

JO AUGUSTUS, JUSTINE BOLD
AND BRIONY WILLIAMS

AN INTRODUCTION TO

MENTAL HEALTH



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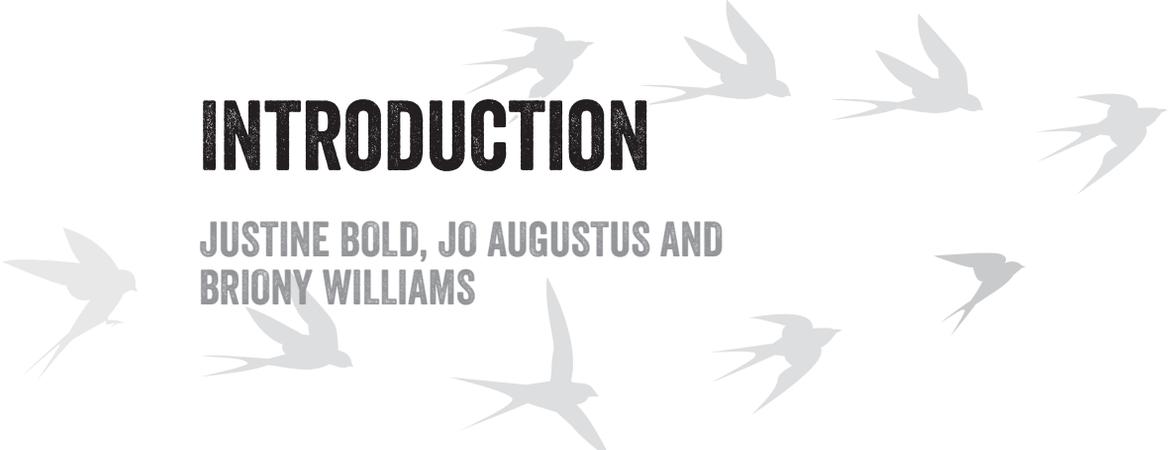
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INTRODUCTION

JUSTINE BOLD, JO AUGUSTUS AND
BRIONY WILLIAMS

It is hoped that this book will inform the professional training of the many health professionals and **practitioners** working with patients with **mental health** difficulties including social workers, mental health professionals, doctors, nurses, **occupational therapists, counsellors**, nutrition and CAM (complementary and alternative medicine) practitioners so helping to optimise available treatment options and improve chances of **recovery** for people affected by mental health problems.

The chapters that follow consider the factors underlying the development of mental health issues as well as providing guidance on how patients can best be diagnosed and be supported by evidence-based treatment. This book has an inter-professional focus as the three authors come from different backgrounds and disciplines; it aims to review the evidence and raise the awareness of the benefits of person-centred and integrated approaches to patient treatment and care as patient-centred care is associated with individual patient well-being (Gameiro et al. 2013). Narrative accounts from service users experiencing mental health problems have been included to provide additional insights. The authors believe that understanding the lived experience of mental health problems and key issues faced by people diagnosed with mental health problems is key for the health professionals of the future. It is hoped that greater understanding of the experience of mental health problems and treatment might help foster a more supportive environment for patients/clients that promotes recovery from **mental illness**.

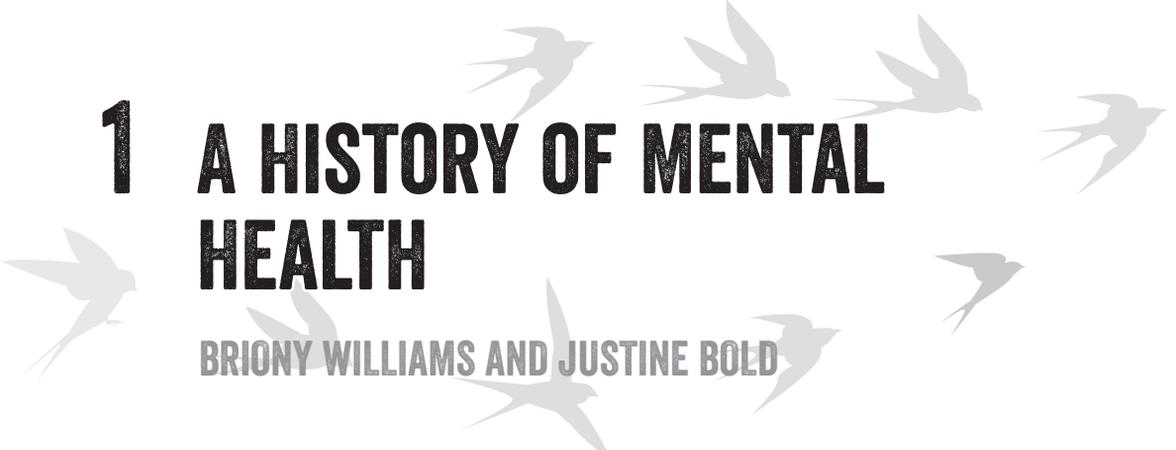
Key issues around policy and ethics are also included and there are chapters on the history of mental health treatment as well as a brief guide to different approaches to diagnosis and treatment and supportive therapies. Some of these chapters have been structured using Engel's (1977) bio-psycho-social model of health, which is widely recognised as being a foundation for much of modern-day mental health clinical practice as it considers social and psychological factors not explored in traditional biomedicine. An example of how this has been used is in Chapter 1, on the history of mental health. This is considered from a biological point of view, then psychological and then a social perspective as the authors thought this a useful way to shape historical presentation, understanding, progression and links between the key areas. **Psychological well-being** is a central theme of this book in the context of promoting a recovery journey that is unique to every individual. Ryff and Singer (2006) refer to factors that constitute an individual's psychological well-being: positive relationships with others, personal mastery, autonomy, a feeling of purpose and meaning in life, personal growth and development. Thus, psychological well-being is arguably achieved by maintaining a balance between events that present both challenge and

