there is rarely, if ever, evidence of madness of the psychotic type. The perpetrators of murder-suicide who kill family members appear to be of two types. In one the individual has a psychotic disorder and believes he/she is “saving” the loved ones, in the other, the individual is angry and is “keeping” them.

CONCLUSION

Suicide is an act that may flow from a range of emotions. The lay public and some academics believe that all suicide is the result of mental disorder. That is not the case. Some suicide to advance the cause of the group to which they belong, others to avoid disgrace and yet others to avoid painful and degrading death.

It is probable, however, that the majority of those who suicide are isolated, angry and sad. Certainly some will suffer these symptoms to such a degree that they could be diagnosed as suffering from a mental disorder.

Emile Durkheim, a nineteenth century French sociologist, identified important markers that indicate an increased risk of suicide. He found that suicide could be anticipated when there was decreased social integration, regulation and control, and increased isolation or oppression of the individual. Other markers include male sex, increasing age, widowhood, single or divorced state, childlessness, high standard of living, economic crisis, high alcohol consumption and broken home in childhood and the clinical characteristics of presence of mental illness, family history of mental illness and a history of previous suicidal behaviour.

There have been two main approaches to the prevention of suicide, which depend on level of risk. One approach is that those who are at high-risk should be identified and receive special supervision and treatment. This has not been very successful, because the markers do not identify those at high-risk with sufficient certainty. This could be considered a medical solution.

The other approach is the public health approach, measures are taken which will lower the risk across the entire population. These have included reducing the availability of lethal means of suicide. Other measures would be to reduce unemployment and alcohol abuse. These could be considered a social solution.

The treatment of high-risk populations has not been particularly successful. This may be because many of those at high-risk often have poor interpersonal skills, few assets, and extensive needs or demands, such that they frequently face disappointment. A half a bottle of whisky may move such a person from high-risk to action. In the competitive modern society with high unemployment and ready availability of alcohol and other drugs, there are many pits.

At the moment we must continue with both the medical and social preventative solutions. The development of a better way of identifying those at high-risk is essential. In the management of acutely suicidal patients we should aim to care for, not simply protect patients, and this may mean treatment in familiar

and warm settings rather than sterile alienating settings. This would require the courts to take a sensible approach to suicide in hospital.

CASE STUDY

Mary Hilton was an attractive child. She lived with her parents and two siblings, an older brother and a younger sister, in the suburbs of a capital city. Father was an accountant. Mother was a part-time secretary. Mary performed well at school in the early years but then began to fail subjects, she lost interest and left without completing high school.

In retrospect, Mary probably began to suffer symptoms of schizophrenia in her late teens. She entered into a lesbian relationship, living for five years, with a woman 20 years her senior. When this relationship ended, Mary married a man 20 years her senior. Two children were born, but the marriage lasted less than a decade and ended when Mary was in her early 30s. The children went to live with their father. Mary did not visit them, denying that she had ever been pregnant or had children.

At this time, Mary's parents brought her to the attention of local mental health workers. Mary was well dressed and groomed and denied any problems. She claimed that her parents were trying to have her locked up. Admission was offered, but the patient refused and as there was no evidence that she was a danger to herself or others, compulsory admission was not imposed.

A year later, at 34 years of age, Mary took a serious overdose of over the counter medicine and was admitted to the psychiatric ward of a general hospital. She still presented well dressed and groomed and able to deny any symptoms. However, she was placed on a compulsory order and over a few days, she began to express delusions.

She stated that she was Joan of Arc and that she had been reincarnated. She said that she was very keen to die so that she could be reincarnated again. She asked that when she died that her flat and belongings not be disturbed, as she would need them again. Her delusional system was illogical, for example she expected to be reborn as a "chosen baby", but a baby would need care and would be unable, at least for some years, to make use of her flat and belongings. When such points were raised, Mary's statements would change slightly, but the central tenant that she wanted to die so that she could be reborn, never changed.

Over the next few years every possible means was employed to divert Mary from this desire. She was treated with antipsychotic and antidepressant drugs and provided with comprehensive support in the community.

Her mental state deteriorated and she had disorder of the form of her thinking such that it was difficult, but not impossible to follow her ideas. This improved with antipsychotic medication, but the desire to die did not alter.

It was considered inevitable that this lady would suicide. She was placed in hospital on a compulsory order. In hospital she met Allan, a man of the same age, who had persistent hallucinations instructing him to kill himself. She appealed to the Mental Health Review Tribunal and because she presented well and denied symptoms, she was released from hospital. She went to live with Allan and died by overdose at his home a few days later.

There was no criticism of the Mental Health Review Tribunal decision to release Mary from hospital. She could perhaps have been kept in hospital for years and her delusions may have resolved. But they had not changed in the previous five years, and keeping her in hospital, while perhaps reducing the risk, did not guarantee her safety.

CASE STUDY

Ben Metro was 18 years of age. He was expelled from a detoxification service the previous day as he had taken illegal drugs while in an inpatient facility, and he was not eligible to immediate readmission. He presented at a general hospital claiming suicidal thoughts and was admitted to the psychiatric ward.

He had been admitted to this ward twice before claiming suicidal thoughts. On both occasions he had left in less than 8 hours, without telling staff of his intention to leave. He had a very extensive drug abuse history, using all locally available illegal drugs. He had been expelled from school and jailed for assault. His mother had died in a suicide pact with a young man she had met on the same ward one year earlier.

Ben was taken to a pleasant ward and introduced to friendly and supportive staff – one male and one female. He was prescribed a medication to reduce his distress and given a single, open room. He was on an appropriate level of nursing care, being checked every 10 minutes.

He sat on the floor in his en suite, placed his belt around his neck and hitched it through the towel rail. By leaning sideways he was able to stop the blood leaving his head and he was dead when the nurse went to check on his progress.

It could be argued that this man should have had a nurse constantly with him. That level of staffing is not always available, and that level of observation can be intrusive and dehumanizing. Reasonable care was taken in this case. Ben was given support, pleasant surroundings, calming medication and reassurance that he would have regular contact with nursing staff. For a person with this degree of alienation from society and a serious drug problem, the risk of suicide is chronically high.

CASE STUDY

Ken Brown was 50 years of age. He was a successful retail pharmacist. He was admitted to the psychiatric ward of a general hospital with major depression. He had suffered two other depressive episodes over the previous five years. One had failed to respond to medication and Ken had required ECT.

Ken was happily married and had two adult children, one qualified pharmacist, worked with him in his shop. On weekends Ken enjoyed sailing on his small yacht.

On admission this man claimed depressed mood and admitted some feeling that he was a failure, despite his obvious success. He did not smile, lacked energy moved and thought slowly and had difficulty with sleep. Medication again failed to lift his mood. He was commenced on ECT. He appeared to improve and was more active. After the third treatment he left the ward without telling staff and drowned himself in the harbor.

This course of events is not unknown. Certain symptoms of depression respond before others. Sleep and energy levels often improve before the mood lifts. Sometimes depressed people lack the energy to kill themselves. Paradoxically, it is possible for depressed people to be at greater risk to themselves as they improve.

CASE HISTORY

It would be inappropriate to describe a living person who is at risk of suicide. However, people with borderline personality deserve mention. These are young people who are usually at high-risk of suicide. They have difficulty maintaining close relationships and are frequently, suddenly and inexplicably, very angry. They often cut themselves on the outside of the forearms, as a means of reducing tension. They also have

sudden suicidal impulses, sometimes in response to minor conflict or frustration, and sometimes for no obvious reason. They often take alcohol and other drugs which exacerbates their difficulties.

In response to suicidal impulses they may attempt to cut the arteries on the inside of their wrists or take overdoses of medication or poison. Of course, some respond by jumping from heights or into the path of moving vehicles.

Sometimes the desire is to die, sometimes to attract help. Sometimes when the intention is to attract help, they miscalculate and die by accident.

These people do not have a psychotic illness and therefore, compulsory admission to hospital cannot be legally justified. Even when compulsory admission is justifiable, it may be considered inappropriate, as compulsory admission relieves these unfortunate people of responsibility for their actions. Many believe that people with borderline personality should not be relieved of responsibility for their actions, as if they are to live in the community they must learn to act and react responsibly.

Thus, the management of people with borderline personality is a tricky business, and with our present limited ability to manage them, some will inevitably die young, either by suicide or accident.

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CHAPTER 13

STRESS REACTIONS AND TREATMENTS

In an earlier chapter on madness in court, it was claimed that the public gets angry when a criminal act has been performed and a defending lawyer suggests the presence of mental disorder. The public takes a dim view of cheating, and worries that someone *may not* get something (punishment) that they *do* deserve.

When it comes to stress reactions, some members of the public are again concerned about the possibility of cheating. Here the worry is that someone may *get* something (the sick role) that they *don't* deserve. The sick role means the individual doesn't have to work, is relieved of responsibilities and may even qualify for a pension or financial compensation.

The public is ready to award the sick role and full benefits to anyone who has lost both legs fighting for his or her country. But readiness lessens, as the injury becomes less obvious. The person with back pain is regarded with suspicion, "perhaps he doesn't really have that much pain, perhaps he could be cheating".

Most agree that patients with schizophrenia who are hearing voices, deluded and behaving oddly, should be granted the sick role. But there is less agreement about patients with depressive disorder, "after all" the argument goes, "we all get depressed from time to time".

Until recent times, there has been public skepticism about the possibility of stress leading to disability: "I've had two car accidents and it didn't do anything to me". However, the post traumatic stress disorder (PTSD) suffered by Vietnam veterans, has been widely reported by the media and the public is now better informed and increasingly prepared to accept that stress may lead to incapacitating psychological disorders.

The term stress is frequently used, but rarely defined. Originally it was used to refer exclusively to nasty things like a shouting employer or the house burning down. Later it was understood that winning a fortune in the lottery could be stressful. Thus, nice things could also be stressful. A wide definition is that stress is an event or situation to which we must adjust. This view of stress is based on the observation that our bodies and minds have a biologically set state, which has been variously described as the resting, basal, stable or homeostatic state. Departure from this state triggers mechanisms which restore it to the set state (as when the blood pressure is returned to the resting level). The set state feels pleasant. Being in aroused states, generally speaking, feels unpleasant (as when palpitations or fear of dying are experienced); this encourages conscious actions (such as retreat) which aid the restoration process.

POSTTRAUMATIC STRESS DISORDER (PTSD)

Most families have a distant relative who has "never been the same since" a stressful event – often a female who "never got over it". Significant loss, such as the loss of a spouse or child is an established cause

Grieving widow commits suicide

AN inconsolable widow has taken her own life almost three months to the day after her husband was killed in the World Trade Center in New York.

On December 10, Patricia Flounders, 51, fired a single shot to her head as she stood in the bedroom of the couple's dream country home in Pennsylvania, completed just three days before the terror attacks.

Her husband of 21 years, Joe Flounders — a bond trader on the 84th floor — was in the south tower when the second plane hit.

Illustration 13.1 Patricia Flounders shot herself in the head in her Pennsylvania home, three months after her husband was killed in the World Trade Center atrocity.

The stress of losing a spouse may trigger various reactions. We are given insufficient details to attempt a diagnosis, the newspaper stating only that Ms Flounders was "inconsolable". In this case, where loss led to suicide, one possibility is major depressive disorder. Another is posttraumatic stress disorder, for although Ms Flounders was not with her husband when he died, she had ample opportunity to witness his death via television.

of an episode of depression and car accidents, for example, are known to make people, "nervous about cars". Traumatic events take many forms and effect different people in different ways; the one with the highest profile is PTSD (Illustration 13.1).

During and after the First World War soldiers came to medical attention who had been exposed to combat and were subsequently troubled by emotional and psychological symptoms. This was unexpected and a new diagnosis of "shell shock" had to be invented. Psychological stress was ignored as a causative agent, one theory was that "microsections" or tiny particles from exploding bombs had entered the brains of affected soldiers. Resistance to the notion that psychological factors could cause significant disorder was so strong, that the notion physical particles could enter the brain with out any sign of physical trauma was temporarily adopted.

Such symptoms should not have been unexpected, however, as "soldier's heart", which was panic disorder induced by the terrors of the battlefield, had been described during the French Revolution and similar conditions have been reported at most subsequent military conflicts.

During and after the Second World War the preferred term was war neurosis. There were so many such casualties that individual treatment was not possible. Combatants had to be treated in groups, this being the origin of group therapy. ECT had become available and was widely used in military hospitals. So was abreaction, the administration of a drug that made possible the reliving of frightening experiences and the ventilation of emotion, in a safe setting.

