Using 'citizenship' to deal with feelings of hate in psychiatry

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Clinicians' feelings of hate towards their patients may contribute to adverse clinical outcomes through unintended harm or intended abuse. Ideas of 'citizenship' may assist psychiatrists and other mental health professionals to deal with naturally arising feelings of hate, through engagement in dialogue with patients and colleagues, in a spirit of ethical encounter and fellowship.

Health-care systems (Risse, 1999), including mental health systems (Hunter and Macalpine, 1974), are created with good intentions, and most health-care professionals enter their careers in good faith. However, health-care professionals can sometimes harm their patients, through no fault, unintended fault or deliberate abuse.

It is estimated that 5–10% of all hospitalizations are secondary to adverse drug reactions, and such reactions contribute to 20–25% of inpatient hospital deaths (Sharpe and Faden, 1998). There are inherent risks in some treatments, whether psychiatric, medical or surgical. However, provided that the relevant risks of treatment have been explained to patients and they have made an informed choice, any harm that might occur would not be considered abusive.

Failure by doctors to lay the foundations for informed consent was highlighted as a major issue by the inquiry into the deaths of children following heart surgery in Bristol (Kennedy, 2001). There was an absence of dialogue, particularly on the part of the surgeons who reportedly gave the impression that they considered the process of obtaining informed consent a 'chore'. The importance of dialogue as an aspect of citizenship in clinical practice is emphasized in this paper.

The deliberate and only partially disguised harm and abuse of patients by doctors was considered good practice in Nazi Germany under certain circumstances (Meyer-Lindenberg, 1991; Friedlander, 1995). An officially sanctioned programme, starting in the University Department of Paediatrics in Leipzig in 1938, condoned the killing of severely physically or mentally disabled children through systematic starvation and administration of lethal doses of medication over a period of 7 years. These patients' lives were considered 'lives unworthy of life' (Friedlander, 1995). With the outbreak of the Second World War, such practices were extended to the extermination of all severely mentally ill patients. The systematic gassing of humans was practised first on the mentally ill and then generalized during the Holocaust to the Jewish and other populations. It is estimated that 100 000 mentally ill German patients were killed in six specially organized centres between 1940–45. Doctors and nurses, and other health-care professionals, actively participated in the killings.

A council report by the Royal College of Psychiatrists on *Institutional Abuse of Older Adults* (Garner and Evans, 2000) confirms that institutionalized practices of abuse against the mentally ill and other vulnerable people have not been confined to Nazi Germany, although they are different in scale and nature. As more research in this area has been undertaken in the USA than in the UK, this report cites a study of nurses and nursing assistants working in nursing homes in the USA. It was reported that 36% of staff had witnessed physical abuse (with 10% admitting to it personally), and 81% witnessed psychological abuse (with 40% admitting to it personally).

There are a number of reasons why health professionals, including psychiatrists, may be associated with harmful outcomes or abuse in the care of their patients in contemporary society. A report (Eldergill et al, 2001) on three men with mental illness whose care was associated with adverse outcomes concluded that government policies were to blame. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Department of Health, 2001) found staff training, diagnostic category, time from admission, time from discharge, poor compliance with treatment and substance misuse relevant. Failure

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to recruit sufficient staff or suitable staff are also relevant in the author's experience.

The first part of this article concentrates on feelings of hate as possibly contributing to harmful outcomes and abuse in mental health care in some cases. Feelings of hate may contribute to adverse outcomes through both unintended harm and intended abuse. The second part of this article suggests the importance of the idea of citizenship in laying the foundations for ethical reflection, clinical dialogue and systems of clinical governance that may help overcome such feelings and achieve good outcomes.

HATE

Dealing with psychiatric patients can be a challenging experience. For example, some mentally ill patients continue to take illicit drugs despite advice that the drugs are highly likely to cause deterioration in their illness. The fact that the patient, rather than anyone else, may be the one that suffers most does not make it less challenging for the psychiatrist. This is most obvious in the case of patients who repeatedly present in crisis with acts of deliberate self-harm. These patients are often more emotionally challenging for staff than patients who threaten to harm others.