reward (Ryff and Singer 2006; Winefield et al. 2012). Diner, Oishi and Lucac (2003) develop the concept of psychological well-being to include the awareness that the individual has of their own integrity, in all aspects of their being. Thus, well-being also includes an awareness of the individual's sense of well-being.

International mental health is also explored in this book, both as a chapter and also as a theme. Through the recognition that globalisation is of great importance, the authors have drawn on a variety of international research in the hope of inspiring the reader to appreciate the possibilities of learning from international perspectives and in doing so, further developing the concept of global mental health learning communities. Finally, we very much hope this book is forward thinking in terms of its interdisciplinary focus, as it includes material on third-wave therapies and we explore the links between physical and mental health and other lifestyle and nutritional factors including coeliac disease, which can all impact upon mental health.

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1 A HISTORY OF MENTAL HEALTH

BRIONY WILLIAMS AND JUSTINE BOLD

LEARNING OBJECTIVES

After studying this chapter you will be able to:

- understand the history of **mental health** from a bio-psycho-social perspective;
 - understand specific interventions that were used in the treatment of mental health conditions;
 - consider how history has helped shape and develop current mental health practices.
-

INTRODUCTION

In the past there have been many explanations for understanding **mental illness** including possession by the devil and punishment by a god, curses of witches or wizards and also physical causes such as bad humors and an imbalance of chemicals. The ancient Greek writer Homer interpreted the 'irrational' elements in human nature as an interference by the gods. In some cultures today these explanations still exist. Psychological explanations did not emerge until fairly recently. These biological, social and psychological theories about the origins of mental illness influenced and directed the treatments and services. New treatments were generally developed because of expanding knowledge and changing societal views. However, where people were cared for (i.e. at home, in the community, hospital or in an asylum) was influenced by societal views of mental illness. Biological, psychological and social explanations gained power at different times in history and at some points in history competed for supremacy. There are still biological, psychological and social theories of the origins of mental health problems, which make the causes of mental illness difficult to understand. Modern-day psychiatry is criticised for having a primarily biological understanding of mental illness (Scull 2014). The rise in biological psychiatry is viewed by Bentall (2004) as 'owing more to politics and financial interests of drug companies than to science and evidence' (p. 173). After the Second World War there was a move by psychiatrists in America to put forward psychological explanations of mental health problems, and cures involved talking therapy

(Scull 2011). The social model that emerged from the disability movement in the late twentieth century meant that service users started to be more willing to question the opinion of professionals and be less willing to accept what they are told by **consultants**. This chapter will now explore the history of mental illness and treatment in terms of biological, social and psychological contexts.

BIOLOGICAL EXPLANATIONS

Biological theories of the origin and treatment of mental health problems are put forward by those interested in the physical workings and structures of the body. Known as the medical or biological model, it is concerned with classifying and understanding mental health problems through science, using terms such as diagnosis, prognosis and treatment. Proponents of biological theories look to understand the causes by using X-rays, brain scans and blood tests to measure chemicals in order to classify the illness (make a diagnosis). The diagnosis and the prognosis (the likely outcome) inform the treatment plan. Treatments involve medication to change body chemistry and physical interventions such as surgery and **electroconvulsive therapy (ECT)**. Some of these medical treatments have been invasive and involve unpleasant side effects. Some treatments such as ECT and prefrontal lobotomy were barbaric in their conception and delivery – done by those in power to those in distress. However some medical treatments and research have led to a much better quality of life for people living with serious mental health problems.

EARLY PHYSICAL EXPLANATIONS

Physical explanations involved humoral medicine, which started with the classical Greek physician Hippocrates (460–377 BC) and was disseminated more widely by the Roman Galen (129–216 AD). The basic idea behind humoralism was balancing fluids found in the human body; these were named the four humors and were black bile, yellow bile, blood and phlegm and they represented different qualities. The humors could be matched to different parts of the body, the four seasons and different emotional characteristics (see Table 1.1).