Toward the end of the Second World War, flamboyant, popular and successful General George Patton visited a field hospital where he saw a soldier with psychological symptoms. Patton slapped the soldier with his gloves and called him a coward. Patton was forced to apologize to the patient, the medical and nursing staff and all the soldiers under his command, by General Eisenhower. This story illustrates the intolerance of such symptoms which existed, even at the highest levels, in relatively recent times.

The Vietnam War was the coming of age for PTSD. This was an unpopular war. Western troops, many reluctant, were fighting in a foreign land in a war to which they were not fully committed. When they returned home, rather than a heroes welcome, many were shunned or criticized. The deployment was particularly stressful, there was jungle-fighting, ambushes, land-mines and booby-traps, and it was often impossible to distinguish the enemy from innocent civilians. Such circumstances were particularly stressful.

Just as the media, with modern technology, was able to immediately report on anti-war activities, it was able to immediately report on the toll paid by soldiers. It became quite clear that combat was leaving some soldiers with psychiatric scars, and this became public knowledge.

There is no objective test for PTSD. Instead, the diagnosis is made according to the patient's claims, answers to questions and behavior during interviews. The diagnostic criteria of the two main diagnostic systems (Diagnostic and Statistical Manual, volume 4 [DSM-IV], and the International Classification of Diseases, Version 10 [ICD10]) differ slightly, but the essential criteria are the same. These include, 1) a history of a traumatic event, 2) the re-experiencing of the traumatic event at later times, 3) reminders of the event triggering distress, 4) distressing emotional states, 5) emotional numbness, and 6) increased arousal or jumpiness. To make the diagnosis it is not necessary for all criteria to be met, and many are overlapping.

There is some debate about what constitutes a traumatic event. For present purposes, this debate is academic. The DSM-IV requires that the person has experienced an event that "involved actual or threatened death or serious injury, or threat to the physical integrity of self or others", and that during this event the patient's response "involved intense fear, helplessness, or horror".

The re-experiencing or re-living of the traumatic event may have the patient or others suspecting madness. Later, even in a place of great safety, the patient may involuntarily experience aspects of the event in a vivid and disturbing manner. Re-experiencing may take place during waking hours, at which time there may be intrusive images or sensory experiences, and the patient acts or feels as if the event is recurring. Re-experiencing may also take place during sleep, taking the form of nightmares.

Reminders of the trauma may arouse fear and other distressing emotions, the heart may race and the patient may feel frighteningly short of breath. This may lead patients to avoid reminders. The nature of the reminders will depend on the nature of the trauma. Following military trauma, brass bands, firearms and helicopters may be avoided. Commonly, all reminders cannot be avoided, and the television news or chance stimuli lead to episodes of distress. Talking about the traumatic events commonly triggers distressing emotions, thus PTSD sufferers frequently avoid or refuse to discuss them. This can be unhelpful as such avoidance may delay recovery, and talking about the event may help the adjustment process. [This is not a straightforward matter, see later for the argument against compulsory debriefing.]

A characteristic symptom is emotional numbing. Patients are unable to feel emotional closeness to family members or to find pleasure in former activities. This leads to withdrawal from loved ones and the wider community, and loss of interest in old hobbies.

Heightened arousal is common, causing difficulty in falling to sleep and in concentrating. Patients are easily startled, with an exaggerated response to stimuli such as ringing telephones. They experience a range of other distressing symptoms including excessive anger, sadness, guilt and shame. These may be relatively sustained or fluctuate, experienced in pure form or in combination. Patients may take alcohol, prescription or illegal drugs to obtain relief from their distress, and this may lead to the secondary problem of addiction (Illustration 13.2).

PTSD patients often have poor memory for many details of the traumatic event. This is surprising, given that certain details are often all too easily remembered, that is, re-experienced. These observations suggest that memory may play an important part in PTSD.

Studies indicate that about 55% of the people living in USA have experienced at least one traumatic event,

Suicide toll

MORE British veterans of the Falklands War have taken their own lives than were killed in the 1982 conflict with Argentina. A support group said the suicide toll was greater than the 255 killed in action and blamed post-traumatic stress disorder.

Illustration 13.2. It has been claimed that in the twenty years since the Falklands War, more British veterans had died by suicide than had died in action. This was attributed to posttraumatic stress disorder. It was stated that 255 died in the war.

Without knowing other figures, it is impossible to be certain, but the impression is that the suicide rate among these veterans probably has been higher than that of the remainder of British population. Also, it is not clear what proportion of those who died by suicide were actually suffering from posttraumatic stress disorder. However, as the symptoms of posttraumatic stress disorder may be highly distressing (re-experiencing the traumatic event, emotional numbness, high arousal etc) and the condition may be complicated by substance abuse and family disharmony, a raised suicide rate could be anticipated.

as defined by diagnostic criteria. Such experiences include combat exposure, rape and sexual attack, and childhood neglect and physical abuse. Women are more likely than men to develop PTSD. Of the people exposed to a traumatic event, around 8% of men and 20% of women develop PTSD. About 8% of the population (5% of men and 10% of women) will experience PTSD at some stage in life (Kessler et al, 1995). The rates may be different in different populations.

A lifetime prevalence of about 8% of the population represents a large medical and economic burden. But that is not the complete picture. In the aftermath of trauma, many people who do not meet the strict criteria for PTSD, nevertheless suffer psychological distress. Some have symptoms of PTSD, but not enough to satisfy that diagnosis, others suffer adjustment disorders, and as mentioned above, other major mental disorders, such as depressive disorder, may be triggered by trauma. Of those who develop PTSD, at least a third will not recover for many years (Kessler et al, 1995). Many with PTSD are unable to return to full-time employment. Thus PTSD is a significant public health problem.

It is remarkable that a condition which was unknown a century ago, and for which soldiers were branded cowards during the Second World War, has been found to affect at least 8% of the population at some time in their lives, and represent a public health problem.

The mechanisms underpinning PTSD are not fully understood. Learning is important, and explains how features of the environment at the time of the trauma become triggers for re-experiencing symptoms. One theory includes that re-experiencing occurs because this material is still held in active memory and had not been processed and placed in old memory. Patients may conceptualize the traumatic event in such a manner that they cannot go forward in life, "I will never be safe again". Such events, due to earlier experiences, may have particular personal meaning to the individual - the individual who has invested time and effort and for whom physical prowess is an important component of personal identity may be more prone to develop symptoms if exposed to traumatic circumstance in which he/she is powerless. Behaviour such as the avoidance of reminders, reluctance to discuss events and resort to alcohol and illegal drugs make resolution more difficult.

Statistically significant differences have been demonstrated in neurotransmitter and hormonal levels in groups of people who have been exposed to stress. To this point, however, no organic test has been developed which will identify individuals who have developed pathological stress responses.

There is increased secretion of adrenalin and noradrenalin from the sympathetic nervous system and the adrenal glands. This may be responsible (at least in part) for the chronic high level arousal and enhanced startle response. Low levels of cortisol, a hormone important for adjustment to stress, and serotonin, a neurotransmitter with many functions, including the modulation of mood, have been reported. There are low levels of the opiates which are normally produced by the body, and this may be related to complaints of emotional numbing and amnesia. There are enhanced levels of corticotropin releasing factor (CRF) a hormone secreted by the brain which controls the levels of many of the neurotransmitter and hormones mentioned in this paragraph.

Brain imaging studies of people with PTSD have suggested a reduction in the size of the hippocampus, a brain structure with a role in memory formation (Bremner, 1998). Such brain changes could tie many features of PTSD together. They could perhaps be caused by a toxic effect of hormones that reach high levels at the time of the trauma. However, it is unclear whether this suggested change in the size of the hippocampus is cause or effect. It is quite possible that people with pre-existing change are the ones who will go on to develop PTSD. This idea will surely be pursued in the future.

As stated, the outcome of PTSD is not always favorable. Nevertheless, treatments have been devised which have been scientifically tested and have been found helpful to many. Cognitive-behaviour therapy, a blanket term which includes the examination of the thinking of patients, the identification of any illogical or unjustified conclusions and the suggestion of alternative ways of conceptualizing information, is a central pillar. Education can also be included under this heading. Patients are informed about the normal reactions to trauma and that their reaction is not uncommon. They are advised of the necessity to confront the memory of the event and give up any avoiding behavior as these delay the best possible adjustment.

Exposure treatment can take place in two forms. In one, the patient is asked to relive the traumatic event in imagination, trying to recall in detail, the thoughts and feelings of that time. In the other form, the patient is asked to physically confront the situations that have been avoided because they trigger distress – for example, visiting the site of an accident, or in the case of overseas active service, visiting a military establishment. The patient is accompanied and supported during this treatment and exposure is repeated until high levels of distress are no longer triggered. This treatment is believed to help correct illogical thinking, re-organize memory and draw distinctions between the past and the present.

In a minority of cases, exposure treatment worsens symptoms (Tarrier et al, 1999). This work should only be attempted by properly trained and experienced therapists.

A wide range of other psychological treatments, such as relaxation training, are believed to offer some benefits. Hypnotherapy, however, is not without significant risks (Shalev et al, 1996).

Medication has an important place. The most effective drugs are the selective serotonin reuptake inhibitors (SSRIs). The earliest and best known of this group is fluoxetine, which became famous selling by the name, Prozac. Many others have been marketed subsequently. These help with the symptoms of high arousal, avoidance and emotional numbing. They have the additional advantages of reducing alcohol consumption and being safe in overdose. Other medications which may be useful are other antidepressants and the mood-stabilizing drugs. The benzodiazepine drugs, which are tranquilizers, one of the first being Valium, are best avoided. This is because in PTSD patients they may have unpredictable effects and drug dependence may develop.

CASE DRAMATIZATION

Annie Macquarie was 22 years of age and lived with her boyfriend Bruce, in a small rented house in a tiny fishing and tourist town, seventy kilometers from Hobart, the capital city of Tasmania, the island state of Australia. They were happy. They had been living together for two years, they planned to marry “some day” and had approached the owner of the house they were renting to explore the possibility of purchase. They did not have extravagant plans for the future. They wanted children “eventually” and they not unreasonably anticipated having horses for their children.

Annie had been raised in the town where they were living. She was the older of two. Her 21 year old sister was married and lived with her husband and infant son in Hobart. Her parents lived together; father was receiving disability benefits because of a back injury which occurred at work 10 years previously, mother was working as a salesperson in a grocery store.

Annie had been a good student. She had been popular with teachers and students. She had been an excellent net-ball player. It was said that she could have represented the state of Tasmania, but this would have meant going to live in Hobart. She completed high school at the age of 17 years. Even though the employment opportunities in country Australia were limited, Annie, outgoing, clever and energetic never had any difficulty in finding work. For the last two years she had been employed as a guide at the Port Arthur Historic Site, an old convict prison and settlement complex. Bruce, who had been raised in a nearby farming town, was 25 years of age and had been employed at the Historic Site as a gardener, for six years.

On the 28th of April 1996, Martin Bryant, a 28 year old, single, unemployed man went to the Historic Site to kill people. Bryant has always refused to answer questions about his motives, although after capture he was keen to know if he had “the record”, meaning, had he killed more people than any other lone gunman on a single day. He had killed 35, so the answer was affirmative.

At 1.30 pm Annie went into the “Broad Arrow” cafe to buy sandwiches. She saw some friends sitting toward the back of the room and went to talk about an upcoming party. She was near a “surfie looking” man who had placed his duffle bag on a vacant table. He unzipped it and took out an AK47 semi-automatic rifle. Annie was slightly to his right and looking along the barrel into the room. The gun roared and she saw blood splash out of Moh Yee Ng’s neck as he was thrown, as a corpse, across the room. The

gun roared again, blood sprayed out of the head of Soo Leng Chung, his female companion. Annie felt a sharp pain in her chest and realized that she had been shot at point blank range. She remained standing, unable to move or make a noise. People were screaming and rushing in every direction. A bunch were trying to get out a fire-exit. The gun swung that way, as Annie was frozen to the spot, but too close to shoot, the gun was raised over her head and fired along the other side of her face, into the people trapped at the fire-exit, which had been kept locked for safety reasons.

Annie was laying under bleeding people. She could see Bryant move among the corpses and shoot a couple of people who were only pretending to be dead. Then he picked up his bag and left the restaurant. Firing and screaming continued outside for what seemed like hours. She expected him to return and discover that she was still not dead and needed another bullet.

Annie had not been shot. A hot bullet case, ejected sideways from the rifle, had gone down inside her blouse. She did not know how she came to be under a pile of people. It is probable that she was knocked down by rushing customers, who then fell on top of her, and that Bryant shot one or more of them while they were in that position.