Winnicott (1949) first recorded his observations that some patients generated feelings of hatred in their therapists during treatment. Maltsberger and Bui (1974) have extended Winnicott's observations. Their description of 'Countertransference hate in the treatment of suicidal patients' is vivid and merits quoting:

> **'While sadistic acting out against a patient is sometimes relatively easy to rationalize, the therapist who is well able to tolerate conscious and physical manifestations of angry and sadistic affect, i.e. he who does not have to rely on isolation or other defenses to ward off such feelings, will be able to attend to his own emotional excitation. This means for most people a sense of muscular tightness and tension; especially the abdominal muscles may feel tense, and there is a tendency rhythmically to tighten the musculature of the jaws, buttocks and the anal sphincter. Sometimes there are sensations of sexual arousal. There may be a sense of tingling in the buttocks or anus, and at the same time a sense of fullness in the chest and head. Subjectively, there may be a sense of righteous indignation. If the therapist can tolerate it he may experience lively impulses to attack the patient, beat him, cut him or mutilate him, where others may experience anxiety. Able psychotherapists monitor themselves even for slight degrees of such responses and use them as indicators that the patient is in danger of evoking an anti-therapeutic response…The kind of countertransference acting out that is more likely to result in suicide involves the therapist's unconscious impulses to kill the patient.'**

Watts and Morgan (1994) reported that psychiatric patients who killed themselves while inpatients on psychiatric wards tended to be less liked by staff than other patients. Morgan coined the term 'malignant alienation' to describe this phenomenon of apparent lack of therapeutic alliance between patient and staff. The term 'malignant' seems appropriate because the consequences of such dislike appear to be potentially grave.

Reference to the challenging nature of some patients' behaviour should not be confused with blaming them for such behaviour. Some patients repeatedly and deliberately wish to cause harm and offence. These are a minority, and most of them are psychopaths. Others deliberately cause offence, in moments of anger or weakness, and then come to regret it and may even apologize. Although such patients are more common, they are still a minority. Most psychiatric patients are remarkable because they soldier on despite serious distress and disability and are persistent in their attempts to comply with the best possible treatment and meet legitimate social expectations of their conduct. Whatever their reasons and motivation, the reality is that a significant number of patients will be emotionally challenging.

Health-care professionals' feelings of hate, malignant alienation and attitudes of blame are often fuelled by a sense of moral outrage, where professionals reflect the attitudes of their families and the communities in which they practice. Such attitudes often reflect deeply ingrained religious and cultural values. A clean appearance, temperance, protection of the health and integrity of one's body and a heightened sense of individual responsibility for one's behaviour are examples of some potentially deeply ingrained values that the conduct of some psychiatric patients may offend. For example, a young doctor with such values may find it difficult to feel sympathetic towards a scruffy and dirty middle-aged man who presents drunk repeatedly to the casualty department, feeling hopeless and threatening yet another overdose; the seeds of malignant alienation are there.

De Mare et al (1991) and other group psychotherapists, such as Bion (1961) and Nitsun

(1991, 1996), have extended the work of Winnicott to groups. In particular, they have observed that hate is a surprisingly common and potent force in such settings. Hate both obstructs the formation of such groups and disrupts their effective working capacity. It is impossible to review the origins and nature of such hate in this short article, but it relates to feelings of envy, rivalry and frustration that may arise out of group situations.

Most patients live in families and communities that are relevant to their problems. Many patients, especially those who are more severely affected by their psychiatric disorder, may have more than one therapist, even a whole team treating them. The treatment process is usually a group process, even when one is not attempting group psychotherapy in a formal sense. This places the patient at risk of becoming the victim of hate-related group processes. For example, a psychiatrist and a nurse may have had an argument over the discharge of a patient from the inpatient ward. The psychiatrist may then be called to the emergency clinic to see a new patient who shares certain characteristics with the disputed patient. There is a risk that the psychiatrist's reaction to the new patient may be adversely affected by interactions around the previous patient. The risks of an inappropriate response in such a situation are potentially serious, including future successful suicide attempts in some cases. In this example, group processes may contain the seeds of malignant alienation.

Psychoanalysts (e.g. Balint, 1964) have taken a leading role in helping psychiatrists, GPs and other health-care professionals to recognize, examine and modify their emotional reactions to their patients. Such examination is both essential and helpful. One of the limitations of the psychoanalytic approach is that it takes a rather scientific and mechanistic view of the mind and shies away, as a model, from addressing explicitly and systematically the ethical concerns that may preoccupy the health professional. This is a limitation it shares with other scientific models of behaviour, such as cognitive and behavioural psychology and the biomedical model (Tjetveit, 1999).