Table 1.1 Humors

Humor	Season	Element	Characteristics	Description
Black bile	Autumn cold and dry	Earth	Melancholic	Despondent and gloomy
Yellow bile	Summer hot and dry	Fire	Choleric	Bad tempered
Blood	Spring hot and wet	Air	Sanguine	Courageous, hopeful and amorous
Phlegm	Winter cold and wet	Water	Phlegmatic	Calm, cool and unemotional

Classical medicine in the medieval period was all about balancing these humors, by changing diet, lifestyle, occupation and climate or by administering medicine. In order to bring the body back into equilibrium, patients were given purgatives with emetics to induce vomiting, laxatives and people were bled using leeches or cupping (Macdonald 1981). This was as true for mental illness as it was for somatic diseases. So, if someone was melancholic, they suffered from an excess of black bile; if they were manic, it was either too much blood or yellow bile that was the problem. Balancing one's lifestyle, therefore, was central to one's emotional well-being (Smith 2016). The Chinese at this time had similar thoughts, believing madness was an imbalance of the primal forces of yin and yang.

BLOODLETTING

One form of treatment involved in balancing humors was bloodletting. Galen (129–200 AD) declared blood as the most dominant humor so the practice of venesection gained even greater importance (Magner 1992). There was more than one method of bloodletting, including removing blood from a blood vessel by cutting or localised methods including scarification with cupping and using leeches. Benjamin Rush, founder of the American temperance movement (Shryock 2006), also often referred to as the father of American psychiatry, was well known as an advocate of vigorous bloodletting (Garrick 2010), while Earle Pliny questioned the appropriateness of bloodletting as a treatment for mental health problems in 1854. Pliny's overall conclusion supported a trend towards a correlation between better **recovery** and less use of bloodletting procedures. Rush had a long-running feud with his college of physicians regarding his use of bloodletting, which forced him to resign (Greenstone 2010).

LOBOTOMY

Prefrontal lobotomy is intentional damage to the prefrontal lobe of the brain, which claimed to be a cure for **schizophrenia**. A lobotomy is surgery that could be seen as a combination of neurosurgery and psychiatry called psychosurgery. The origins of psychosurgery can be traced back to antiquity, with evidence of Stone Age craniotomies dating as far back as 5100 BCE (Smith 2016). Carpenter and Davies (2012) note that in searching for treatments for schizophrenia, 'prefrontal lobotomy had the broadest application and achieved a desired calming effect but at the expense of vital emotional processing and motivational qualities' (p. 1168).

ELECTROCONVULSIVE THERAPY (ECT)

ECT is a treatment that involves sending an electric current through the brain to trigger an epileptic seizure. It was first used in 1939 and is still used to relieve the symptoms of some mental health problems such as severe depression, post-natal depression, schizophrenia and sometimes **bipolar disorder**. The treatment involves applying brief but powerful shocks via two electrodes called paddles placed

on the patient's forehead. Using ECT as a treatment may have been based on the knowledge that head trauma and convulsions were observed to improve mental disturbances. Hippocrates noted that malaria-induced convulsions cured some insane patients (Sabbatini 1998). In the Middle Ages some physicians observed that after a bout of fever such as the cholera epidemic in insane asylums people's mental health symptoms improved. Between 1917 and 1935 four methods for producing physiological shock were discovered and tested including malaria-induced fever, insulin-induced coma and convulsions and ECT (Pridmore 2009). ECT was considered less dangerous than the drug-induced convulsions or comas. The technique became widespread in hospitals across Europe and North America. ECT was widely used in the 1950s and 1970s and sometimes without anaesthetic and often without **consent**. Some people may experience the procedure as a punishment rather than a treatment and the main side effects are usually short term, but many people experience memory loss. Although the success of ECT in treatment of **depression** is established, people still have no understanding of the evidence of how it works (The Royal College of Psychiatrists 2013). Possibly due to the fact that it is not understood, it has received much criticism. Misgivings about ECT were highlighted in films, the most famous of which was *One Flew Over the Cuckoo's Nest* in 1975 (McDonald and Walter 2001) and near this time ECT became a target of the anti-psychiatry movement. ECT was used as a treatment for homosexuality in the 1960s, as it was considered by psychiatrists at the time to be a mental illness. However, advocates of anti-psychiatry, supportive of talking therapy, were very much against using ECT. The treatment declined in use in the 1960s and 1970s, however revived in the 1980s. In more recent times the use of a professional anaesthetist is mandatory as well as the use of muscle relaxant to make sure that the patient experiences no skeletal fractures. The Royal College of Psychiatrists (2013) reported on a survey of 7,880 clinics in England and Wales assessing outcomes for people who received ECT in 2012 and 2013. The findings were that 1,712 people changed either minimally, much or very much, there was no change in 113 people and 28 people got worse.

MEDICATION

By the late 1950s and early 1960s, new medications began to change psychiatry, starting with the discovery of the first antihistamines (effective in dealing with hay fever) in the 1940s and 1950s. These drugs provided a chemical basis from which a wide range of drugs used in psychiatry were developed. These early antihistamines often induced sleepiness and sedation. Pharmacologists and psychiatrists wondered if this sedative effect could be used to 'calm' the positive symptoms in schizophrenia (Marston 2013).