The Port Arthur Historic Site was well chosen as the setting for a massacre. There were hundreds of tourists, a place of historical interest and leisure, there was no security and the nearest police were over 60 kilometers away. [An aside: the death toll could have been three times higher. Bryant had attempted to board a boat taking over a hundred people 200 meters off shore to “The Isle of the Dead”, which had functioned as a boy’s prison and the cemetery of the region. He was refused a seat as the boat was overloaded and he had a heavy bag.]

Bryant left the Historic Site and went to a nearby guest house, where he holed up, claiming to have taken the proprietors hostage [in fact, he had killed them soon after he arrived]. Thus, Bryant was not taken prisoner until 8.25 am next morning. Some thought the carnage could only have been achieved by a group of perpetrators, thus it was 24 hours before the police could confirm that the danger to life was over.

Annie’s memory of what happened after Bryant left the restaurant is patchy. Her mother reports that she could not get into the Historic Site to look for her daughter, she was stopped by the police for security reasons. She did not get to her daughter until some five hours after the killing began. At this stage, Annie was wide-eyed, white faced, trembling and whimpering. She did not speak; she cowered and behaved as if she expected to be attacked at any moment. She did not eat that day or sleep that night. She began to say a few words the next day, she did not converse. She replied with, “Don’t leave me” to most of the things said to her. Her mother did not leave her side for days. Over the next week she began to take a small amount of food and with sedation, was able to achieve a couple of hours of sleep at night.

Annie received appropriate care. She was given support and encouraged to ventilate. When it became clear her progress was slow she was prescribed appropriate medicine. She was encouraged to attend group discussions about the event, not to avoid anxiety provoking thoughts or locations, and to try to return to her former life.

Three years after the event, Annie was not doing well. She was still highly aroused. Her eyes were wide, her hands trembled and her movements were quick and continuous. She talked incessantly. Her only topic was how Bryant [she referred to Bryant only as “he” and “him”, and everyone knew whom she meant] had ruined her life. She would not talk about the traumatic events, claiming that she had done so, that it had not helped and on the contrary, talking about “it” only made her feel worse. At times she was unreasonably irritable. She lost 12 kilos immediately following the incident, and this had not been regained. She looked very thin, and had little appetite for food. She was sleeping poorly – she stayed up until after 2 am, she would only go to bed when she was very tired, and she would only sleep for about 3 hours. She had never returned to her rented house, but had stayed with her mother, who had quit work and taken up a carer’s benefit, so that she could provide continuous care.

Bruce, who had not been at the Historic Site on the day of the killings, stayed in their rented house and visited Annie at her parent’s home most days. They never again spent time alone together. He grew tired of Annie’s incessant talking, he believed that she was absorbed in “her own issues” and had lost interest in

him. After one year he gave up the house, stopped visiting and started seeing other women. Annie claimed to be sorry her relationship with Bruce had ended, but there was little evidence to support her claim.

She received further cognitive-behaviour therapy. She was strongly advised to confront her distressing thoughts, and to find some activities outside her parent's home, as a first step to return to a more balanced life. Mother was advised that having a full-time carer was probably hampering rather than assisting Annie's adjustment at this point, and that she [mother] should seek some activities independent of her daughter. Annie's medication was changed a number of times with little effect.

At five years there was some improvement. Annie had commenced going out with groups of friends. She preferred to go with more than one other person, but she would not go to crowded places like restaurants, bowling alleys or picture theatres. She did not have, or seem to want, a particular male companion. She did a small amount of paid work as a baby sitter in private homes. Mother had given up her carer's benefit and had gone back to work half-time in the grocery store. Annie was still highly aroused, still looking like a frightened bird. She slept six hours per night and she had regained six to eight kilos.

This was not a good outcome. But given the severity of the trauma, the uncertainty about security following the trauma that lasted for many hours, and the patient's immediate response, the outcome was not unexpected. The more distress immediately following the trauma, generally speaking, the poorer the prognosis. Annie was unable to speak and a day later she could only say she did not want others to leave her. Her arousal with inability to sleep and eat was extreme. She was given good advice and service. She was unable to follow the suggestion to confront her fears as vigorously as her clinicians wanted. This was not through lack of willingness to cooperate, but a reflection of the severity of the case. This person's life was severely damaged by PTSD, it is hoped that she will continue to improve.

CASE DRAMATIZATION

Colin Temple was referred by his treating psychiatrist to a tertiary treatment facility for assessment for ECT. He was 45 years of age, married for 12 years and living with his wife and their three young sons, in house that they were renting. He was a plumber, but was living on workers compensation payments following a motor vehicle accident, which occurred while he had been driving between jobs.

Since the accident, of which Colin remembered little, he had been moody, irritable, lacking energy, sleeping poorly and drinking more than formerly, to help him get to sleep. He had occasional suicidal thoughts, but could not understand why he should have them. He thought of suicide as "probably the only way out", but he could not answer the question, "The way out of what?" He had been treated responsibly for depression secondary to the accident and all the above symptoms were consistent with that diagnosis. Appropriate doses of different classes of antidepressants, including the SSRIs and sleeping medication had been used with some success. The legal issues about termination and financial compensation were soon to be decided, but before this could be finalized, it was necessary that all possible avenues be explored to return Colin to his highest possible level of function.

The referring psychiatrist had considered the diagnosis of PTSD, but had considered the evidence to be less than compelling. He made the point that PTSD and depression often occur in combination, and as there was good evidence of depression and poor evidence of PTSD, he maintained that treating Colin's depression was the best way to go.

Colin was born and raised in a large port city. He was the middle of three children born to a policeman and a hairdresser. While Colin had good relationships with teachers and the other students, he found schoolwork difficult. His older brother and younger sister went on to university. Colin wanted to leave school as soon as possible, but he also wanted some training or employment qualifications. The Navy was the answer and he was able to join as an apprentice plumber and boilermaker at 16 years of age. He left at 23 years of age after having visited half a dozen overseas countries. He then worked in civilian plumbing for five years until he had saved enough to go around the world to the places he had wanted to see, but

had not seen, with the Navy. On his return he was ready to “settle down” and soon began to live with Jenny. They had been “seeing each other” for a year before his world trip.

Jenny described Colin as a kindly but quiet man and a good father. He had been working for his last employer for three years before the accident. She said that Colin had changed since the accident and she was not confident that their marriage would survive. She verified the symptoms described by Colin, saying that he now seemed more aloof and was certainly more irritable, particularly when the children made noise, and he drank more. She also said that Colin had not driven since the accident. She said she had to do the driving and that when she drove, he was very “scared” and shouted at her to be careful, even when there was no danger.

This latter point indicated the possibility of PTSD needed to be explored in greater detail. In spite of his refusal to drive, Colin continued to claim that the accident had little effect on his mental state. To support this contention he pointed out that he had little memory of the event, and said that if it had been important, he would remember it more clearly. He also said that he had returned to work after his van had been towed away and that it was not until the next day that he began to feel any distress. He was advised that this reaction was not proof that the accident was unimportant and he was encouraged to recall all possible details. Colin did not want to recall the accident, although he denied that doing so caused him any distress.

When the story was pieced together, Colin had been driving the firm’s van to a job. At an intersection a car had come through a red light and hit the van just behind the driver’s seat, knocking the van onto its side. Colin had seen the car approaching for a couple of seconds. Colin was not pinned in the van. However, the van was lying on the passenger door and the driver’s door was jammed by the impact. He had smashed the front windscreen with his readily available tools to get out. During one retelling of the incident, Colin “remembered” that he has been very concerned that the welding gas cylinders in the back of the van could explode and incinerate him.

Cognitive-behavior therapy was continued and Colin was encouraged to recommence driving. He and Jenny co-operated. A rehabilitation service arranged for him to have driving experience and he was able to greatly diminish his fear of driving and being driven. Family conferences were provided. Colin’s antidepressants were increased in dose. His depression lifted, he lost all suicidal thoughts and he was not given ECT. He was able to return to work, but through arrangements with his employer, he worked mainly at the main workshop and was required to drive only short distances. It is probable that Colin suffered primary PTSD and secondary depressive disorder, both of which responded to treatment.

CASE DRAMATIZATION

Alice White was 52 years of age and worked as a receptionist. She lived with her husband, Ken, in a house which they owned, in a middle class suburb of a small city. They had married young and had three children; all had left home and found work. Alice and Ken had two grandchildren and another was expected in a few months. Ken was a self-employed electrician.

Alice went to a large hardware store to buy some glue. She had paid and was about to leave the building when a well-dressed young man approached her, saying, “Excuse me, madam. I’m the deputy-manager of this store. I believe you have taken items without paying for them. I have rung the police and they are coming to investigate. Will you please come to my office.”

At first Alice did not comprehend what was being said. She could hear and understand the words that were being said, but she could not understand their combined meaning. She did, however, feel that she was being threatened and that she was in danger.

She remained standing in the same place, beyond the payment section, but inside the doors of the store. She later said she had been startled and froze like an animal in the headlights of a car.

The deputy-manager called over a female staff member and repeated his request for Alice to accompany him to his office. To this she replied, “No”, and remained motionless. She later said she had refused because it seemed that to go with him would be to place herself in even greater danger.

Alice remained standing but began to regain her composure. The deputy-manager, who had gone away, came back and said that there had been a mistake, that he apologized for the inconvenience and that he had cancelled his call to the police.

Alice’s response was that she wanted the police to come so that her name could be cleared and that she would not leave until that happened. The deputy-manager apologized a second time and tried to persuade Alice not to insist on the police becoming involved. She was not swayed and eventually the Police and Ken were called and came.

While she waited, other shoppers looked at Alice quizzically as she stood alone in the shop foyer. Strangers asked her whether she was “all right” and whether they could do anything to help. She replied appropriately and declined offers of help. A friend happened along, Alice explained the situation and the friend waited with her.

When the police arrived the deputy-manager apologized a third time, in front of them. Alice asked the police if she was free to go, and whether it was “safe” to go. They reassured her, and she finally left with Ken.

Alice slept poorly for two nights, and dreamed about the incident. She felt angry, humiliated and frightened. She telephoned the friend who had waited with her, seeking reassurance about how much of “a public spectacle” she had made of herself. She thought about suing the deputy-manager, but took no action. Two weeks later she was functioning normally.

Full details of this case are not available, but it is possible to speculate. Alice’s response was unusual. It is possible that, having been wrongly accused, she opportunistically and purposefully refused to leave the store and created a disturbance to punish her accuser. It is also possible that Alice consciously exacerbated her situation to strengthen her hand in a financial compensation suit.

While Alice’s actions doubtlessly caused the deputy manager embarrassment and concern and may have damaged his prospects with the company, and would probably have increased the size of any financial compensation payment, there is nothing to indicate that these were her conscious aims. On the contrary, the evidence suggests that, at least when first accused, Alice was not able to understand her situation and would not have been capable of formulating a devious plan.

It would be reasonable to accept Alice’s words. She described being accused as a threatening experience which created a sense of danger. This was a respectable person whose integrity was semi-publicly challenged. With the mention of the police, her liberty was also in doubt. She was not able to fully comprehend what was being said and she stated she froze like an animal in the headlights of a car. This suggests that Alice’s reaction involved reduced capacity for conscious, decisive action, a reversion to a more primitive level of functioning.

Alice’s failure to move from the spot, may have been the action of a conniving person preparing for a compensation suit. Alternatively, it may have been the choice of an innocent, accused person who wanted to be cleared by the police and was guarding against any suggestion that she had disposed of evidence. A more interesting explanation is that Alice was incapable of deciding what to do, and consequently, could do nothing. This is consistent with her wanting the police to tell her it was “safe” to leave. This may have been a question from a worldly-wise individual wanting to double check on the possibility of current or potential future charges. It was more likely, however, a question from a temporarily somewhat incapacitated individual who was unable to decide about her safety and looked to an external authority to make that decision and direct her actions.

This lady experienced distress as a result of psychological stress. The stress was not life threatening and was not of the type associated with PTSD. Nor were there sufficient symptoms to make that diagnosis. Nevertheless, there were symptoms suggestive of PTSD and with more severe stress, Alice could perhaps

develop that disorder. On the available evidence, Alice's reaction could probably be diagnosed as an adjustment disorder.

DEBRIEFING

PTSD is common and frequently disabling. In the late 1960s and 1970s, the concern of the public and employers about this disorder rapidly escalated. Prevention is better than cure: this is a humanitarian view which is warmly endorsed by those responsible for compensation and disability payments. It is also the flag which has protected and continues to protect a fleet of ignorant, self-aggrandizing voyeurs.

