PSYCHIATRIC REHABILITATION

A PSYCHOANALYTIC APPROACH TO RECOVERY

RAMAN KAPUR

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My hope is that this book recognises their support to me and makes a small, if modest contribution to the care of people with severe mental illness.

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INTRODUCTION

The state of mind to be rehabilitated or recovered

As a young clinical psychology trainee, my first experience of coming face to face with severe mental illness was when I inadvertently interviewed a young married woman in her mid-twenties, who had just suffered a schizophrenic breakdown. Back then, in 1980, clinical psychology trainees were not allowed to speak to such patients. It was seen as dangerous and we could only see patients suffering from dog phobia or agoraphobia. Even then, patients had to be screened by a psychiatrist before we could see them. This memory has stayed with me over my thirty years in mental health. My recollection of the interview is as follows: "I'm just plain scared out of my wits. I just want to talk to someone. These dangerous things come into my mind and take me over and I don't know what to do. Please help me,"

As a trainee, I tried my best to engage this patient in some kind of helpful conversation and I did believe my attempts to help her were successful. However, when my supervisor found out that I had dared to sit in the room with a "mad" patient, she reprimanded me and said if I ever was to do such a thing again, I would be thrown off the course. I never returned, as I had promised, to see this patient and to this day I wonder what became of her.

Without all the theoretical concepts and clinical expertise I now have at my disposal, I felt I did do my best to help this patient who felt lonely, isolated, afraid, even terrified about what was going on inside her mind. Of course, conventional psychiatric nomenclature gives patients suffering from mental health problems a diagnosis, and subsequent pharmacological or psychological treatment interventions to deal with their difficulties. The recent ICD 10 (International Classification of Diseases) and DSM—5 (*Diagnostic and Statistical Manual of Mental Disorder*) have many classifications that fit many of the signs and symptoms we see in everyday psychiatric practice. However, these classification systems singularly fail to capture the subjective experiences of the patient suffering from severe mental illness. The recent upsurge in cognitive behavioural therapy (CBT) does "what it says on the tin": addresses cognitions and behaviour with the hope that feelings will follow. The style of CBT is very much to focus on how the patient thinks through structured interventions aimed at facilitating change.

General psychotherapeutic approaches tend to address more relational and emotional elements of the patient's distress. It was these approaches that were most available to me in my first five years in clinical psychology, where I worked in primary care, acute psychiatry, and elderly severely mentally ill settings. This more general humanistic/psychodynamic approach is based on a view that if you are able to empathise with the patient and "show them the errors of their ways" or dysfunctional thinking (Kapur, 1988), changes will follow. Transactional analysis and Gestalt therapies are based on this idea with structured exercises to facilitate change. Invariably, the therapist is active with the patient, suggesting ideas or ways of thinking and feeling in a different way. Most of these psychodynamic approaches are based in the world of interpersonal psychoanalysis and the writings of psychotherapists such as Harry Stack Sullivan (1962) and Frieda Fromm-Reichmann (1950), along with the work of Irving Yalom (1970, 1983). Within this interpersonal model, the focus is very much on providing a corrective emotional experience (Frank, 1959) to the patient, whereby he is left feeling accepted and understood, with the idea of forming a therapeutic alliance (Hovarth & Greenberg, 1994) with thetherapist/patient relationship seen as the platform for positive changes.

Psychotherapy is taken as dealing with the dysfunctional relationship patterns of the patient and through an exposure to a corrective

emotional experience, changes in these patterns are seen to emerge. Here the emphasis is on insight, facilitating interpersonal changes within the context of a supportive relationship, exuding the characteristics of warmth, empathy, and unconditional positive regard (Rogers, 1951). This formed the basis of my early work in psychiatry and with other patient populations (Kapur, 1987, 1988).