A new class of antidepressants called SSRIs (selective serotonin reuptake inhibitors) were better tolerated and medically safer than prior antidepressants. The first of these, Prozac, was released in 1987. Following this introduction new anti-psychotics were released: 'atypical neuroleptics' such as Risperdal and Zyprexa. These drugs were heavily promoted as they had apparent advantages over earlier drugs, and were widely prescribed by psychiatrists. At this time public research money strongly shifted towards neuroscience and pharmaceutical research (Klein and Glick 2014).

The National Institute of Mental Health (NIMH) invested to enhance public awareness of the benefits to be derived from brain research (Marston 2013). By the 1990s biological psychiatry appeared to have become the main theory and therefore treatment. However, public and private investment and pharmaceutical innovation decreased in the 2000s (Klein and Glick 2014). No new classes of medication psychiatric drugs were discovered despite funding and research. The media highlighted previously unrecognised side effects of widely used medications. SSRIs were implicated in increased suicidal behaviour, and some patients reported severe 'discontinuation syndromes' when stopping treatment. Atypical neuroleptics were associated with a 'metabolic syndrome', which includes significant weight gain, increased diabetes risk, and other medical complications (Marston 2013). However the money spent on basic brain research led to no advancement in understanding of psychiatric aetiology, nor to new biological treatments. Pharmaceutical companies were fined repeatedly and for huge sums for promoting powerful, expensive psychiatric medications for unapproved uses (Marston 2013).

SOCIAL THEORIES

The ancient Greek writer Homer, thought to have lived between the twelfth and eighth centuries BC, suggested that human action is caused by bodily organs, notably the brain. Plato, the Roman philosopher writing later, thought that the essence of the human body is the psyche, rendered in English as 'soul' or 'mind' (Spillane 2006). This focus on the soul continued up to and through the fifteenth century, as before this people were viewed as having souls, rather than minds. Descartes (1596–1650), writing in the seventeenth century, described the concept of mind–body dualism for the first time. He proposed that the body is a machine and that its physiology can be explained according to the principles of physics. The soul differs, having one entity and being free. Descartes (1968) concludes that he is a soul and he has a body contingently attached to the soul (Spillane 2010). This dualism has created boundaries between mind and body, the effects of which have lasted up to the present day. In terms of gender, women were portrayed as more closely linked to nature and less completely integrated into civilisation and the cultural order than men. This connection between women and nature and natural cycles dates back to Greek mythology, with goddesses such as Persephone and Demeter being connected to the earth. The mind was generally related to men and civilisation and the body to nature and women; consequently loss of the mind was viewed as also a loss of civilisation and required the person to be controlled and protected (Lloyd 2002). It must be remembered that women at this time did not generally have independence, society was patriarchal and women were subject to family control as men were viewed as the rational agents and makers of order and measure.

Social models regard the wider influence of social forces as more important than other influences as causes of mental illness (Tyner and Steinberg 2013, p. 104), seeing the person with mental health problems as a player on a big stage. There is currently a growing interest in 'recovery' in mental health policy and practice, although research has shown that many mental health service users consider that the medical model still dominates, which they see as damaging and unhelpful. The social model

looks at how mental health issues are understood in society, people's personal understandings of mental health issues, the social model of disability in relation to mental health and a possible social model of madness and distress. Some of the features of the social model are:

- being rights based and anti-discriminatory, rather than focusing narrowly on the individual;
- valuing self-management and self-support;
- a commitment to anti-oppressive practice;
- supporting race equality and cultural diversity;
- prioritising advocacy and self-advocacy;
- minimising compulsion in the psychiatric services by prioritising prevention, rapid and appropriate support and advanced directives;
- breaking the bad/mad link that continues to be a driver in mental health policy and provision;
- prioritising participation in the development, management and running of policy and services;
- equalising power relations between **service providers** and service users in services and support (Beresford 2005, p. 115).

The social model sees the labelling and **stigma** following from a medical model of mental illness as a major barrier for mental health service users (Rowntree Foundation 2018). It argues that the medicalisation of experience and social problems has dominated the conceptualisation of madness and distress. The influence of psychiatry and psychiatric thinking has also had the effect of medicalising a wide range of social concerns, reframing them in diagnostic categories for 'treatment' (Newnes 2015). These range from the human effects of war, 'post-traumatic stress disorder' (PTSD) to the non-conformist and non-cooperative behaviour of children and young people, 'attention deficit hyperactivity disorder' (ADHD) (Newnes 2015). Psychiatry also encompasses violent, criminal and dangerous behaviour by the use of an increasing range of labels like 'dangerous personality disorder' and 'narcissistic personality disorder'. Case Study 1.1 explores the treatment of women diagnosed with 'menopausal mania'.