In 1983, Mitchell introduced the concept of "critical incident stress debriefing", a process which is purported to assess and prevent the adverse consequences of traumatic events.

A central feature of debriefing is ventilation, or unrestrained talking about the individual's experience during a traumatic event. This frequently involves the release of emotion and the correction of factual inaccuracies. Such ventilation, sometimes assisted by disinhibiting drugs, had been described many decades previously, during the Second World War.

The precise aims of debriefing, amazingly, have not been precisely stated. As mentioned, assessment, and prevention of adverse psychological consequences, are two. The "normalization" of the response is said to be another. By this is meant, individuals are informed about the normal responses to stress and encouraged to accept their own thoughts and emotions in the light of this information. How this is distinct from the broad aim of preventing adverse psychological consequences is unclear.

The methods of debriefing have been more precisely stated. In the original descriptions, debriefing was to be used to assist emergency services workers (police, fire brigade, and health services). It was to be provided as a single session, conducted by a specially trained mental health care professional, to groups of individuals.

Subsequently, these methods have been varied. Debriefing has been applied to groups of civilians (as opposed to emergency services workers) and to individuals (as opposed to groups). Courses rather than single sessions of debriefing are offered. Most worryingly, minimally or untrained debriefing workers have been used. The fad of debriefing became so popular that in some regions each emergency services organization had to have one of their members volunteer to be the identified debriefing worker. Such volunteers usually have insignificant training.

It is well known among health professionals, although rarely written about, that when a disaster occurs in a western county, droves of psychological trauma workers suddenly appear.

When the Port Arthur Massacre occurred in Tasmania, some debriefing workers came at their own expense and uninvited from other states of Australia, many telephoned, even from overseas, seeking an invitation. Some tourists who were in the region, who felt qualified, came forward. One backpacker had some crumpled pages on PTSD in her pack, apparently for just such an emergency. She wanted to be involved and for her document to be photocopied and provided to hundreds of survivors, relatives and uninformed health care professionals.

In the period immediately after trauma, victims may experience a range of reactions. Some do not want to be involved in discussions, while for others, there is an irresistible outpouring of words and emotion. All, however, are vulnerable to exploitation. People seeking to assist victims must be well trained to recognize the different reactions. They must also be assisting for the benefit of the traumatized individuals, and not to gratify their own psychological needs. In dramatic and emotionally charged situations, helpers must avoid voyeuristic pleasure and "savior" satisfaction (satisfaction derived from behaving, or causing others to regard one, as a savior).

Opponents of the debriefing industry have drawn an analogy with physical trauma. The argument is that if trauma results in a gash, the doctor does not keep poking his or her finger into the wound asking if it still hurts. No metaphor is perfect and this one is perhaps less perfect than most, but it serves to draw attention to the normal healing process of all organisms. The argument concludes that the debriefing industry has the potential to disturb the healing process, and in the worst case scenario, may provoke unnecessary psychological scars (Mayou et al, 2000; Greenberg, 2001; Ehlers and Clark, 2003).

Some employers impose compulsory debriefing on all staff who are exposed to stressful incidents. Different local factors contribute to these requirements. Well meaning employers, persuaded of the value of debriefing, sometimes think they know what is best for their employees. Other employers are responding to workers groups which, believing in the value of debriefing, have negotiated this service as a “condition” of the “workers’ award”. Yet other employers are simply mindful that the size of compensation packages is reduced if “prevention” had been available.

Debriefing has now been used for some decades. A large number of studies have been conducted looking at whether this “treatment” has beneficial effects or not. Recently, all the results of these studies have been pooled and analyzed, using special statistical methods to give categorical answers to this question.

A recent analysis of the best studies, by a group with impeccable credential, using the best statistical methods (Rose et al, 2001) found that single session debriefing did not produce statistically beneficial effects. They also drew attention to the finding that in some studies debriefing actually produced detrimental effects (Hobbs et al, 1996). Their conclusion, which has been restated (Rose et al, 2002), was that compulsory debriefing should be ceased immediately.

Arendt and Elklit (2001) also pooled the results of many studies and made similar conclusions, that debriefing does not prevent psychiatric disorders or mitigate the effects of traumatic stress. They then looked at the components of debriefing as they were originally described, and found that some had merit. Debriefing was more effective when used with emergency services workers than when used with traumatized members of the public. A number of factors may be relevant. Emergency services workers are a special group of people. They have chosen to enter this field, and they have been able to predict and prepare for traumatic experiences. Those who are unsuited tend to leave the field, those who are better suited tend to remain. Perhaps most importantly, these people work in teams, there is camaraderie and members know and support each other before, during and after difficult times.

While debriefing in general was not found to be effective, there were indications that group was more effective than individual debriefing.

There are indications that the interactions between and the support given by group members to each other are more important than the actions of the debriefing worker. This is consistent with the above paragraphs.

Arendt and Elklit (2001) also found indications that highly trained debriefing experts are more effective than untrained volunteer debriefing workers. This should come as no surprise. One of the most important counseling or psychotherapy skills is to know when to shut-up and let the patient explore issues unmolested by therapist interjections. The skill of doing nothing requires extensive training and supervised experience. The untrained amateur is unable to let the group do the “therapy”.

In summary, unassailable studies indicate that single session debriefing following traumatic events is of limited, if any, value. It may have a place in the care of emergency services workers, where it should be non-compulsory and performed in group settings by a highly trained therapist who takes a predominantly passive role.

That single session debriefing has been found to be ineffective (van Emmerik et al, 2002) should not be taken as meaning that nothing can be done to help those people who suffer psychological distress following trauma. On the contrary, much is possible. Treatment should be provided only to those who need it. Ongoing care, including cognitive behavior therapy or other forms of psychotherapy, and medication of the type mentioned above under PTSD, will provide considerable relief.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

EMDR was originated by Francine Shapiro in 1987. At that time she was a psychology student. One day she was walking through a park preoccupied with old memories and disturbing thoughts. As she looked at rows of trees, her eyes moved back and forth and her memories seemed to dissolve spontaneously. She extended this experience into a system of treatment for PTSD. She gained her PhD and published the results of a study in 1989 in which all of 22 patients suffering from PTSD made a recovery following a single 60 minute EMDR session.

EMDR created enormous interest, particularly among psychologists, but also among some other mental health professionals. Dr Shapiro organized training events and over the next eight years, trained over 22 000 professionals - all of whom paid hundreds of American dollars for brief courses. The interest, training and clinical use of EMDR continues apace.

Lay journalists of both newspaper and television have reported EMDR in glowing terms, with statements that it is a breakthrough and that it works ten times faster than other treatments.

The procedure, however, is not without critics. Some complain about what they believe to be the blatant commercialization of a healing technique. This is not the place to explore that issue, but people have profited from their ideas and inventions as long as history has been recorded. At first glance it is hard to see why EMDR should not yield this type of reward. Before looking at other criticisms, let's get some familiarity with the procedure.

Patients who are suffering PTSD are asked to visualize the triggering traumatic event as vividly as possible. While retaining this image they are asked to make a brief statement which encapsulates their reaction to the image (eg, "I am about to die"). They are then asked to rate their level of distress on a scale from zero to 10. Then they are asked to make a positive statement that encapsulates the reaction they would like to have to the situation (eg, "I can cope with this"), and to rate their degree of belief in this positive statement on a scale from zero to 8. The patient is then asked to look at the therapist's finger as it is moved back and forth at about two movements per second for 12 to 14 seconds. Then the patient is asked to "blank out" the distressing image and again rate their distress. This process continues until the distress rating falls to two or lower and the belief in the positive statement reaches six or higher.

How does EMDR work? The EMDR International Association states that, "The event that provoked the upset becomes 'frozen in time', and 'stuck' in the information processing system". This is a vague statement, but it is consistent with the theory that PTSD involves memory. The EMDRIA goes on to say, "Researchers have suggested that the eye movements trigger a neurophysiological mechanism that activates an 'accelerated information processing system'". This statement is worryingly vague. The EMDRIA supports Dr Shapiro's claim that one session of treatment may be sufficient, stating that EMDR allows "more rapid working through of disturbance than more conventional forms of therapy".

There have been several important developments. From the beginning, some clinicians believed EMDR, with the "magical hand movements" to be hocus-pocus. However, independent studies did appear to show EMDR to be quite effective in the treatment of PTSD. Next, EMDR was compared to the recognized treatment called exposure therapy (the patient relives the traumatic experience as directed by the therapist) and no difference was found – both worked, about equally well. Finally, in an experiment which compared two groups of patients who had exactly the same treatment, except one group performed the eye movements component and the other simply fixed their eyes on a stationary spot, it was found that the eye movement part of the treatment was unnecessary (Pitman et al, 1996).

EMDR is an effective treatment of PTSD. But no more so than the exposure therapy which has been used in the treatment of this condition for decades. That is because EMDR is a variant of exposure therapy. The patient receives emotional and personal support while they re-experience the traumatic event. It also has components of "cognitive restructuring", another well established form of therapy, in which the patient is encouraged to interpret things in a new way. EMDR takes old treatments and rolls them into a user friendly package. The eye movement component which endowed the treatment with its name and

its magical potency is unnecessary. In 1999, Dr Shapiro wrote of “the unfortunate naming of the procedure after the eye movements, which...(are)...only one of many components of this complex, integrated treatment”.

There is much disquiet about EMDR among the hard-nosed critical thinkers of the psychology profession. For these people the main issues are “EMDR’s aggressive commercial promotion and its rapid acceptance among practitioners” (Herbert et al, 2000). The EMDR caravan, however, continues to roll on. The cries of the critics with science on their side have had little effect. EMDR is the repackaging of established psychological treatments into a convenient form. Whether the originator *should* be able to present her treatment as original, and whether she *should* make a fortune from her efforts, are matters we will not consider. In the current age, convenience is highly valued and rewarded. Gullibility of professionals, however, remains a matter of concern.

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CHAPTER 14

RECOVERED MEMORIES

RECOVERED MEMORY THERAPY

Recovered memory therapy (RMT) emerged in the 1980s. It was very popular for a time, it is less so now, although it is still practiced and conferences attract large, eager audiences. There is evidence that RMT may do more harm than good.

The basic theory is that, 1) childhood sexual abuse leads to psychiatric problems in later life, 2) memory of this sexual abuse is forgotten, and 3) uncovering these memories will cure the psychiatric problems.

The best lie is the one which is closest to the truth. And the hardest “therapy” to debunk is one which is closest to orthodox practice. All would agree that childhood sexual abuse may cause psychological or psychiatric difficulties in adult life. Not always, but often.

Many experts in the field do not believe that childhood sexual abuse can be forgotten and then “remembered” years later (Brandon et al, 1998). Other equally reputable people, are more circumspect and believe this to be possible (Brewin, 2000). Such remembering becomes theoretically possible because “active forgetting” is a theoretical component of the theory of psychoanalysis. This form of treatment, initially described by Sigmund Freud, depends in part on “active forgetting” which he called “repression”.

Psychoanalysis was revolutionary and comprehensive theory. It was and is useful as a model for understanding normal mental development, for describing mental processes and for providing therapy for certain mental conditions. Psychoanalysis is like a mechanical clock, it is complex and depends on a large number of pieces fitting together, each influencing and influenced by its neighbors, to work. Among other issues, psychoanalysis examines the relationship between the patient and his/her parents, and the relationship between the patient and the therapist. In addition to repression, psychoanalysis investigates a vast number of complimentary mechanisms which keep drives and conflicts out of conscious awareness, not to mention a vast array of mechanisms by which change or recovery is resisted. In short, repression taken out of psychoanalysis is as much use in explaining a mental syndrome as a wheel or a lever taken from a mechanical clock is for telling the time.

Those who do not believe that traumatic events can be forgotten point out that, but for Freud’s speculation, which has never been scientifically validated, the idea that such terrible events could be forgotten, would be dismissed as ridiculous. After all, the problem with post-traumatic stress disorder is not that events cannot be remembered, on the contrary, the problem is that distressing events cannot be forgotten.

Let us turn now to the RMT belief that uncovering these “forgotten memories” will cure current psychiatric problems. At a first glance common sense level, this would seem to make sense, after all, much psycho-

therapy involves talking about past events. But this is a dangerously misguided view of psychotherapy. Central to psychotherapy is patient growth. Such growth may involve the gradual getting in touch with unconscious feelings and ambitions, in a nurturing patient-doctor setting. This is quite different to exposing the patient to all the bad events of the past that can possibly be dredged up. In psychotherapy the patient is gradually prepared for any distressing material which may emerge, in RMT that preparation does not take place, instead, there is a helter-skelter rush to uncover the “forgotten memories”.