However, I was always uneasy about these approaches and felt I was missing something. It was this curiosity that took me into the world of London Kleinian and post-Kleinian psychoanalysis (Hobson & Kapur, 2005; Hobson, Patrick, Kapur, & Lyons-Ruth, 2013; Kapur, 1991, 1999). I was appointed as senior clinical psychologist at Shenley Hospital in London from 1987 to 1990, with responsibility for the semi-secure and acute psychiatric wards. Little did I know that my job was to replace several senior Kleinian psychoanalysts who ran the Woodside Therapeutic Community (Sohn, 1985) after the post-Laingian work of Cooper (1986). What a psychic shock!

After managing considerable conflicts between clinical psychologists and psychoanalysts, I found an opportunity to discover a model of the severely mentally ill mind that I thought could address this "missing link" in my professional work.

A necessary precondition to discovering this missing link was to undertake my own personal analysis (up to three times per week) over three years. As my interest was not the "worried well" I decided not to go down the formal route of psychoanalytic trainings which in reality would have taken me out of my NHS patient population. Also, as cited in my two main pieces of research on psychoanalytic therapy (Kapur, 1993, 1998) there is no training course in the UK to help mental health clinicians work with severe mental illness. Within my own psychoanalytic experience, I found those in most need got least psychoanalytic help.

As Segal (1986) reports, and as Hobson (2013) so clearly elucidates with "everything happens in the first session", so I found this to be the case. Whatever my own material, what struck me was that my analyst kept very still and only spoke when he had something to say about my "state of mind", particularly in relation to him. This was a huge contrast to the many psychotherapeutic approaches that I had been exposed to and it has shaped my work up to this day. This style is significantly different to most clinical psychology interventions and also other psychoanalytic approaches (Gomez, 1989). It was the focus

on my "state of mind" that paid *wholesome* attention to subjective or intrapsychic processes, in a very simple and powerful way.

M. J. Horowitz (1987) has used the phrase "state of mind" to analyse changes in individual psychotherapy. This phrase, I think, can best capture the subjectivity of those suffering from severe mental illness, as described by my first patient earlier. Also, there is much debate within my own profession on "formulation" (British Psychological Society/ Division of Clinical Psychology, 2013) where it is given as a position statement:

> The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM—5 and ICD 10, in respect of functional psychiatric diagnosis, has significant conceptual and empirical limitations, consequently there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system which is no longer based on a "disease" system.

Many in my own profession (Bentall, 2004; Boyle, 2002; Kinderman, 2014) are anti-diagnosis of any nature, with an emphasis more on formulation (Johnstone & Ballos, 2006) where there is a description of the individual distress along with a description of aetiology and possible treatment interventions. However, the internal world of the patient is not the raison d' être of this paradigm and potentially fails to address the subjectivity and deeper experience of a patient with severe mental illness. Also, and an issue which I believe is extremely relevant for the real world of psychiatric illness, most patients can feel things are being "done to them", rather than waiting to see how their internal worlds are emerging. I would suggest by simply capturing this "state of mind" in everyday practice, it could synergistically complement diagnostic and formulation paradigms to help offer the patient a comprehensive understanding of his mental illness.

Hobson (2013) makes a similar point. I think it is important to bear in mind that the psychoanalytic perspective that both he and I speak from places the utmost importance on the mental health professional being a patient on the couch not only to learn from experience of the psychoanalytic process but also to know what it feels like to be in the vulnerable position of being a patient. As such, in the whole range of psychotherapies, this particular Kleinian model raison d'être means it

is vital for analysts to be a patient themselves in order to be able to treat a patient. He writes:

> Perhaps I am ducking something. This is that, as a patient, I know I would hate to be given a formulation. To be formulated, whether or not I had a part in the formulating process, is not what I had come for. If there are rational and civilized reasons for giving a formulation—and certainly there are—I would offset these with something captured by T. S. Eliot/Alfred Prufrock: "… and when I am formulated, sprawling on a pin/When I am pinned and wriggling on a wall/Then how should I begin/To spit out all the butt ends of my days and ways?" (p. 118)

He goes on to write of the limitations that occur in psychiatry with general diagnostic formulations and then makes an important point which is consistent with the ideas in this text: "I would have thought that the best way to capture something of the individual person is to give a small but detailed portrait of the way this person relates to a therapist in a consultation" (p. 118).

