

Something to Believe In

Two a.m.

A cold and dingy flat, cluttered and dirty, now crowded with strangers, three of us, pens, notebooks and papers readied.

A young woman is on the floor, in a terrible state. Heavy in the cold, damp air, the chilling and sickly-sweet smell of blood, which should be inside and is now outside of her body in frighteningly copious amount. It seems so wrong on a visceral level that it grabs my attention away from the smell of the cat urine and faeces which makes the floor a hazardous place to sit or even stand; away from the smell of an unloved body, in unloved clothes, in an unloved dwelling.

We all knew this young woman, and yet did not know her at all. We only visited in the middle of the night, when a neighbour or a worker assigned to her grew sufficiently concerned about her behaviour. We only ever came to take her away—from what, we didn't know but we all agreed she shouldn't stay in that flat and there was only one other place we could put her: the psychiatric ward. She had frightened too many people with the blood to be allowed back to the non-hospital places of refuge. I had seen her six times in my short career as a trainee psychiatrist; she had been “known to services” since she was a child. When I was just starting medical school, she was beginning a very different medical career, which took her through the entire pharmaceutical and psychotherapeutic arsenal on offer twice, with only brief moments of some peace akin to happiness amidst the vast expanse of misery and sorrow that was her short life hitherto.

I crouch awkwardly beside her, the smells travelling into me on my breath and blooming in my chest like ink in water, but not into the dread and despair, the horror one might expect; it bloomed into a strange, painful nothingness, like I was crumpling into a yawning emptiness. A spreading anaesthesia with every shallow inhalation, growing shallower until at some point they stop.

The young woman sat on the floor like a pile of parts had just been cast into a corner, her skin etched with scars and deep, deep wounds, sinew and bone visible, savage, quick and sharp incisions opening upon her body's attempts to heal from the assaults committed against it— by her, by others, because of course, many invisible hands held hers which held the razor blades. Her hair is filthy and brittle, her skin streaked with fresh and drying blood yet deathly pale from its chronic loss; her face, a shadow of the suffering child, her beauty cruelly slashed and marked; her stare, an effortless kind of

looking without perceiving but without any of the peace of equanimity. She barely seems aware of our presence at all, while we can not help but notice hers. Her flesh has been driven away, banished, deemed no longer needed. The first time I met her, she was, on account of the powerful pharmaceuticals administered, obese and, on account of her deep well of anger, extremely abusive; the same baleful, tarry, black-bile fire on her tongue filled her eyes, set her jaw and powered the bellows of her screams - it wasn't fun to be on the receiving end of but at least it was some indication that she was alive, that she was still proclaiming her existence to all who would listen, that she had not surrendered to nihilism's seductive swallow.

I find myself holding my breath, being unable to feel my heart beating at times, being unable to sense where my limbs were in space or feel the perishing cold of the flat. I feel numb and frozen, just watching on, helpless.

'I don't know what to do to help you,' I think and it echoes around my empty head, and somewhere deep down, a stone sinks and sends a ripple across a pond.

I didn't know what to do because nothing in my knowledge-and-skills-focussed training had really prepared me for this moment, where everyone in the room is exhausted, all the knowledge we have has been exhausted, and we are all feeling the way the young woman feels: empty, hollow and about ready to give up the ghost. If I were to distill my whole purpose in the role of doctor to one root it would be attempting to alleviate human suffering, and there I stood, unable to fulfil that purpose. I have stood in that position many times, seen others standing there too, and they also froze, not knowing what to do but eventually we do something—anything. It has led to some very strange, extreme and irrational behaviour. Often, I felt like I was participating in or watching a symbolic dance to bring about the end of a storm, or to wish hunters good luck with catching a bear: I wasn't entirely sure exactly what difference I was making, whether I was hurting more than I helped, or whether I was solving one problem and giving a person two new ones, each just as bad as the one I solved. But being in that young woman's flat cut through all of the doubts and anxieties. It stirred up memories of my own time as a patient: of being a child, alone on an adult ward in a hospital bed, deeply embarrassed by unnecessary comments a doctor made about my body, a doctor who was completely indifferent to the discomfort she was causing; of the shame of feigning sleep and sickness to fight off invasion of my intimate parts from hordes of the consultant's firm, all very eager to gain experience of a fairly rare example of a fairly rare

condition; of the abject terror of being kept awake all night by the moaning and crying of the elderly women on the ward, delirious and dying. I knew what that child wanted in that moment of horror, and I wondered if it was something similar to the young woman in whose home I stood. It opened up a new way of thinking about how I could help.