But is RMT effective? In one study of 30 patients, all were still in therapy three years after the memory first surfaced, and most were still in therapy five years later. Before the memories “surfaced” 3 (10%) had attempted or thought of suicide, after memories, 20 (67%) were suicidal. Before memories only one person (3%) had engaged in self-mutilation, after memories this became eight (27%). Before therapy 25 (83%) were employed, after 3 years of therapy only 3 (10%) were still employed. Before therapy 23 (77%) were married, after therapy 11/23 (48%) were divorced or separated. Of the 21 who had children, seven (33%) lost custody (cited in Loftus, 1997).

Forty cases of people who had made claims of recovered memories and then retracted them were examined in detail (Leif and Fetkewicz, 1996). “As we collect more and more data on the types of therapies involved in recovered memory therapy, we cannot avoid the conclusion that this is bad therapy. Enormous harm is being done to these patients and to their families. Patients get sicker instead of better, huge sums of money are spent for years of therapy based on the erroneous assumption that the recovery of memories of sexual abuse in childhood is a healing process”.

CHILDHOOD SEXUAL ABUSE (CSA)

CSA is common. It is unfair, destructive, cruel and illegal. It deserves the harshest penalty.

FALSE MEMORY SYNDROME

In living memory, there has been a low level of prosecution for child neglect and sexual abuse. Most would agree that these crimes have been, and continue to be, underreported and less than vigorously pursued by some authorities. Hopefully, this situation is changing.

During the 1980s and 90s, however, a new picture began to emerge. Adult people, usually women, who have had no memory of early sexual abuse, began to “remember” such episodes. This was usually in the process of “therapy”. Many, with the urging of their “therapist”, have caused legal charges to be brought against parents or other “perpetrators”. Convictions have been recorded and in some case, imprisonment has been a consequence.

This is completely different and should not be confused with the scenario in which a person who has been abused in childhood and has remembered the events ever since, and finally pressed charges in later life

In most instances, of “recovered memory” the accused individuals, supported by other family members, deny the charges. In some instances their response is that the accuser is simply lying. Often, the word “lying” does not seem appropriate as the accuser appears to genuinely believe what the accused and their supporters know to be untrue.

Not only are accused people sometimes punished by courts, but the whole family suffers. Families divide into two camps, one which supports the accuser and one which supports the accused. Life-long bonds are frequently irrevocably broken.

Accused people and their supporters have argued that these are inaccurate or “false memories”. The term “false memory syndrome” has been applied when the accusing individuals become preoccupied, doggedly

wanting to “prove” their memories are “true”, striving to “remember” more, regarding themselves as “victims”, spending time and money on further “therapy”. This pursuit is often detrimental to their current interpersonal relationships, education and employment.

Well qualified mental health professionals have come to the assistance of the accused. Support groups have been established around the world. They lobby people in the judicial system, politicians and health professionals. They maintain web pages which promote their views and denounce “bad therapy”. Examples include the False Memory Syndrome Foundation based in Philadelphia, PA, USA, the British False Memory Society (Illustration 14.1), and the Australian False Memory Association.

Evidence supplied by the support groups indicates that innocent people have been accused and some have even been imprisoned. The question which must be addressed is, how false beliefs can be formed?

THE NATURE OF MEMORY

Vast textbooks and mountains of scientific papers have been written on this complex and incompletely understood topic. The following paragraphs list of a couple of points of interest, and do not attempt a comprehensive review.

There is little scientific support for Freud’s model of the unconscious mind where memories of traumatic events are stored. We may push unpleasant memories into the background and they may come to the foreground due to environmental reminders or in a trusting relationship such as therapy, but these memories have been ignored rather than forgotten.

Evidence indicates that we reconstruct our memories. Rather than being stored as complete “video clips”,



Illustration 14.1 This picture of Lavery’s Phrenometer of 1907 appears on the Website of the British False Memory Society, along with the note that the British Phrenological Society was not wound up until 1967. Phrenology was a “science” which claimed that the shape and bumps on the head could be read to reveal the individual’s mental capacity, emotions and personality. This proved to be quite wrong.

The Society is presumably using the image of this device to point to the fact that false ideas have been accepted in the past in the psychology and related fields, and that even those dealing with objective measurements may take more than half a century to be discredited and abandoned.

Picture from, Colin Blakemore, *Mechanics of the Mind*, 1977, Cambridge University Press. Reproduced with permission.

our memories are stored as pieces of a jig-saw puzzle. Many pieces of experience are not remembered at all, but filled in to complete the picture (Schacter, 2001). With this jig-saw model it is easy to see how the beliefs of trusted and authority figures, such as therapists, may influence memories.

RMT often involves hypnosis and involvement in groups of fellow “survivors”. Hypnosis is now known to distort memory and information obtained under hypnosis is no longer admissible in courts of law. Groups with a shared belief can be very persuasive to the individual, for example the term mass hysteria has been applied when school children become afflicted with physical symptoms such as twitching or erroneous beliefs. Certain cults depend for existence on the charisma of a leader and the influence of the congregational group on new converts.

Our memories are frequently faulty. Soldiers have given graphic accounts of actions which they clearly remember, but at which the records show, they were not present. Twins often disagree about which one was involved in a certain event. The great child psychologist Jean Piaget clearly remembered a time when an attempt was made to kidnap him from his nurse. Later in life he was surprised when his parents received a letter from the nurse apologising for having fabricated the event. President Ronald Reagan was fond of telling a story of World War Two bravery which did not happen in reality, but was from a film script.

Memory is so malleable that we should be very cautious in claiming certainty about any given memory without corroborative evidence (Schacter, 2001).

CAUTION

There is need for great caution. It is agreed that CSA is common and damaging. Failure to believe memories of genuine CSA may deny patients of valuable assistance. On the other hand, believing a false memory may also do great damage. Professional bodies published guidelines which encourage the search for corroborative evidence.

Readers are advised to avoid therapy which specifically elicits memories of childhood abuse as the central technique for relieving emotional distress.

CASE REPORT

Rob Kenward, a plumber from Cairns, Queensland, Australia, was jailed for six years for rape. His accuser was attending the Royal Brisbane Hospital with chronic pain in her shoulder. She was assessed by a Psychologist as suffering from physical pain of psychological origin. Soon after she remembered being raped twenty years earlier by Kenward when she had been living in his household.

There was no corroborating evidence, the case being based on recovered memory. Kenward went before the Supreme Court four times. At the first trial there was a hung jury. The second and third trials were abandoned. At the fourth he was found guilty and sent to jail. In jail, pedophiles are regarded as the lowest of the low and Kenward was doused in urine and subjected to other indignities. The Appeals Court quashed the case and he was released.

CASE REPORT

The case of Dr Bennett Braun and his colleagues at the Rush-Presbyterian Hospital in Chicago is of interest. In 1997 Patricia Burgus and her family, the day before going to trial, agreed to accept US\$10.6 million from her therapists (primarily Dr Braun) and the hospital.

Ms Burgus stated that, over six years, two and a half as an inpatient, through the use of medication and hypnotism, Dr Braun convinced her that she had multiple personality disorder with 300 alternate personalities. She claimed that he convinced her that she had developed this condition as a result of repeated childhood abuse including participation in ritual murders, cannibalism, Satan worship and torture of family members. "I was told that, until I hit rock bottom, until I dug all this stuff out, I would never get better and I would never have a chance for any kind of future for my children", she said.

Her children aged 4 and 5 years were hospitalized for almost three years and rewarded for telling "yucky stories" about their family.

Dr Braun and at least one other associated medical practitioner subsequently lost their medical licenses.

CASE REPORT

Beth Rutherford was a 19 year old nurse working on a cancer ward, in Springfield, Missouri. Her father was a church minister and her mother was a nurse; she had two sisters, Lynette and Shara. She consulted a counselor with two master's degrees, one in psychology and the other in social work, because of tension headache.

She was soon told that her symptoms were consistent with CSA. She was told that being a high achiever at school was suggestive of having been abused as she had absorbed herself in academic studies in order to cope with the abuse she was receiving at home. She was told she had to trust her therapist and that the only way out of her predicament was to recover these memories and "deal with them".

She came to believe that her father had impregnated her twice and that on the first occasion he had performed a coat hanger abortion and on the second she had performed a coat hanger abortion herself. She believed her mother held her down while her father inserted implements in her vagina.

Beth accused her parents in a public forum. Father had his ministerial credentials withdrawn and was threatened with criminal charges which could have resulted in incarceration for a minimum of seven years. Beth's sisters believed her and all three moved out of home and ceased communication with their parents.

Beth had been in therapy for two and a half years. She then moved to Oklahoma City, and contact with her therapist ceased. On the day of the Oklahoma City bombing her mother, who had been warned not to make contact, telephoned to make sure she was safe and left a brief message on her answering machine. Gradually the family reunited and Beth came to believe that the CSA had not occurred. She was medically examined and her hymen was found to be intact. She now speaks about her experiences and encourages other "retractors".

CASE REPORT

In the early 90's claims were made by a group of parents that nursery nurses Dawn Reed and Christopher Lillie has sexually abused children under their care at Shieldfield Nursery in Newcastle, England.

There was a pre-trial acquittal in 1994, but the parents and the media were not satisfied. Accordingly, the Newcastle City Council appointed a Review Team in 1996, three social workers and a psychologist, to ex-

amine the allegations. Their report "Abuse In Early Years" was published in 1998 and described the nursery workers as bizarre and dangerous paedophiles who abused children both at the nursery and at other locations and as being part of a "paedophile ring".

In 2002, in a civil case brought by the nurses, the High Court in London found the nurses had been maliciously libelled by the Review Team and awarded them maximum damages. Mr Justice Eady, the trial judge in what has become known as the Shieldfield Libel Trial, found that the Review Team had been intellectually biased and dishonest. The judge said the leader of the team "eschewed rational analysis in the approach to his task from the outset". Of an expert witness he said, "The truth is that where physical findings were negative or equivocal, Dr San Lazaro was prepared to make up the deficiencies by throwing objectivity and scientific rigor to the winds in a highly emotional misrepresentation of the facts".

All of these cases illustrate the danger of using discredited means of obtaining "evidence", for example, material which emerges in the process of "therapy" specifically designed to elicit evidence. And just as it is not wise to place vampires in charge of blood banks, it is not wise to place zealots in charge of investigations on the topic of their zeal.

ALIEN ABDUCTION

In the United States of America, in particular, from time to time, the media reports on individuals who believe they have been abducted by aliens, examined by them and then returned to earth. These accounts are widely believed to be false memories. Alien abduction false memories are patently different in content to those of childhood sexual abuse. Nevertheless, the vast majority contain some sexual elements. Rectal examination with "probes" and the removal of "eggs" or "seeds" are usually reported.

In 2003, Professor Richard McNally of Harvard University made an important observation. He examined 10 "abductees" using measures of arousal such as breathing rate, blood pressure and sweating. He found that when the "abductees" described their experiences, they had the same sort of physical reactions as people who are describing well documented traumatic experiences, such as soldiers with posttraumatic stress disorder.

Does this then "prove" the abductions took place? No, but it does support that the believing individual believes they did. It is important to know that none of these people "knew" of their alien experiences before they consulted "recovered memory" practitioners.

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CHAPTER 15

ELECTROCONVULSIVE THERAPY (ECT) AND TRANSCRANIAL MAGNETIC STIMULATION (TMS)

No treatment in psychiatry is more contentious than electroconvulsive therapy (ECT). Certain groups and individuals have, for decades, claimed that ECT is damaging to the memory and the brain. They have successfully influenced legislation to the extent that, in some states of the USA, for many years, it was almost impossible for psychiatrists to provide this treatment to suffering patients. Fortunately, new regulations have eased most of the ECT embargoes in California

Why does ECT generate such opposition? One reason has to do with our innate disposition. There is a natural repugnance to certain biological activities. Convulsing, like vomiting, is not something we like to watch. There may be an evolutionary explanation. It could be that convulsing and vomiting indicate sickness and as sickness may be contagious, we may be genetically programmed to fear and keep away from those engaged in these activities. As a matter of course, sick animals are less favorable breeding stock and are not selected as mates. We avoid the topic of convulsions and as many people who suffer epilepsy will testify, we sometimes even avoid people who have had convulsions.

Another reason why individuals and groups are opposed to ECT is that they genuinely believe that ECT causes brain and memory damage. In fact, ECT does not cause brain damage and the memory problems are usually mild and temporary. The other side of the story is that ECT is the most effective treatment for some of the most severe psychiatric disorders, and is frequently life-saving. Let us return to the issues of the safety and efficacy of ECT after a look at the historical development of this enigmatic treatment.