Finding a common ethical foundation to meet the challenges of the complex emotional interactions between patients and their psychiatrists is difficult. This is particularly so in an ethnically and morally diverse society as our own. The idea of citizenship is possibly the best starting point if such a common foundation is to be found.

CITIZENSHIP IN CLINICAL PRACTICE

The history of ideas and practice of citizenship has been reviewed by Heater (1999). Aristotle (1948, 1998) originated the civic republican tradition of thinking on citizenship. This tradition emphasizes the active involvement of citizens in public affairs for the mutual benefit of the citizen and the community. The English philosopher John Locke (1962) originated the liberal tradition of thinking about citizenship. The liberal tradition emphasizes human rights and the need to protect the individual from unwanted intrusion by the state. Both traditions have much to offer in terms of moral frameworks within which to negotiate the patient–psychiatrist relationship. For example, the civic republican tradition emphasizes the common characteristics of citizenship between the psychiatrist and the patient, including the potential of the patient to make a contribution as a citizen. The liberal tradition reminds us of the need to respect privacy, autonomy and self-determination.

The following is an example of the contribution patients can make to psychiatric citizenship. In Barnet Mental Health Services, North London, the rotating trainees/senior house officers are first welcomed on their induction day by representatives from the local users' group 'Barnet Voice', together with the medical director and the director of mental health. It is considered that Barnet Voice has a citizenship stake in educating young psychiatrists. Members of this organization take part in a number of induction sessions, including sessions on crisis intervention, risk assessment and the care programme approach. In fact, Barnet Voice members later join the clinical tutor/training programme director to teach introductory psychiatric interview skills to all those incoming trainees who are in their first post in psychiatry (G Ikkos, unpublished observations, 2002).

De Mare and colleagues (1991) have developed an interest in citizenship and psychiatry. They have pointed out that a classical Greek word for society was '*koinonia*', which translates as 'impersonal fellowship' and contrasts with 'personal friendship'. Fellowship seems an appropriate starting point to describe the doctor–patient relationship; it seems a better word than friendship in this context. *Koinonia* has its origins in the word *koine*, meaning the commonly spoken language used by people in their daily dialogue with each other. In the Acts of the Apostles in the New Testament, *koine* acquired the additional meaning of a shared spiritual experience. Following De Mare et al, and others, the author suggests that the conduct of dialogue between patient and doctor in a spirit of fellowship should be the cornerstone of all psychiatric activity.

It was the failure of doctors to engage in dialogue in a spirit of fellowship and to lay the foundations for informed consent that was criti-

cized by the Bristol inquiry. Users' groups raise similar concerns within mental health services, and the concepts of citizenship and *koinonia* may help address them.

Citizenship and ethics

Concepts of citizenship and ethics are closely allied. Ethics shares etymological origins with ethology, the study of the behaviour of animals in their natural environment. It is helpful to remember this because a central concern for Aristotle was what men do in their natural environment. For psychiatrists, this includes their activities at work. Aristotle argued that the crucial requirement of citizenship is the possession and display of *arete*, often translated as virtue. He described the virtuous man as characterized by courage, moderation, liberality (but not excess), pride (but not vanity) and good temper. Aristotle thought differently, but today women and men are expected to share equally in these virtues.

Although the liberal tradition defines citizenship negatively in terms of protection of the individual from unwarranted intrusion from the state, the American academic Stephen Macedo has argued that republicans by no means have a monopoly on civic virtue. Freedom, which, after all, is the very essence of liberalism, does not mean a free-for-all – it requires vital moral qualities in the citizen. He lists these as tolerance, self-criticism, moderation and a reasonable degree of engagement in the activities of citizenship (Macedo, 1990).

Tjetveit (1999) has identified six dimensions of ethics that are of relevance to the mental health professional:

- Virtue ethics
- Professional ethics
- Clinical ethics
- Theoretical ethics
- Social ethics
- Cultural ethics.