I do not know when suffering was first experienced and articulated as “suffering” but it seems to have been around for so long as to appear universal and enduring and yet, because it is unpleasant and uncomfortable, few want to endure it. The misfortunes and cruelties which befell the Biblical character Job in our culture’s archetypal tale on the nature of suffering would be enough to send anyone screaming mad with grief and rage, especially upon learning the trivial and asinine reasons for the terrible events. Distress, anguish and pain have infinite causes and each person experiences them in unique ways; other emotional states connected to suffering are sorrow, grief, terror, anxiety, jealousy and rage and we often seek to escape them, a matter reinforced by learning through our culture the accepted and acceptable ways of experiencing and dealing with those states; for example, in Victorian England, a woman bereaved of her husband was expected to wear mourning dress (deepest black clothing, symbolic of the spiritual darkness of death and grief) for two years. This practice was adopted having learned from the behaviour of the royal family, and was supposed to be an outward expression of the sorrow felt at the passing of a great man. Essentially, the widow was not to have any fun in that time or even look as though she were enjoying herself, lest she face criticism and social censure for not being sad enough. Now, sorrow lasting longer than two weeks after a bereavement is considered to be a diagnosable syndrome of depression, and treatment with drugs and counselling to help a person ‘move on’ is expected to be offered.

When emotional states are experienced as unpleasant, the discomfort can build and become too much to bear, sending a person fleeing in terror from oneself. We haven’t always, but in our culture we often go to a doctor for help with this turmoil—intentionally, having checked the Internet, seen a poster or an advert, or spoken to a friendly loved one, or because we have drawn the attention of some social authority who brings them to someone like me, a doctor designated by the social authorities as having “special expertise in the diagnosis and treatment of mental disorder.” Often people have attempted to flee the uncomfortable feelings by way of drink and drugs, or self-harm, or work or plain old fingers-in-the-ears, hands-over-the-eyes avoidance (what the psychoanalysts call repression and denial), or some other means which cannot be sustained because of the damage and destruction—the suffering— they too cause.

Often people arrive at my door weary, feeling broken down, about ready to lie down and die; they don't want to die, no living organism does, but they've run out of energy and ideas on how to make the torment to stop—often wanting it to stop for good. Then begins a stereotyped process of the mental healthcare system becoming familiar with the person seeking refuge, making them into a legible entity, which can be processed: collecting the symptoms, to formulate a diagnosis which then determines when, where, how and by whom a person will be treated and with what. They will be measured and managed, observed and their progress recorded. It is expected that they will 'get better' because we do everything we can to help them get better— 'everything' meaning everything the public systems of arranging, managing and providing psychiatric care allows (which isn't everything). Because we do 'everything', it is also expected that the person (who has now become a 'patient', 'client', 'service user', 'SU', 'consumer' or some other description which has an unpleasant effect of obscuring the fact that they are a person) does everything they can to 'get better'. This typically means doing whatever we've told them to do to get better - 'doctor knows best' even if she doesn't know you at all. I was never really sure exactly what people were supposed to 'get better' from: their abusive childhoods? Violence and cruelty suffered at the hands of other humans? The harsh economic and educational inequalities brought by modernity? Other myriad forces and happenings which shaped how and why we feel the way we do?

Still, I believed in that way of doing things because that is what I had been taught. I was surrounded by highly skilled, experienced and knowledgeable practitioners, who at least gave the impression of knowing exactly what to do in every situation. I never had a supervisor who said to me that they didn't know what to do to help someone, so I assumed that they always did, that I was to know too. However, I saw plenty of things that made me very sceptical about that knowledge. I saw people being repeatedly given drug and electro-convulsive treatment against their expressed wishes, sometimes even held down and injected, screaming and crying. Even if the treatments 'worked' (i.e., the problematic symptoms were eliminated), many people were left traumatised and disturbed by the experience, much in the same way as I was as a child. The helpers can and often do hurt in one fell swoop, and I don't know how much of that is reckoned with. I saw people who were offered admission to the psychiatric ward for 'respite' but driven away by every non-verbal indication of how unwelcome their presence was, often because the diagnosis of their experience meant they were deemed unworthy or undeserving compared to someone with a 'real' condition. One young person, who had suffered terrible abuse and neglect in their early years, had it recorded in their care plan

that they were not to be shown any kindnesses, such as offers of tea and biscuits or making small talk when they presented to the emergency department for care after self-harming; the person's care workers had had a meeting and decided that such acts were fostering dependence and making them turn up the emergency department more frequently. Nobody stopped to consider how bereft of connection a person must be that the only time it was found was in the hospital. People who had cogent reasons for not wanting the drugs or the hospital admissions were ignored because "they lack capacity" and the practitioners and our system had no other ideas about other ways of achieving the objective: get better, get out of hospital, get discharged from follow-up. The priorities seemed to shift away from the people-first-and-centred way I learned at medical school, where I spent time listening to people's life stories, and how their symptoms or their condition were experienced by them. Instead, here I was trotting along the treadmill of diagnosis, treatment plan, estimated dates of discharge, endless forms and paperwork, mental state examinations to determine when someone was 'fit for discharge' and meetings to discuss "cases" where there were "complexities" and "interface issues" with other services. I came to a position of seniority in a time of highly time-pressured, waiting-list focussed, outcome-driven psychiatric assessment and treatment, and had adapted to it through training. I saw older colleagues fight against this way of working and get pulverised, the stress and misery that accompanies a prolonged resistance being too much to bear on top of the enormous amount of pain they had to contain. I would cringe upon hearing myself say certain things in certain ways which sounded like they could have come from a machine; I would tie myself in knots trying to justify decisions I didn't think were right but which I felt nudged into making by the system in which I worked. Even in my most senior (and most loved) position, there was precious little space for investing time in understanding the individual's unique expression of their experience, or developing a trusting relationship built on mutual respect and honouring inherent value. Many people come to us with very complex burdens, pain and confusion which has been with them for many years and complicated by the length of time it has been troubling them. I was given thirty minutes to one hour to make my assessment, formulate my diagnosis and come up with a treatment plan; a GP has less than ten minutes. A full, detailed psychiatric history takes a minimum of three hours to obtain and I've only ever done it over two or three sessions, so I could rarely ever get to know the person in the detail I had been taught was really important for developing a good relationship with someone. On top of that, having to see three to five people a day meant I rarely had time to even think or reflect, and when I heard harrowing story after harrowing story, that time