CASE STUDY 1.1: THE TREATMENT OF MENOPAUSAL MANIA, GRACE'S STORY

My third experience was in a semi-narcosis unit. That means the people were sedated to overcome their mental health problems. The women with 'menopausal mania' needed a lot of personal care as they were basically asleep all the time. The worst bit about it was that we were persuaded that this was the treatment that worked. Having since been through the menopause and not enjoyed it one bit, I cannot see how medicating all those women could have helped overcome their symptoms. Except they were asleep for a long time and by the time they were woken up properly, all their symptoms had resolved naturally.

RELIGIOUS EXPLANATIONS

Historically religion and the church were very important in people's lives and influential in the way people understood mental illness. Mental illness was for many centuries seen as possession by the devil and treatment for mental illness focused on demonology and exorcism was performed on the person who was suffering. Direct linkage between spirit-possession and madness can be found in both Jewish and Christian scripture (Islam and Campbell 2014). The origin of attributing mental illness to supernatural causes predates Islam and is found to have existed in pagan Arabia and in Ancient Greece. The causes of insanity were unknown, so supernatural phenomena were employed to explain its existence (Islam and Campbell 2014). The New Testament contains writings about people who were possessed and were given treatment by Jesus or one of the apostles using exorcism.

When evening came, they brought to Him many who were demon-possessed; and He cast out the spirits with a word, and healed all who were ill. (Matthew 8:16)

So his fame spread throughout all Syria, and they brought him all the sick, those afflicted with various diseases and pains, those oppressed by demons, epileptics, and paralytics, and he healed them. (Matthew 4:24)

The ability to exorcise devils was seen as a mark of divine favour or saintliness in Christian religion. There are references to exorcism in the lives of the saints and the search for examples of exorcism to support a case for canonisation (Kemp and Williams 1987). Rather than being rooted in formalistic religion, belief in the supernatural origin of mental illness may be rooted in a broader cultural context, reflecting long-held superstitions and mystical beliefs (Kapferer 2003). Evil spirits were exorcised through incantation, prayer, cajoling, threatening and even included physical torture, scourging and squeezing the evil spirits out.

TREPANNING

This is the process of making a burr hole in the skull, essentially believed to be a primitive form of craniotomy. This was carried out to release 'evil spirits' believed to be inside people suffering from mental health disorders. Thousands of trepanned skulls from the Neolithic period (c.9000–3000 BC, depending on the region) have been found from many civilisations across the world including those in Europe, South America, China and Africa (Hobert and Binello 2017), demonstrating how widespread the process was. There is evidence of new bone formation around the holes on a number of skulls indicating that some of the victims of these primitive rituals survived the procedure (Hobert and Binello 2017).

WITCHCRAFT

People died in witch-hunts across Europe in the sixteenth and seventeenth centuries. Witchcraft trials in Salem commenced with a small group of girls who saw strange things and behaved in bizarre ways and were investigated by village elders. Cotton

Mather, a church minister, investigated the behaviour of the children. Mather concluded that witchcraft, specifically that practised by an Irish washerwoman who had yelled at the children, was responsible for the children's problems. The girls accused several local women of practising witchcraft and placing curses on them. At its worst in the year 1691 about 250 people were arrested and tried for witchcraft, of these 19 were executed, 2 died in prison and 1 died of torture (Deutsch 2013). Talismans and amulets are worn as protective devices against witchcraft.

THE INCREASE IN ASYLUM PROVISION

Prior to and during the Middle Ages, people with mental health problems were taken care of at home or by their immediate community. There was no formal provision of services; people with mental health problems were a domestic responsibility dealt with by friends and family. Due to the shame and stigma attached to mental illness, many hid their mentally ill family members in cellars, caged them in pigpens, or put them under the control of servants (Porter 2002). People with mental health problems were widely abused and restrained, particularly in Christian Europe. Others were abandoned by their families and left to a life of begging and vagrancy (Porter 2002). By the end of the medieval period there was a decline in the belief of charity as a duty. The Industrial Revolution that started in the UK in 1760 was relevant in changing the way people with mental health problems were viewed. Scull (2011) suggested that the intensification of labour created by the Industrial Revolution pushed families to admit their lunatic relatives to the asylum because they were an increasing burden in an era of extreme poverty (Melling 1999).

The first mental institution in the UK was called Bedlam, in London, which was founded in 1247 for those suffering from a mental disorder. It was taken over by the Crown in 1377. It is also likely that separation from society and the segregation of people with mostly severe mental illness became more necessary as work with machines was common. The number of asylums increased after 1780 (Rogers and Pilgrim 2001). Treatments generally used in asylums included cold baths, hot candles 'cupped' to chest and back, leeching, and electrostatic shocking to jolt patients to reality. Solitary confinement (a Quaker philosophy) was considered calming and an opportunity for reflection that might lead to rational behaviour (Norris 2017). An 1808 Act authorised magistrates to build publicly funded asylums in each county and the first Lunacy Act issued in 1845 made this compulsory. Physical control of inmates appeared to be the primary concern when asylums were planned and built, with manacles in each cell attached to the walls with chains and windows recessed and barred (Norris 2017).