State of mind evidence

Hobson (2013) describes three classes of evidence that make up an understanding of someone's life. First, there are the facts around age, gender, employment, etc., followed by reports of what a patient may disclose through his personal history and his reported good or bad experiences of his "significant others". It is his third class of evidence that is of particular interest in capturing a patient's state of mind. He writes:

> These are facts of how the patient engages with the therapist, as well as with the patient him/herself. Of course, one might say that such relations too, express unconscious phantasy (where "phantasy" refers to a largely unconscious inner world of personal relations). And indeed they do. But there is something special about the nature of the evidence on which one draws to arrive at judgements about interpersonal engagement that is special, whether or not one is focused on the "unconscious phantasy" part of what is happening.

> The evidence is special by virtue of its source in the unique qualities of "inter-subjective engagement". At the next most basic level, we apprehend and come to understand the nature of persons' and people's mental states through our emotional engagements "with" persons and the attitudes they express. (pp. 12–13)

In psychoanalytic parlance, this would be termed the "free associations" of the patient which are understood and received by the therapist/analyst. It is these spontaneous patient utterances that constitute the material for the understanding and capture of the state of mind of the patient; for the therapist or mental health professional to be quiet and gather the evidence and material simply from allowing the patient to speak first.

Some examples from my own clinical practice, in the formality of a psychotherapy setting or in a ward or in an outpatient clinic, can provide powerful insights into the patient's state of mind.

Three states of mind

1. Visit to a mental health project

"So you're Dr. Kapur. I think you can cure me."

From day to day working in general psychiatry to the formalised setting of psychoanalytic work, the patient will always be emotionally alive in what he does with others. Yet, very little attention is paid to the impact of deeper processes on staff and in return, how staff deal with these processes (Kapur, 1991). However, even brief comments from the patient can offer some powerful insights into "who is doing what to whom".

In this particular utterance the patient is expecting me to be God and cure her from severe mental illness. This, potentially, is her predominant state of mind. She gazes into me as if I am some Indian god (Kapur, 2008a) who can take her illness away and provide her with a peace of mind she does not have. Of course, a natural reaction on my part would be to respond to this request for a miracle by offering all sorts of "psychological magic". Alternatively, if I suffered from faulty narcissism, I could participate in some deluded phantasy that I could indeed cure her of her illness and bask in a mad idealisation of my powers.

However, another ordinary and more thoughtful response would be to realise the depth of her despair, that she is so desperate to be relieved of her inner torment that she wants me to perform a miracle. So, perhaps, I could inform the staff of this insight in order to help them to react in an ordinary way, to take seriously her despair, rather than in an extraordinary way to offer the promise of a cure and then feel inadequate when this fails. In doing so, the patient could then engage in "ordinary hard work" to tune into the patient's state of mind (Lucas, 2009) and offer a response that takes seriously her desperation to get better but, what is important, then embark on the work of helping the patient engage with the ordinary activities in the service and undertake the small, but significant steps required for her rehabilitation, such as engaging in support and care plans and vocational rehabilitation, facilitating more independent living.

By keeping this predominant "state of mind" in place the mental health worker can respond more accurately to the needs of the patient, not feel inadequate when even best efforts fail, and provide realistic opportunities for the patient to be rehabilitated and recover from the impact of severe mental illness on his life.

2. First outpatient appointment

"I have had so many problems with depression, I have tried so many medications and physical treatments and I've learnt to put up with things. Now, you're my last chance."