HISTORY OF ECT

ECT was first performed in Rome in 1938. As with many treatments in medicine, it is possible to find accounts of similar treatments stretching back over centuries.

Electricity has been applied to the body for medicinal purposes for millennia. The distant accounts are fragmentary. In AD 46, Scribonius Largus described the application of electric torpedo fish to the head as a treatment for headache. In 1470, a Jesuit missionary in Ethiopia, applied electric catfish to people in an effort to expel devils. It is unknown whether these people were suffering mental disorders, or to which part of the anatomy the “treatment” was applied. In the 18th century electric eels were applied to the head. In 1814 electricity was used in the treatment of mental disorders, but it was applied to the hands, neck,

back and buttocks. However, there is no evidence of electricity being applied to produce convulsions in the treatment of mental disorders before 1938.

Convulsions, however, had been induced for medicinal purposes at different times over centuries. They were induced by chemical agents, but again, the history is fragmentary. Paracelsus (1490-1541) used camphor by mouth to induce convulsions in the treatment of mental disorders. In 1785 an account of the treatment of psychosis treated with camphor and convulsion appeared in the London Medical Journal. Also in the mid-18th century, the herb, hellebore, was used to treat mental disorders. Its effects included coma and convulsion.

ECT emerged at an interesting time. Until the early 1920's little could be done for people with serious mental disorders, other than humane custodial care. Then came a series of active treatments which encouraged optimism and set the scene for the development of ECT.

From around 1917 Julius Wagner-Jauregg developed a treatment for the otherwise progressive and fatal condition, general paresis of the insane. This condition is the result of the syphilis organism attacking the brain. Wagner-Jauregg, Professor of Psychiatry in Vienna, had noted that certain patients with mental disorders improved whenever they suffered a fever. He attempted to cause fevers by various means, but without success. Finally, he was able to induce fevers by injecting patients with blood taken from people who suffered malaria. In so doing, Wagner-Jauregg infected his patients with malaria, however, their fevers had the desired effect of improving their mental condition, and the malaria could be controlled with quinine. This was a major advance and Wagner-Jauregg was awarded the Nobel Prize in 1927. Syphilis is now treated with antibiotics.

In 1933, Manfred Sakel, who was working in Vienna at the time, announced successful treatment of schizophrenia with insulin. This hormone has a central role in regulating the level of sugar in the blood. It had been used by others in psychiatry to lower the blood sugar and thereby produce sedation and stimulation of the appetite. Sakel's method, however, was to induce coma. In the process, convulsion sometimes occurred. A course of treatment involved up to 40 comas and took a period of months. There was no doubt among the doctors of the time, that insulin coma therapy was effective. Some believed that the treatments which resulted in convulsion were the more effective.

Thus, Ladislaus von Meduna (1896-1964) entered a scene which, after generations of therapeutic impotence, was beginning to show sparks of confidence. In 1934, in Budapest, he injected camphor to produce the first modern convulsive therapy.

Von Meduna had developed the theory that there was a "biological antagonism" between epilepsy and schizophrenia. By this he meant the two conditions could not exist simultaneously. This theory was based on two clinical observations. The first was that when a person with a severe mental illness suffered a seizure for some reason, their mental state improved. The second was that a person could not suffer from both schizophrenia and epilepsy. The first of these observations is probably accurate, the second is certainly not. Opponents of ECT attempt to make much of the fact that one part of the original theoretical basis is no longer tenable. That is as silly as suggesting we reject penicillin because its antibacterial properties were discovered by chance.

Von Meduna found that camphor did not reliably produce convulsions. Some patients had no seizures, others had many. He then began to use a synthetic camphor which was marketed under the names of Metrazol and Cardiazol, and obtained more predictable results. In 1935, von Meduna published his first results. He reported that convulsive therapy produced beneficial effects in 10 out of 26 people with schizophrenia. Given that there was no other effective treatment, these results were important, and the treatment quickly spread around the world.

Even with the synthetic camphor, however, the procedure was problematic. There was always a delay between injection and the onset of convulsion, during which time there was no turning back, and patients could become highly fearful. There is individual variation in susceptibility to all medications, and a guiding principle is that excessive doses of all medications should be avoided. There was no way to be certain of the lowest effective dose of synthetic camphor and missed and multiple convulsions continued. ECT had



Illustration 15.1 Ugo Cerletti (1877-1963) was the leader of the team that developed and first used ECT in Rome in 1938.

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the advantage of an immediate and certain convulsion and eventually completely replaced chemically induced seizures.

The first ECT was performed by Ugo Cerletti and his colleagues, in Rome, in 1938 (Illustration 15.1).

Cerletti (1877-1963) received his medical degree from the University of Rome in 1901. He studied in France and Germany before returning to Italy where he worked as a psychiatrist and an anatomical pathologist of the nervous system. In 1935 he went to Rome as the Chairman of the Department of Psychiatry at the University of Rome and Director of the Clinic of Nervous and Mental Illnesses. It was at this clinic, now the Department of Neurosciences of the University of Rome, that ECT was first administered.

Cerletti had conducted extensive research in epilepsy. In Genoa, he attempted to discover whether scarring in the temporal lobe, which is found in certain types of epilepsy, was the cause or the result of epilepsy. For this research it was necessary to induce convulsions in laboratory animals (dogs). A method, which had been used since the late 19th century, was to place one electrode in the mouth and the other in the rectum of the dog and pass an electric current between them. These may seem bizarre and invasive places to be putting electrodes. The explanation is simple. When applying an electrical current to a body, it is most important to obtain good electrical contacts. Otherwise there is high resistance,

the need for greater electrical energy and the risk of burns. Moist, hairless skin or membranes, such as those of the mouth and rectum, are suitable, and convenient when dealing with hairy animals.

Regrettably, nearly half the dogs used in these experiments died. It is important to note that these experiments were conducted in accordance with ethical principles of the day.

In 1936, stimulated by the success of von Meduna the previous year, Cerletti organized his staff to examine the possibility of using electricity to produce convulsions in humans. The major concern, of course, was safety, given the death toll of the experimental animals.

He sent his assistant Lucio Bini (1908-1964) to Budapest to learn about chemically induced convulsions, and asked him to develop a safe method of producing convulsions with electricity. Bini believed that the dogs had died because the electricity passed through the heart and caused cardiac arrest. He therefore developed a method of applying both electrodes to the head, which proved to be entirely safe. With the assistance of a technician, he built an apparatus for administering electricity, which is now at the History of Medicine Museum, Rome.

The group conducted extensive animal studies. Then they heard that at the local abattoir, electricity was applied to the head of animals as a means of slaughtering them. This application of electricity to the head, apparently for fatal purposes, caused them great concern. However, on investigation, they discovered that electricity was being used to render the animals unconscious, before they were slaughtered in the normal manner. Rather than weakening, the abattoir practice strengthened the case that electricity could be safely applied to the head. This is source of misinformation used by some opponents of ECT, who have claimed that the treatment was derived from a process for slaughtering pigs.

In April 1938, the first treatment of a human with ECT was performed. In spite of their extensive preparation, the team was still apprehensive. Any mistake or accident could potentially have serious consequences for the patient and themselves.

They referred to the first patient as SE. He was a 39 year old engineer from Milan. He had been found wandering by the police. He could not give an account of himself, and nothing could be discovered about his family. He had formal thought disorder (his thoughts did not follow logically) and was using neologisms (words which may have meaning to the patient, but do not appear in the dictionary and are not understood by others). He was hallucinating (he was hearing or seeing things which others could not hear or see). It was believed that SE was suffering severe schizophrenia and that the chance of recovery was poor. The researchers fulfilled the ethical requirements of the time. They were convinced that SE was suffering and that convulsive treatment would be safe, and further, they believed electrically induced convulsions would relieve his suffering. Using the standards of the 21st century, this man would not receive experimental treatment as he was not able to give informed consent.

Those present at the first treatment were Cerletti, Bini, two other junior psychiatrists, the neurologist and Deputy Director of the clinic, Vittorio Chailiol, a nurse and a hospital attendant. SE lay on a bed. Bini's equipment was on a nearby table. The nurse attached the electrodes to SE's temples. The first stimulation, on Cerletti's instructions, was 80 volts for one tenth of a second. This caused momentary contraction of the muscles, but no seizure. The patient was unperturbed and physical examination revealed no adverse effect on the heart or reflexes. Cerletti then directed a stimulus at 90 volts for one tenth of a second. Again there was momentary contraction of the muscles, but no convulsion, and the patient remained composed. He made an utterance which appeared to include neologisms, but as he spoke in Italian, these cannot be translated into English. By this time the research team was wet with perspiration. Cerletti stated that they would make a third and final attempt, using 110 volts for two tenths of a second. SE's muscles contracted and then followed a classical convulsion.

SE had 11 treatments over subsequent days and was discharged from hospital much improved. Eventually the team received information that this man had previously been admitted to another psychiatric hospital and been treated with chemically induced convulsions, to which he also had a good response. In May the following year he wrote to the doctors thanking them for his treatment.

ECT spread rapidly to other countries. It was first used in the USA in 1940. Use increased until the end of the 1950s, at which time the antidepressants became available and use plateaued. Since the 1980s, however, use has again increased.

This wide acceptance of ECT is the result of many factors including, 1) the belief that in certain circumstances, ECT is more effective than medication, 2) the observation that ECT works more rapidly, which can be most important when managing suicidal patients, 3) careful patient selection, so that only those conditions likely to respond are treated, and 4) improvements in technique which reduced side effects.

The improvements in technique have included, 1) the administration of general anaesthetic during ECT so that patients are unaware of the procedure, 2) the administration of muscle relaxants as part of the anaesthetic so that the convulsion is muted and bodily damage due to strong muscle contraction is avoided, 3) other anaesthetic changes such as increasing the supply of oxygen to the patient prior to ECT, 4) electrical stimuli which are designed to produce therapeutic convulsions without delivering unnecessary energy to the brain, 5) development of a range of ways of applying electrodes which can be used according to the details of particular cases, and 6) methods for monitoring the activity within the body and brain, before, during and following convulsions (Illustration 15.2). These advances, which are discussed in detail in textbooks (Abrams, 1997), have made a considerable contribution to patient comfort and satisfaction.



Illustration 15.2 Modern ECT apparatus is a sophisticated piece of engineering and which provides physiologically friendly, brief square wave electrical stimuli. In addition, it monitors and provides the doctor with traces of brain and heart activity. In size, all the machines on the market are smaller than a desk-top computer. The electrodes for providing the stimulus and collecting the physiological data are single-use and adhesive. Generally, bands are no longer placed around the head to hold metal electrodes in place.

THE PROCEDURE

To the causal observer, ECT looks to be a straightforward process. The majority of the difficult work is performed before the day of the procedure. Preparatory work includes making an accurate diagnosis, deciding whether ECT or some other treatment is the more appropriate, deciding on the most appropriate placement of the electrodes and other technical issues, and advising and answering the questions of patients and relatives. An anaesthetic assessment is also made, and depending on the institution, certain laboratory tests may be performed.

Generally speaking, the stimulus can be applied using one of two electrode positions. In bilateral stimulation, one electrode is placed on either side of the forehead and the electricity passes through both left and right sides of the brain. In unilateral stimulation, one electrode is attached to one side of the forehead and the second electrode is placed further back on the scalp, on the same side of the head. With unilateral stimulation more of the electricity predominantly remains on one side of the brain, but when the convulsion commences, it extends and involves both sides of the brain.

The electroencephalogram (EEG) is a recording of the natural electrical activity of the brain, and there is electrical activity in all parts of the brain in the resting state. This is quite separate from the electricity which is used as the stimulus to trigger the convulsion. There is a great increase in EEG activity during convulsions. The recording of EEG before, during and after ECT assists the psychiatrist in making decisions and has become standard practice. Two sets of electrodes are used to obtain information about the electrical activity in two regions of the brain.

The patient will usually lie on a trolley and be wheeled into the procedure room. There is a minimum of four people present, an anaesthetist who will administer the anaesthetic, a psychiatrist who will administer the ECT, and two assisting nurses.

The anaesthetist places cannula in a vein on the back of a hand, the psychiatrist will clean the skin of the forehead to ensure good electrical contact, and attaches one or two electrodes to the forehead, depending on whether one or both sides of the brain are to be stimulated. In modern ECT practice, the electrodes are single-use and self-adhesive, thus, there is no need for bands to hold metal electrodes in place. The psychiatrist attaches two further electrodes to the forehead to pickup the EEG from the front of the head.

The anaesthetic nurse may attach ECG electrodes to the chest and a monitor to one finger which will indicate the heart rate and the amount of oxygen in the blood. The ECT nurse attaches electrodes to the arm which will pick up evidence of the electrical activity in the motor region of the brain.