It is important to be aware that some people were locked away due to being inconvenient to family or through social embarrassment (for example women who got pregnant out of wedlock or were deemed to be 'inconvenient' wives). These people may not have initially been mentally ill, but may have developed mental health problems as a result of their institutionalisation. Moreover, financial hardship was commonplace and some who were admitted to the asylum may have been poor rather than mentally ill. The local poor law receiving officer was the first port of call for those in need. One of three solutions would be considered, 'outdoor

relief', usually a small amount of money, transfer to the workhouse, or transfer to the county asylum. The first option was very rarely offered and the majority of the time the poor would be sent to the workhouse (Bartlett 1998, p. 422), but some may have been transferred to the asylum. Described as a 'sham lunatic', an individual faked insanity in order to be kept in the safety of a lunatic asylum or the workhouse in the absence of a stable residence of their own.

Law and mental health policy focused on the living conditions in the asylums and the 1828 Madhouse Act introduced a system of licensing and visits to check conditions.

There were other reasons for being admitted, these included alcoholism, financial issues and shock. A handbook published in the *Eugenics Review* in 1912 (Lidbetter 1912, p. 26), states 'one out of every five inmates of lunatic asylums have "lost their reason" through drink ... altering the brain substance, and producing insanity', and that 'the dreadful disease known as epilepsy, often comes to the children of drinkers'. Dr Campbell working at the Garlands Hospital identified that the most 'likely cause of insanity was mental shock or worry from money losses'. By the end of the nineteenth century, the county asylum was seen by people as the place for the insane to be. By the time the 1845 County Asylums Act was passed, less than 5,000 patients were housed in asylums (Cherry 2003, p. 10) but by 1900 this number had increased to around 100,000 (Bynum, Porter and Shepherd 1988, p. 2). In the 1960s mental health provision changed, institutions were closed and care moved again into the community.

Interestingly, as Peter describes in Case Study 1.2, it was social history that influenced his decision to train as a social worker.

CASE STUDY 1.2: SOCIAL HISTORY AS AN INFLUENTIAL FACTOR IN CAREER CHOICE, PETER'S STORY

As an undergraduate, I became interested in theories of institutionalisation, particularly Goffman's work on asylums in the United States and Townsend's work on old people's homes in the UK. These works haunted me as I began a career as a social worker and became 'part of the system' that continued to place individuals in large-scale institutions, without any thought for personalisation.

The works of Laing and Szasz also stayed with me and I still lean towards a definition of most mental ill health as being on a normative spectrum – 'problems in living' – rather than states of mind that require some form of intervention by professionals. The all-pervasiveness of media imagery and social media models of personal and familial 'norms' are very damaging these days to individuals who struggle to find fulfilment in life. I wish there were a significant 'counter movement' that provided all ages with realistic aspirations regarding personal growth, relationships, family and career.

I have always been associated with the voice of service users and carers and welcome the radical, 'madness' views that some of these groups promote. My biggest regret is that I did not become more active politically in my early career, and I would urge all mental health professionals to become political and unionised. When we have decent levels of health and social care services, then we will all enjoy better mental health – service users, carers and professionals alike.

PSYCHOLOGICAL EXPLANATIONS

Sigmund Freud questioned the relationship between organic sources of madness and the psychological causes of mental illness. Freud and his followers played an important role in listening and trying to understand the complexity of the history of people with mental health problems. Breuer (1842–1925) was an Austrian physician and Janet (1859–1947) was a French neurologist, psychologist and philosopher. Works by these pioneers represented a departure from the traditional view that mental illness and unexplained medical disease were the result of divine retribution or demonic possession. Freud began the psychoanalysis movement, which accounted for the widest range of mental states as potentially leading to psychic pain without direct organic cause. He observed patients of the French neurologist, Charcot, and formulated that some of their behaviour had its roots in trauma rather than a physical biological disease. Breuer developed the cathartic method in the 1880s and he and Freud wrote together in 1895 about the treatment of hysteria. Janet published several texts on the importance of the unconscious from 1889 onwards, however Freud expanded this theory publishing theories on the unconscious roots of mental disorders that could not be explained medically, which he termed psycho-neuroses. Freud developed psychoanalysis to treat these ‘neurotic’ patients. It could be said that these men developed the principles of what later became talking therapies and established the significance of early adverse childhood experiences and trauma.

The First World War and the impact of shell shock, now called post-traumatic stress disorder, on servicemen blurred the distinction between neurosis and insanity. Many shell-shocked ex-servicemen were transferred to asylums. For the first time neurosis as well as psychosis became a focus of interest to psychiatrists.

THE PSYCHOANALYTICAL INFLUENCES

Psychoanalysis is mostly concerned with our inner world, suggesting it has a powerful influence on how we feel and think so therefore how we behave. Our inner world is partly conscious and mostly unconscious. It is made up of memories, feelings, beliefs and fantasies (Howard 2011). Freud suggested that there are three causes for mental distress:

- The *real world*: which includes traumatic events like crime, accidents and disasters.
- The *id*: the instinctual feelings that demand fulfilment.
- The *super ego*: when we are fearful of being punished for a moral transgression.