In practice as a clinical psychiatrist, the author has found the distinction between professional ethics and virtue ethics particularly important. When the virtuous psychiatrist and virtuous patient come together, particularly when they recognize each other's virtue, there is unlikely to be much of a problem. More interesting and challenging is the situation where the psychiatrist is asked to treat a patient that appears not to be virtuous. Highlighting the distinction between personal commitment to virtue and professional commitment to 'make your patient your first concern' (General Medical Council, 1997) may provide the foundation for an examination of the clinician's countertransference and, perhaps, the better attainment of more successful therapeutic outcomes. This is an example of citizenship values helping to deal with hate feelings through ethical reflection in the clinical situation.

DISCUSSION

In highlighting feelings allied to hate in mental health staff, we must not fall into the temptation to blame them any more than we blame patients with such feelings. The case of Dr Harold Shipman has reminded us that some doctors, like some patients, can act in a psychopathic manner. This is obviously blameworthy. The Bristol inquiry concluded that the surgeons and other professionals that were criticized had no ill intent. Their failings appear to have been that they did not reflect critically on information available on their practice and not to have engaged effectively in the citizenship of teamwork. Although of a markedly different order to Shipman, these are also blameworthy. Some mental health professionals may engage in deliberately blameworthy behaviour. More often, however, they may experience feelings of hate that may lead them to act in harmful but unintended ways. Other reasons may also be relevant, such as inappropriate workloads, expectation to perform tasks beyond their abilities, poor supervision and absence of constructive appraisal and opportunities for remedial training (Ikkos, 2000).

Health service managers have a responsibility to create a setting within which citizenship can be practised. The last Conservative Government introduced *The Citizen's Charter* (Department of Health, 1991) and *The Patient's Charter* (Department of Health, 1993). However, during that government's reforms of the NHS, the primary responsibility of the chief executive was to balance the books. This created situations in which dialogue was blocked. The finances of the hospital or community trust were given priority over patient welfare. For example, within a community trust, elderly mentally ill patients were resettled from long-stay wards to the community despite clinicians' warnings about known risks to these patients' health from such practices. A number of them died within the first week of transfer (Barnet Health Authority, 1997).

The present Government has recognized the problem and introduced 'clinical governance' in the NHS (Department of Health, 1997). Through this process, the chief executive of a health service is ultimately responsible for the quality of care provided and not for just the finances of the organization. Citizenship appears to place emphasis on active ownership and participation in social processes, whereas governance seems to place emphasis on processes of being governed

and being held accountable. Both citizenship and governance are necessary, and governance is an indispensable aspect of citizenship.

Ideas of citizenship do not provide the solution to problems of clinical harm, poor performance and patient abuse. They provide the foundation for ethical reflection as one of the pillars for the creation of systems of clinical governance within which the application of clinical skills may reach standards of excellence for the benefit of patients (Department of Health, 1998).

Citizenship also reminds us that responsibility for health care extends beyond health-care professionals and health service managers. The parents have had an important role in the Bristol inquiry. Relatives, other carers and neighbours have a stake in delivering support to the mentally ill at home. Dr Jim Birley, previously President of the Royal College of Psychiatrists, has told the author of the importance of the support of local residents in South London to his work when he was actively engaged in rehabilitating long-term mentally ill patients in the community some years ago. More recently, he has been supporting similar projects in the ex-Soviet Union, and he has emphasized the importance of the mentally ill patients' relatives in making things happen.

The importance of ideas and activities of citizenship in psychiatry have previously been highlighted by users (Barham and Barnes, 1999) and psychiatrists (Birley, 1991) alike. Examples of activities of citizenship initiated by the Royal College of Psychiatrists include the creation of the Patients' and Carers' Liaison Group. The current Stigma Campaign is also a citizenship project. The author is presently reviewing the relevance of ideas of citizenship to psychiatry in the context of contemporary political philosophy. **HM**

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KEY POINTS

- Clinicians' feelings of hate may underlie unintended harmful outcomes and intended abuse in clinical medicine in general, including psychiatry.
- It is often more constructive to examine feelings of hate as natural clinical phenomena rather than as indications of moral failure on the part of either the patient or the clinician.
- The idea of citizenship may provide the foundation for the examination of feelings of hate in a way that is both ethically rich and clinically useful.
- The ideology of citizenship underlies the ethical foundations for the creation of systems of clinical governance for the practice of clinical excellence.
- Activities of citizenship in clinical practice are likely to reflect practices of citizenship in society in general, but a higher standard of citizenship is demanded of professionals compared with other citizens.