The anaesthetist asks the patient to breathe some oxygen from a mask and at about this time, injects an anaesthetic agent into the cannula in the hand. This causes the patient to lose consciousness, which means the patient is no longer aware of what is going on in the procedure room. The anaesthetist injects a muscle

relaxant. At this time the psychiatrist is checking the “impedance”, a measure of the contact between the patient and the stimulation electrodes.

When the patient’s muscles are fully relaxed the anaesthetist may place a rubber pad between the teeth, depending on a range variables. When all is ready, the psychiatrist presses a button and the stimulus is applied to the patient.

The stimulus is a square wave, with a pulse width of 1.0 millisecond. Using one popular ECT device (Thymatron), the stimulus can be delivered at a maximum frequency of 70 pulses per second. Therefore, in one second the stimulus runs for 0.14 seconds. The longest that a stimulation can continue using the above device is 8 seconds. Thus, with the maximum settings, the stimulus runs for a total time of a little over one second (1.12 seconds).

If the muscle relaxation has been extensive, little of the convulsion will be observed. The muscles involved include those of the face and jaw, so that the eyes are strongly closed and the jaw is clenched. The arms usually flex at the elbow and the fists clench. The knees may bend slightly and the toes usually point.

When the convulsion has ceased the patient is rolled onto one side. The anaesthetic agent and muscle relaxant wear off within seconds of the end of the convulsion and the patient begins breathing spontaneously. The whole procedure from arrival to departure from the procedure room takes in the order of ten minutes.

ELECTRODE PLACEMENT

As stated above, there are two electrode arrangements. In bilateral ECT, one electrode is placed on each side of the forehead and electricity passes through both sides of the brain. In unilateral ECT, one electrode is placed on one side of the forehead and the other electrode is placed further back on the same side of the head, such that the electricity is predominantly limited to one side of the brain.

The most troublesome side effect of ECT is temporary memory difficulty (see below). Memory is not located in one particular region of the brain. Instead, current wisdom is that memory depends on many regions of the brain being anatomically and functionally linked together. However, it is also known that severe memory problems can occur when certain structures are damaged on both sides of the brain. For example, severe memory disorder occurs when both left and right temporal lobes are destroyed.

It has long been believed that bilateral ECT has a stronger antidepressant effect than unilateral ECT, it has also been found to produce more memory disturbance than unilateral ECT.

New evidence has shown that a larger amount of electrical energy applied with unilateral electrode placement can produce the same antidepressant effect as bilateral ECT, but with less memory disturbance (Sackeim et al, 1993). Research in this field continues.

DEATH AND ECT

Death during ECT is extremely rare. ECT is safer than dental extraction under anaesthesia. The few deaths which have occurred have been a result of anaesthesia, not a result of ECT. Examining the records of more than fifty years ago, when anaesthesia and ECT were crude by modern standards, one death was found in 46, 770 treatments (Kendall, 1977).

There are less deaths among people with depression who are treated with ECT than among people with depression who are treated by other means (Avery and Winokur, 1978). This is because depression may result in suicide and ECT, being a powerful and rapid treatment of depression, lowers the risk of suicide.

PERMANENT BRAIN DAMAGE AND ECT

ECT does not cause brain damage. Every possible investigation has been conducted, including blood enzyme studies, imaging of the structure of the brain, imaging of the chemical composition of the brain and post mortem studies. No abnormalities have been detected which can be attributed to ECT.

MEMORY AND ECT

Loss of memories is fundamentally threatening to the individual. It strikes at the sense of autonomy and self.

Memory loss is of two types, loss of events that occurred before, and loss of events which occurred after the incident under discussion, in this case, ECT. These are called anterograde and retrograde amnesia. There may be marked differences between subjective and objective memory difficulties. Subjective memory difficulty is the experience of the individual, that there is impairment in memory, this may or may not be substantiated by objective memory testing using special neuropsychological instruments.

Two recent developments have greatly reduced the memory disturbance associated with ECT. In the early years the electrical stimulus was in the form of a sine wave, contemporary machines provide the stimulus in the form of a brief square wave. The old sine wave delivered unnecessary electrical energy to the patient, which did not improve the therapeutic outcome, but did disturb the memory; the new brief square wave delivers much less unnecessary energy and accordingly, disturbs the memory much less. The other advance is the modern unilateral (one side) electrode placement which disturbs the memory much less than the older bilateral (both sides) placement. Unilateral ECT is not usually associated with subjective experience of memory difficulties (Squire and Slater, 1983).

In disentangling the effect of ECT on memory other factors must be taken into account. Major depression itself, through distractibility and the slowing of thought processes, has a detrimental effect on memory. Some of the medicines which are used as alternatives to ECT, may also have a detrimental effect on memory. Thus people who suffer an episode of major depression may have a poor memory for this episode of their lives whether they have ECT or not.

Using sophisticated methods, following ECT, temporary memory disorder can sometimes be demonstrated. On the other side of the register, many studies have shown a subjective improvement following ECT (McCall et al, 1995). The latter findings are due to improvement of the underlying depressive disorder.

The following points summarize our present knowledge regarding the effect of ECT on memory: 1) memory difficulties may follow ECT and while these usually subside within a few weeks, some claim lasting difficulties, 2) the modern brief square wave stimulus is far less likely to produce memory difficulties than the old, now abandoned sine wave stimulus, 3) unilateral is associated with far less memory disturbance than bilateral ECT, 4) memory disturbance is by no means inevitable, the majority of patients who receive unilateral ECT make no claims of memory disturbance, 5) most individuals who experience subjective memory difficulties have no disability on objective testing, 6) where memory disturbance does occur, it is more for impersonal rather than important personal events, and 7) depression per se and antidepressant medication may also be associated with memory difficulties.

In conclusion, as the serious mental disorders for which ECT are administered, such as depression, cause suffering and disability and may end in suicide, energetic treatment is indicated. Where psychotherapy and medication have not provided remission, ECT should be considered. The risk of memory disorder must be considered, but particularly when modern techniques are used, the risk of memory disturbance is very small.

CONDITIONS TREATED WITH ECT

ECT is predominantly used in major depressive episode, especially where drugs have failed or there is serious risk of suicide. It is also used, but less frequently, in the treatment of mania, schizophrenia and postpartum (post childbirth) disorders.

Major Depressive Episode

ECT has been shown to be superior to placebo (sham treatment) in at least five careful studies. For example, Gregory and colleagues (1985) studied 60 people with major depressive disorder using three different treatments, 1) bilateral ECT, 2) unilateral ECT, and 3) placebo ECT. The patients were randomly assigned to their treatment group and the patients, treating staff and those who made the assessments were all unaware as to which group the patient belonged. The result was that both the active treatments were superior to placebo ECT.

It is unlikely that further comparisons between ECT and placebo will be conducted. The superiority of ECT has been demonstrated and it would therefore be unnecessary and unethical to perform further research on this point. In such a study, half of the suffering patients would have to receive ineffective placebo.

ECT has also been found, in more than a dozen studies, to be superior to the available antidepressant drugs. A flawless study by Gangadhar and colleagues (1982) is of interest because of the clever design. Twenty four patients were randomly assigned to two groups. One group received real ECT and placebo tablets, and the other group received placebo ECT and an antidepressant medication called imipramine. In this way it was possible to compare ECT with the antidepressant imipramine, while all patients received an effective treatment, and patients and ward staff could remain unaware of which patient was receiving which treatment.

Mania

Mania is a state of mood elevation or irritability and physical over-activity. Patients may be insightful, uncooperative, unable to sleep, and refuse food and fluid. This disorder may be very difficult to bring under control and life threatening exhaustion and imbalance of the chemicals in the blood may occur.

This is a very difficult condition to study. Very often patients are mood elevated and do not want treatment, accordingly, as a group, they do not readily agree to participate in studies of treatment. Also, as a feature of the disease, they tend to be distractible and unreliable, and they find it hard to cooperate in lengthy studies.

Small and colleagues (1988) studied 34 patients and found that in the acute phase, ECT was superior to lithium carbonate, a medication known to be effective in this condition. While there are few excellent studies of the effect of ECT on mania, universal clinical experience is that ECT is very effective, and can be life saving.

Schizophrenia

It will be remembered that von Meduna developed camphor induced convulsive therapy as a treatment for schizophrenia, and that SE, the first patient to receive ECT was suffering from this disorder. It comes as a surprise then, to find that ECT is not widely used in the treatment of schizophrenia.

Schizophrenia may be conceptualized as presenting acute phases, characterized by hallucinations and delusions and chronic phases in which loss of drive and self neglect are prominent symptoms. ECT has a place in the treatment of the acute symptoms of schizophrenia, when they have been unresponsive to medication. It also has a place when schizophrenia is complicated by symptoms of depression. There is no indication for ECT in uncomplicated chronic schizophrenia.

Postpartum disorders

Following childbirth, a range of psychiatric disorders may develop. The majority can be managed with support and the judicious use of medication. Acute, severe conditions can occur, however, and mother may represent a danger to herself and her baby. For the sake of simplicity, the majority of the severe postpartum conditions are similar to an episode of major depression, while the remainder are similar to an acute episode of schizophrenia.

ECT is useful in these severe conditions (Reed et al, 1999). One advantage of ECT in severe postpartum mental disorders is that the remission is rapid and breast-feeding and mother-baby bonding can commence without delay. Another is that with ECT, the danger to both mother and baby rapidly passes. The final advantage is that the medication required by the mother, and therefore the medication reaching the breast-fed baby, is minimized.

Maintenance ECT

ECT is inconvenient and stigmatizing. Accordingly, it is generally reserved for cases where medication has failed. In those circumstances, ECT may provide miraculous relief.

Conditions such as major depressive disorder rest on a genetic basis. There is no means of altering our genetic makeup, and hence no permanent cure. Relapse is common and is prevented, in most cases, by continuous use of medication. When ECT is needed to induce a remission and continuous use of antidepressant medication fails to prevent relapses, maintenance ECT should be considered.

Maintenance ECT is conducted on an outpatient basis. The frequency varies; often, initially, one treatment is given per week, and this is extended overtime to one treatment four to six weekly (Gagne et al, 2000). Maintenance ECT is difficult to organize but can be worth the trouble.

CASE DRAMATIZATION

Harold Watts was an accountant of 44 years of age, married to Ellen and the father of Josephine aged 21 years who had recently married and Paula aged 19 years who had recently left home to live in a de facto relationship. Harold was brought to hospital by ambulance, accompanied by police and Ellen and a next door neighbor.

Ellen had gone to investigate two loud noises in the garage, which was attached to the house. She found Harold lying on the floor next to an overturned chair, apparently dead. She did not attempt first aide, but rushed to her friends next door. They ran back with her, by which time Harold was beginning to move and groan on the floor. They rang the ambulance. There was a belt secured to a rafter with the buckle end hanging down. The buckle was broken. It seemed that Harold had tried to hang himself, the first noise Ellen heard being his weight jerking down on the rafter and the chair falling over, and the second, some seconds later, was when the buckle broke and Harold's body hit the floor. It was not clear who contacted the police.

When the ambulance arrived, Harold was sitting in the living room saying it was all a misunderstanding and he didn't need any attention. The ambulance officers noticed thick purple marks around his neck and that the whites of his eyes were distinctly pinkish. The police were shown the hanging belt and Harold was taken to hospital.

He was oriented in time and place and an X-ray of his neck was normal. He could move all limbs and he did not appear to have sustained any permanent damage from his attempted hanging. He cried and said he was just missing "the girls" since they both left home at the same time. Ellen, one of the neighbors, a hospital doctor and an ambulance officer were discussing the situation in the corridor. Ellen was saying she would take him home and perhaps they should take a holiday together, when a nurse passing his cubicle

noticed that Harold was strangling himself with the leads of a heart trace machine. They all rushed in, removed the leads and called a psychiatrist.

Harold had been drinking excessively over the last month. His appetite for food had decreased. He denied feeling depressed, but had been moved to tears when watching sentimental television shows. He had been preoccupied with thoughts of his dead parents and dead brother. He had found himself thinking about cemeteries and his own funeral. Then he started to experience powerful urges to kill himself. He could not explain these urges, but nor could he guarantee he would not act on them.

Harold's business affairs appeared to be without blemish and he denied any professional indiscretions or worries. It was true that their daughters had left home four months previously, but there had been no acrimony and they visited.