In Freud’s view the amount of psychic energy is limited and must be shared between all three parts of the personality: the id, ego and superego; this explains why in mental distress too much energy is being used up with the ego trying to deal with unresolved conflicts. A healthy individual is able to resolve conflicts as they arise and therefore keep psychic energy for the ego to be able to develop and interact with the environment. Freud also proposed that children go through a series of psychosexual stages focused on different parts of the body. He suggested if a child does not work through a stage they become stuck at this stage of development and their personality

becomes dominated by it, and the following stage cannot commence until the previous one has been negotiated. This theory may support the development of personality disorders, which are understood to develop when trauma interferes with the development of a child's personality.

TREATMENT THROUGH LSD

Freudian psychoanalysts viewed LSD as the ideal tool to reach the 'realms of the human unconscious'. Psychologists employed LSD as a tool in therapy, hoping to delve into suppressed memories and elicit revelatory experiences that could alter behaviour and cure pathology (Jacobs 2008). Psychedelics have been used by shamans and medicine men since ancient times, as a way to gain access to the spirit world. Psychedelics grow naturally in seeds, mushrooms, cacti, bark and roots of various plants. Concerns about the long-term effects of LSD led to laws restricting its use.

SHELLSHOCK TO POST-TRAUMATIC STRESS DISORDER (PTSD)

The Great Wars of the twentieth century and the lasting effects servicemen experienced led to the emergence of military psychiatry as a discipline and have over the years contributed to a greater understanding of trauma. PTSD was defined in the 1980s (McKenzie 2012); prior to this trauma associated with war and fighting had different names. In the First World War (1914–1918) it was referred to as shellshock or neurasthenia, in the Second World War (1939–1945) it was known as combat fatigue (McKenzie 2012).

In the First World War, initial treatments included ether and chloroform anaesthetics or electrical treatments (McKenzie 2012) and there was an emphasis on getting soldiers back to active duty as quickly as possible. In 1915 'forward psychiatry' was developed by the French and by 1918 the British also had forward psychiatry units. The acronym 'PIE' is used in forward psychiatry; it stands for proximity to battle, immediacy, and expectation of recovery (Jones and Wessely 2003). In the First World War, camps were set up near the front line and aggressive treatments such as electrotherapy were sometimes used to get soldiers back to the war (Tatu and Bogousslavsky 2014). While the majority of service personnel returned to the fighting, it is documented that some soldiers who refused to go back to fight were accused of malingering and tried by court martial and sentenced to death (Tatu and Bogousslavsky 2014). Around 1918, psychodynamic methods inspired by Freud started to be used in favour of the more aggressive treatments (McKenzie 2012). Even so, it has been questioned whether these early approaches serviced the needs of the military more than the needs of traumatised service personnel. By the Second World War in the 1940s treatments included barbiturates (McKenzie 2012) but seem to have remained largely similar to those used in the First World War. Hence academics have questioned whether lessons learnt from the First World War were actually applied at all in the Second World War (Rae 2007). It is fair to say that both treatments and understanding have progressed considerably since then, and current UK clinical guidance (NICE 2005) recommends both **cognitive behavioural therapy** and antidepressants for PTSD associated with combat.

BEHAVIOURAL INFLUENCES

The behavioural model put forward in the 1920s suggests that behaviour, autonomic responses, thoughts and feelings are linked and are all important mental processes and that thoughts and feelings are altered by changes in behaviour. The emphasis in this model is on behaviour because it is easily observed, measured and modified. Behaviour is learned when it is reinforced, therefore it is proposed we can also learn maladaptive behaviours. Classical conditioning was researched by Pavlov in 1897, who presented food to dogs at the same time as a sound, so the dogs gradually associated the sound with food and eventually salivated when they heard the sound. This model shows how everyday sounds and smells can be turned into traumatic stimuli because they are associated with a traumatic event (Gibson 2006). Skinner working in 1936 proposed that reward and punishment were important in strengthening and weakening behaviour. If we are rewarded when performing a behaviour we are likely to repeat that behaviour, if we are punished we will avoid the behaviour. If punishment is stopped when we perform a behaviour we are more likely to reproduce the behaviour. The behavioural model is criticised as focusing on symptoms and ignoring the cause.

COGNITIVE BEHAVIOURAL MODEL

The cognitive behavioural model was developed in the 1970s. At the time there was increasing dissatisfaction with **behavioural therapy**, which was seen as reductionist. Cognitive behavioural therapy was influenced by two clinicians, Albert Ellis and Aaron Beck. Beck developed the cognitive model, which suggests people have a schemata, which could be seen as a framework holding rigid long-lasting views about themselves, the world and other people. Due to their schemata people create rules about how to behave. Some of these rules are maladaptive and although understandable at the time of creation can cause problems later in life during adulthood. A critical incident or stressful life event can fire up the maladaptive rules and increase negative automatic thoughts and symptoms of **anxiety** and depression (Beck 1976).