In this first interchange the patient can relocate his "depressed self" into the psychotherapist's hands to "fix". The recipient of this state of mind is in the role of being the human anti-depressant for this patient and is faced with the pressure of feeling that he is the patient's last hope. It may also be that this meets an element of the depressed self in the psychotherapist and potentially, the recipient of this state of mind is faced with a momentary decision as to what to do, "How do I deal with feelings of depression and sadness in my own inner life?"

In the particular theoretical and clinical framework adopted in this text (see Chapter One and Hobson, 2013) this "moment of depression" would be "thought about, considered and then articulated" to the patient with a comment such as: "I think you feel that if I can't quickly remove this feeling of depression from you, that coming to

see me would be a waste of time and I would be yet another failed treatment for you." When I did offer such a comment to the patient, it opened up a whole plethora of memories and feelings to do with past failures, unrealistic hopes and expectations that were not met, and feelings of deep inadequacy. By offering some thought to this state of mind, some movement was made in the internal world of this patient, which led to some "lifting" of the heaviness of memories and experiences in his mind that left him so depressed. The ongoing and future psychotherapy was characterised by this working and reworking of this state of mind through thinking about and verbalising what was happening between both therapist and patient, rather than entering into a reactive anti-depressant physiology/psychology that potentially would end in the failure and defeat of further unrealistic hopes for a "quick fix".

3. Ongoing psychotherapy

"What I feel you want me to do is address the anger … I think that if I addressed the anger you would feel that I can carry on, but what I can't get you to realise is that I don't want to address my anger. I'm afraid of you saying to me 'Roisin, it is eleven o'clock, it is time to go, get out through the door.' You can switch off … I can't … I would be out of control if you said to me go away at eleven o'clock. I can't see it doing me any good. I can only see it destroying me, like a self-destruction. I don't want that. I have been through enough pain in my life. A lot of it I have caused myself, just in my own negative thoughts. I haven't got a lot of self-confidence. I still don't, but I am slowly starting to say to myself, if people can't accept you for what you are, whatever that may be, that's tough, that's their problem not yours, and I'm really applying that to my parents. For once I am starting to stand up and if I feel like saying no, I say no. I'm not downright rude but whatever the situation is that comes up, whether it's right or wrong. I don't know, that remains to be seen, but I feel for once I am standing on my own two feet. I am doing what I want to do, most of the time, not always. Whatever I do it's my consequences, it's me that has to be responsible for it and I want to do that. I do honestly feel we have come to the end of the road."

This would be representative of a typical psychotherapy session, whether it is a first session, as it was in this excerpt, or an ongoing

psychotherapy. Whatever the temporal location of this excerpt, several themes can be inferred from the patient's statement of mind:

- The patient recognises that she struggles with strong emotions, particularly anger, but is terribly worried that she will be "switched off" and cast out by the therapist.
- She is frightened of relinquishing any self-control that she has developed over what seems to have been a troubled and painful life.
- She also recognises the effect of perpetual negative thoughts on her self-confidence and tries pragmatically to "accept who you are, what you are, people can like it or lump it".
- She talks about standing up for herself as a way of defending herself but also potentially to take some pride in herself.
- She believes that personal responsibility is a good idea but worries it could not be her saviour but the "end of the road" of her efforts to feel better.

Clearly, there are lots of themes to pick up on and it is difficult to decide which is the predominant "state of mind". My own view would be to "distil" her state of mind down to this comment:

"For a long time you have managed difficult feelings by yourself and you would like a way to get some help from me or others, to stand up to the overwhelming negativity that can cause so much distress. However, depending on another human being to do this is frightening, as depending on others has not always been good for you."

So here I am simply trying to capture the predominant state of mind, particularly in relation to me, to give her some understanding of the intensity of feelings she struggles with.