Harold was transferred to a psychiatric hospital for observation, with a diagnosis of probable major depressive disorder. There was some uncertainty as Harold did not complain of depressed mood, although depressed mood is not always present, the term "masked depression" sometimes being applied in such circumstances. Supporting the diagnosis of depression was the self-destructive behaviour and the history of thinking about topics related to death.

Harold's apparent attempt to strangle himself with the leads of the heart trace machine raised some questions. This method, in this place, the Emergency Medicine Department of a general hospital, was most unlikely to be successful and there was uncertainty as to whether it was a genuine attempt or simply attention seeking behaviour. This raised uncertainty about the severity of Harold's depression.

Within an hour of admission to the hospital Harold again performed self-destructive behaviour. He was being closely watched. He asked to go to the toilet and was allowed access to a specially designed toilet which contained no cloth towels and no suspension points from which one could hang, and no sharp edges which cutting could be performed. Soon after he had been left alone a heavy thud was heard. Harold was found on the floor outside the toilet cubicle in a pool of blood with a large laceration on the top of his head. He had climbed up and stood on the wall of the toilet cubicle and dived down head first onto the floor. This was a most resourceful and determined attempt, and left no doubt that Harold was a serious danger to himself.

His head wound was sutured, his skull was X-rayed and ECT was commenced next morning. He immediately lost his suicidal urges. He revealed that he had been feeling guilty as if he was responsible for events which he heard about on the news, which were completely beyond his control. He had not admitted to this when admitted to hospital because he felt ashamed. Harold left hospital two weeks later and returned to work.

CASE DRAMATIZATION

Hilda Durant was a 54 year old podiatrist who was married to Colin, an earth moving contractor. Colin took Hilda to their general practitioner who referred her for hospital admission. She displayed psychomotor retardation, meaning she moved very slowly, slumped back in her chair and did not move her hands when talking. She was slow to answer questions and her answers were brief and relatively uninformative. Her body and mind were working slowly.

She admitted to depressed mood and some suicidal thoughts, for at least two months. She had difficulty staying asleep, could not concentrate and lacked energy. She had a history of a similar episode five years previously which had responded to ECT and she and Colin had no hesitation in agreeing to a another course.

Hilda responded well to the first and second treatments. Her sleep improved and she became more energetic and active. On the morning before the third treatment she left the hospital and drowned herself in a nearby river.

With the benefit of hindsight, the ECT had helped the psychomotor retardation (the slow thinking and movement) but had not yet eradicated the depressed mood and suicidal thoughts. This is not unique to ECT. The remission of depression is uneven, with medication, ECT or other treatments. The last thing to improve is the way the patient feels. There is often some frustration on both sides, when a patient begins to recover, with hospital staff telling patients that they look better and patients protesting that they don't feel any better.

The case of Hilda Durant proves the old clinical adage that depressed patients with psychomotor retardation are at greater risk to themselves when they are half better. This happened a couple of decades ago, so the staff were not sued.

CASE DRAMATIZATION

Betty Day was 35 years of age, twice divorced, currently living with an unemployed alcoholic man in rented accommodation. She had given birth to two children, to different fathers, and both had been taken into care.

Betty had been to university, she had dropped out of second year Arts. Her parents lived in a comfortable middle class suburb. There was no one else in Betty's current social circle who had attended university, she lived in a lower socio-economic suburb and had no contact with her parents.

Her early life had been unremarkable, raised with a younger brother who was now living in another state. She had not been outgoing, but was successful at a church girls' school. At university things started to go wrong. She started taking drugs and behaving in an aggressive, disinhibited and promiscuous manner. At first her parents had thought it was simply that she was not ready for the greater freedom of university life and tried to regulate her behaviour by increasing their supervision. She had been living in a flat, they insisted that she move back home. She stayed up all night and played loud music and walked around the house naked. She did not study and within a fortnight left home and slept on the floor of other student's flats. Gradually she became unpopular and unwelcome among the other students and she began frequenting working class pubs. She talked loud and continuously, she was often hoarse from talking and sometimes said she could only keep quiet when she was drunk to the point of unconsciousness.

She was admitted to a psychiatric ward at 24 years of age when she had a brief episode of depression and scratched her wrists. She was thought to have a psychopathic personality disorder, meaning a personality type that is exploitative, impulsive and has no respect for rules or the rights of others. She was given a small dose of an antidepressant medication and swung up into a floridly manic state with over talkativeness, loud disinhibited behaviour and racing thoughts. She was not euphoric, but irritable. In spite of her irritability she could agree that she was not her "normal self" and that she needed help to "slow down".

Various medications were used. She developed a skin reaction to one of the mood stabilizing drugs. A combination of two others gave her only slight relief. She needed large doses of antipsychotic medication on which she gained a large amount of weight. She became a pathetic creature. From a successful dainty church school girl she became an obese, frequently drunk, ostracized woman who couldn't stop talking and slept with any one who offered her affection. It seemed that those who could tolerate her behaviour could only do so because they too were drunk most of the time.

She became known to the police as a psychiatric patient and they began to bring her to hospital rather than charge her when they were called to attend to her unruly behaviour. On one admission, because her chronic mania was unresponsive to all other treatments, she was offered a course of ECT. This had very good results and she was discharged as a composed and cooperative person. Unfortunately, this stable state did not last and it became clear that medication alone would not keep her in remission.

Betty readily agreed to a trial of maintenance ECT. After a course of six ECT as an inpatient she was discharged and then had one weekly ECT for a month, then one monthly and finally, one six weekly thereaf-

ter. On this regimen she remained well for years. At times she would need to increase the frequency of ECT to one per fortnightly for six weeks and then go back to the less frequent treatments.

She did not reestablish close contact with her parents. She remained overweight and talkative but she was able to largely abstain from alcohol. She entered a new stable de facto relationship, found some work as a teacher's aide and was able to get one of her children returned to her care.

TRANSCRANIAL MAGNETIC STIMULATION

Transcranial magnetic stimulation (TMS) is an exciting development in the field of psychiatry. It shows promise as a new treatment of certain disorders. Using electromagnetic technology, tiny electrical pulses are delivered to particular parts the brain.

An insulated coil is held in contact with the head over a particular region of brain. When a strong electric current is passed around the coil, a magnetic field passes out from the coil, through the scalp and skull and into the first few millimeters of the outer layer of the brain. Rapidly fluctuating the strength of the current in the coil produces fluctuation in the magnetic field, which in turn causes tiny currents in the brain (Illustration 15.3).

Some points of comparison between TMS and ECT deserve mention. ECT has a negative public image, requires general anesthesia and is associated with convulsion, temporary memory difficulties and sometimes, muscle stiffness and headache. It requires the staff, space and equipment for both providing anesthesia and the electrical stimulus. These features are all a consequence of the fact that the skull is highly resistant to the passage of electricity. This resistance means that electricity cannot be accurately focused on particular parts of the brain from electrodes placed outside the skull. The electricity introduced by ECT disperses through the brain, causing a generalised convulsion and memory difficulties.

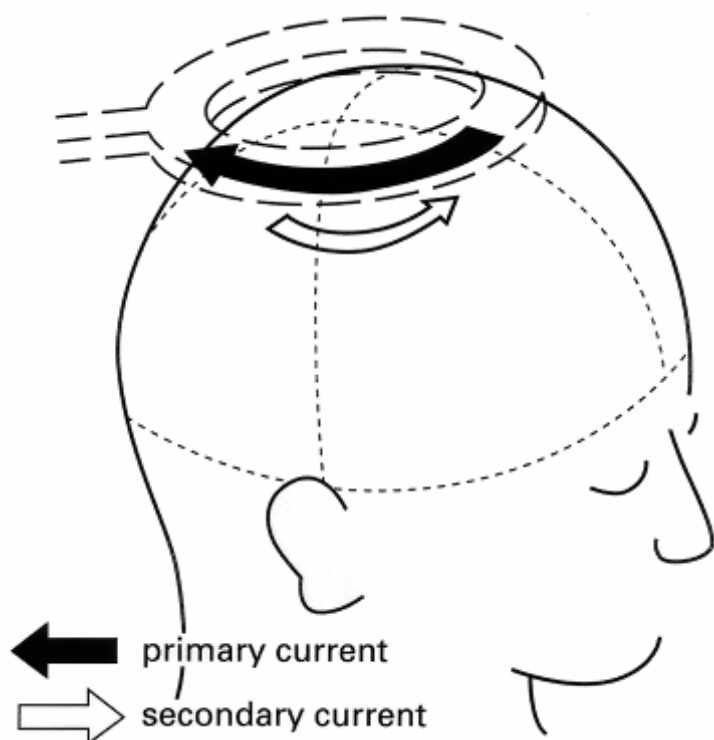


Illustration 15.3 To deliver transcranial magnetic stimulation (TMS) a large circular coil held over the top of the head. A large primary current passes around the coil and a smaller secondary current occurs in the opposite direction, in the underlying brain tissue. The secondary current is of the order of one hundred thousandth of the primary current. Depolarisation occurs at about 2 cm below the lower face of the coil.

The large circular coil was the only type available in the early days, it is quite serviceable and continues to be used in some centres. At the moment a figure of eight coil is more commonly employed. This is, in fact, two circular coils mounted side by side. Greater activity occurs below the junction point, so that more localised stimulation is possible. But the principles are exactly the same.



Image of TMS machine

Illustration 15.4. TMS apparatus usually composed of a computer as the control mechanism, a stimulus generating mechanism and a bank of conductors which store charge. The different makes have different appearances, but in general they occupy a volume of one or two suit cases and are mounted on wheels. A range of coils are available.

In contrast, the electricity introduced by TMS can be finely localized. A pin placed on a wooden table can be moved with precision by a magnet held underneath. This illustrates that magnetic fields pass directly through non-conductors of electricity (such as the skull) and that they are strongest at the space immediately adjacent to the magnet. These characteristics allow small currents to be precisely placed in the cortex of the brain. At this point in time there is no ability to stimulate deeper structures. Imaging studies confirm that localized stimulation of the outer layer of the brain causes activation of distant and deeper areas of the brain, via extensive nerve cell connections.

A TMS machine which could reliably provide safe single pulse TMS to the brain was first described by Anthony Barker in 1985 and machines capable of stimulation at up to 50 times per second (Hz) became available a decade later (Illustration 15.4). Stimulation at 1 Hz or less is termed slow frequency, while that above 1 Hz is termed fast frequency TMS. Both slow and fast frequency TMS are being examined as treatments of depression and other psychiatric disorders.

Evidence suggests that slow TMS reduces, while fast TMS increases, the activity of brain cells. In the future it may be possible to reduce or increase the activity of cells in different brain regions of people with mental disorders, depending on the results of imaging studies which reflect brain activity.

Theoretically, psychotherapy, drug therapy, light therapy and ECT achieve their effects by inducing chemical activity which cause changes in brain cells. This theory is equally applicable to TMS.

In the early years of TMS research there was concern about potential adverse effects, including the triggering of convulsions. While it is wise to remain cautious, no serious side effects have been reported since guidelines were determined in 1996. Interestingly, there is evidence that TMS has a protective rather than a damaging effect on brain cells (Post and colleagues, 1999).

TMS in depression

There have been more than twenty studies in which the antidepressant effects of TMS have been compared to placebo treatment in major depression. The overwhelming majority found TMS to be significantly more effective than placebo.

Five meta-analyses have been performed. A meta-analysis is a sophisticated statistical method of pooling the results of a number of studies in search of definite conclusions. All five meta-analyses, which differed in their methodological approach, concur that TMS has antidepressant effects greater than placebo (McNamara et al, 2001; Holtzheimer et al, 2001; Kozel and George, 2002; Burt et al, 2002; Martin et al, 2002).

The next question is whether the antidepressant effect of TMS is great enough to be clinically useful. There have been four studies in which TMS has been compared to ECT in major depression. All have shown TMS to be as effective or almost as effective as ECT (Grunhaus et al, 2000; Pridmore et al, 2000; Dannon et al, 2002; Janicak et al 2002). While still early, there are strong signs that TMS will have a place in treating depression.

TMS in other psychiatric conditions

Early studies have examined the effect of TMS on schizophrenia, posttraumatic stress disorder, anxiety and obsessive compulsive disorder. However, there is no indication at this time as to whether it will have a place in the treatment of these conditions.

CONCLUSION

ECT is one of the most effective psychiatric treatments available. Its major place is in the treatment of major depression that is unresponsive to medication and may end in suicide. It has been used for over six decades, however, technical advances have made it a gentle procedure. It may be associated with memory disorder, but with current techniques, this is usually mild and temporary.

TMS is a new and exciting technology that is relatively free of side effects and holds promise in the treatment of psychiatric disorders. Currently, there is strong evidence that it has a place in the treatment of depression.

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