COMMUNITY CARE

Services started shifting away from the asylum after the First World War and outpatients and services in the community were set up. Deinstitutionalisation involved moving care and treatment of people with mental health problems from the asylum into community-based settings. The policy of closing the asylums began the challenges made to the power of psychiatry and psychiatric institutions that were a feature of the 1960s (Cummings 2012). Other reasons may include the development and increased use of major tranquilisers. However, Scull (1977) believes it was only due to the cost of running large institutions and keeping people in hospital. At the start of the process of moving to community care, in the 1950s asylums housed approximately 154,000 people, in the 1970s the number was 100,000 and by the end

of the process the asylums had all closed (Gilbert et al. 2014). Under the 1962 Hospital Plan, acute psychiatric inpatient services were developed on district general hospital sites, local authorities were developing **community mental health teams** and there was an increased outpatient role. However, as the author (BW) recalls, working in a district hospital in the early 1980s the number of acute psychiatric inpatient beds in the district hospitals was significantly higher than the number today.

The 1980s brought changes to the management structure and systems in the National Health Service (NHS). Roy Griffiths believed 'that a small, strong general management body is necessary at the centre of the NHS' (Taylor 1984). Following this a proposal was put forward for a fundamental restructuring of the NHS structure and a reorganising of duties and responsibilities, accountability and control. Griffiths' ideas involved a new NHS management board, at arm's length from the secretary of state and civil servants, and identifying general managers with overall responsibility for performance and budgets at district health authorities and hospital units. For the first time in its existence the NHS had managers leading their hospitals. In 1997 Labour issued the 'new NHS – modern, dependable,' which built on current trends with better communication within the service, GP out-of-hours services increasingly using nurses to assess emergency calls, NHS Direct (the new nurse-led helpline) and a focus on quality with new national supervisory bodies. Labour established a National Institute for Clinical Excellence to investigate and approve cost-effective pharmaceuticals and interventions for use in the NHS and a Commission for Health Improvement (later the Healthcare Commission) to check what was happening. As part of the programme to modernise and reform the NHS, the Labour Government set up National Service Frameworks (NSFs) in order to improve patient care and reduce inequalities in a series of identified priority areas (Gilbert et al. 2014). The National Service Framework for Mental Health emerged because of pressure to reform community mental health care. Media coverage of a series of high-profile adverse events involving people with mental illness contributed to a public perception that community care had failed (Kings Fund 2014). The incorporation of the European Convention on Human Rights into UK law was a further reason to reform mental health legislation. Over several decades large mental health hospitals were closing and being replaced by community psychiatric teams, mostly with too few staff yet with wide responsibilities for cases of many different types. There was a generic approach where teams were responsible for all the problems in their community, which often proved inadequate and problematic. Teams with particular skills and smaller caseloads were formed to provide specialised services, for example assertive outreach, home treatment teams and **early intervention** services with the aim to reduce the need for admission, personality disorder and prison in-reach. **Crisis resolution home treatment (CRHT)** teams helped people through short-term mental health crises by providing intensive treatment and support outside hospital, ideally at home. The National Audit Office reported in December 2007 that the introduction of CRHT teams was associated with reduced pressure on beds, and the teams were successfully reaching service users who would otherwise probably have needed admission (Mays, Dixon and Jones 2011).

The Mental Health Act 1983 was reviewed and *Modernising Mental Health Services* (DoH 1998) proposed a strategy with two essential elements:

- increased investment to provide more beds, outreach facilities and 24-hour access and new treatments; and
- increased control of patients to ensure compliance with treatment in the community, and a new form of revisable detention for those with a severe personality disorder.

In 2001 a White Paper, *Reforming the Mental Health Act*, highlighted the concern that had led to the release of hundreds of patients, some of whom did not receive care, and others becoming a risk to themselves and the community. Such releases had contributed to 1,000 suicides and 40 murders a year from April 1996 to March 2000 (DoH 2001). Finally a new Mental Health Act was passed in 2007, which allowed compulsory treatment in the community under certain circumstances.

Policy, care and treatment for people with mental health problems has been a combination of compassion, fear and control since written records began. Care for people with mental health problems commenced in the community and now is increasingly returning to be a community responsibility. The medicalisation of mental health problems began to be powerful during the increase in asylum provision and is responsible for positive advances in treatments and some awful experiments on people without power by people with power. Today there are still biological, social and psychological explanations of the causes of mental health problems, however these theories are less divided. Research into adverse childhood experiences by Felitti et al. (1998) has influenced the realisation that neglect, abuse and trauma during childhood are influential in the development of many physical and mental health problems in adulthood. There is an increased understanding that positive conditions in early childhood are vital for positive adult mental health. This knowledge, which brings together biological, psychological and social theories, is vital for leading developments in service provision.

This chapter has explored the historical context of mental illness and treatment in terms of biological, social and psychological contexts. Consideration has also been given to how history has helped shape and develop current mental health practices. This includes the influence policy has, which will be explored in more detail in Chapter 3.

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