Rehabilitation and recovery

> The purpose of this book and indeed the purpose of the clinical practice of psychoanalysis rests on the efficacy of human intervention. Most of us regard the provision of a good object/breast/mother, bearing what is unbearable to the infant and empathising with the predicament of that infant and providing appropriate nourishment and help to deal with that experience and develop knowledge as essential for growth. The bond that develops of being

> valued and concerned with each other, can be strong enough to cope with internal and external events and is the bedrock of human meaningfulness. The combined love and concern of both parties and its development give ground for faith and appreciation in living—one is not alone and human endeavour is the main source of finding and being meaningful.
>
> The aim of this book is in line with the aim of those analysts who consider that the recapturing of the early good object relationship is essential to acquire the strength to meet the vicissitudes of life. (Brenman, 2006, pp. xxiv–xxv)

So writes Eric Brenman, a senior psychoanalyst in his book entitled *Recovery of the Lost Good Object*. Clearly this could never be the aim of the recovery and rehabilitation of work with severely mentally ill patients that this book addresses. However, it is the recovery of some aspect of "goodness" that is central to the rehabilitation process, whether it be in the consulting room or a psychiatric hospital setting. It is the latter that is of interest in this text which I would like to formulate as follows:

A mind damaged by severe mental illness is in fragments. Chaos reigns and there are no boundaries. The patient is often caught in similar chaotic, boundary-less or over-boundaried atmospheres. Badness is everywhere. To recover from this, an atmosphere needs to be created that is boundaried, ordered, and conveys a sense of empathy, concern, and understanding. If the patient feels sufficiently "thought about" then he can be helped to recover to a better state of mind and rehabilitated into the community.

While the therapeutic community movement (which I will refer to later in Chapter Two) has made significant efforts to address the issue of maximising settings to aid recovery (e.g., Campling, Davies, & Farquharson, 2004), there has been little written on maximising the therapeutic potential of everyday psychiatric environments to address the emotional or subjective aspects of recovery and rehabilitation. While the agency I manage, Threshold, is part of the therapeutic community network in the UK (the Community of Communities initiative of the Royal College of Psychiatrists), I believe that not enough attention is paid in the therapeutic community movements to the minutiae of what happens in the atmospheres in the day-to-day running of such settings. This text proposes a comprehensive clinical model that addresses all the needs of the patient with severe mental illness, particularly focusing

on how each individual state of mind is managed in a therapeutic atmosphere designed to maximise hope and independence, the twin paramount aims of the recovery model in rehabilitative psychiatry (Slade, 2009).

I will now review contemporary psychiatric definitions of recovery and then, particularly referring to Brenman's (2006) guide, set the scene for the rationale and content of the following chapters of this book.

Ralph and Corrigan (2005) propose three definitions of recovery:

> 1. Recovery is a natural occurring phenomenon. Some people who meet diagnostic criteria for serious mental illness are able to overcome their disabilities and enjoy a full life in which their life goals are accomplished without any kind of treatment.
> 2. As with other medical illnesses, people can recover from mental illness with proper treatment. Others who do not enjoy spontaneous recovery from mental illness are able to achieve a similar state of goal attainment and life satisfaction as a result of participating in a variety of services.
> 3. Recovery reintroduces the idea of hope in understanding serious mental illness … it means that even though a person is diagnosed with schizophrenia or other serious psychiatric disorder, his or her life need not be limited by institutions. (pp. 4–5)

Slade (2009) suggests that mental health professionals see the second definition as clinical recovery, whereas users and carers of services prefer the first or third definition. However, whatever the definition, the central theme is that there is an experience of moving on, often having a greater trust in the atmosphere and people engaged with the patient and of things changing for the better. So for this to happen, as Brenman (2006) suggests, there has to be trustworthiness in the goodness of others that concern, understanding, and help are at the core of their beliefs. This is the central message of this book and the ideas proposed to create an emotional architecture that maximises the goodness in the air the patient finds himself in. The text will use the model of the traditional consulting room to point to elements of the atmosphere that need to be put in place, along with other critical external world aspects from accommodation to structured activities, to create a setting that maximises hope and independence.

Theoretically and clinically, this book will draw from psychoanalysis, rehabilitative psychiatry, and clinical psychology to formulate ideas