to reflect was so sorely needed. Restrictions and extreme pressures on time were to enhance “throughput”, a starkly utilitarian calculation, which says that the time one person should get could be divided up between six people, so more people are seen and the waiting times go down, which is better overall. It quietly told me what was expected of me: no chat, just business. It confused me, because I thought that the ‘chat’ was the business; how else am I supposed to know how to help, if I don’t understand what is causing the problems the patient comes with?

The system I worked in seemed to be based on a certain understanding of psychiatric conditions: obtain the symptoms, diagnose the disorder, offer the evidence-based pharmacotherapy, and “manage” the “risk”. There was precious little space for enquiring about about what caused the symptoms in the first place. It assumes a sort of tautology —that the symptoms are of an illness called depression or schizophrenia or personality disorder, and that you have those symptoms because you have the illness they cause. A nod might be given to a particular conception of ‘the biopsychosocial’ model (which was not, as is often thought, merely a linear conception of a particular condition having biological, psychological and social causes and effects, but a dynamic and multidimensional expression of the interrelatedness of those domains) but in the end, physicians are going to physick; the psycho- and the -social are huge, perhaps too huge for any one person tasked with what we also have to do to wrap their head around. Even if we had the first clue where to start, we believe we lack the training and the tools to adequately address those things. “I’m not a medical psychotherapist, and at any rate, I don’t have time to do therapy with patients,” we say in the same breath as bemoaning the lack of psychotherapeutic availability and variety. We pass them off to someone else.

I noticed this a lot and started to think the everyday indifference, narrow, algorithmic response to experiences of suffering and the extraordinary and sometimes dangerous attempts at alleviating intractable suffering I witnessed were not generally the expressions of a cruel, sadistic and malicious attitude, nor a callous disregard for people’s dignity that have been accusations levelled at psychiatry and psychiatrists. I have met some people who were like the psychiatrist in ‘You, the Living’ (<https://youtu.be/eJAWzEYPXBM>), but even their anger and blaming of the patients I thought was a symptom of their distress and severe fatigue rather than a real desire to deliberately hurt people. Most of the unusual stuff I saw was doctors trying to help by coming up with something familiar within the framework of doing-medicine, or trying to protect themselves from being hurt any more. Maybe it was not more training and more

education to develop more skills that we needed, but to remember that why all of this is happening — because we are humans, being alive.

I started to think that it just did not occur to people to stop, sit and pay attention to what was present, what was happening now; to take stock of what was known and what was not. To think in terms of interconnectedness and adaptation — if we believe Charles Darwin's theories of evolution then this is the real 'biology' in 'biopsychosocial'. To strip away all the best laid plans which went awry when we started piling on the pharmaceuticals in a panic, and refocus to the here and now, which contains the relationship with the person and their experience of being. I began to test that thought, suggesting ideas to colleagues when "difficult cases" were presented in discussion groups for advice on how to escape the feeling of stuckness, or when I was responsible for setting the agenda for the "care plan". Sometimes it was cautiously received but most of the time it was not. I was looked at strangely at best, or someone raised the spectre of negligence at worst. I remember being incredulous and outraged many times but that was my zealotry and forthrightness, my ego, getting in the way and failing to appreciate my colleagues as people, with their own experiences and ways of seeing things. Now, I don't feel any anger about it; we all have our reasons for doing things our way and wanting others to do it our way too. However, it reminded me of reality: that I was a speck of dust, falling through a shaft of light and I could either spend the rest of my glorious fall through the sunshine fighting to change that massive system to be more like how I wanted it to be — and what right did I have to do that? — or I could focus my energy on doing something I wanted to do, in a way I wanted to do it. This decision came at time when the whole world was in upheaval and experiencing the turmoil, distress, and chaos wrought by an outbreak of disease and the challenges of human responses to such a threat to life and ways of living. In this time, I also connected with Diane, the founder of the BTA, and spurred on by her interest in ways and means of connecting within and without, I knew that it was time for me to radically change how I conducted my purpose: that of holding refuge for a person who is suffering and seeking a way to get free of it.

We live with an age-old habit of dividing things, and we divide experiences into 'good ones' and 'bad ones', with right and wrong ways of expression. I learned to see past those categorisations, to remind myself that they are overlays on being and that it was being which I was interested in. At medical school, we used to wear a white coat on the wards to signify that we were (at least intending to be) doctors. It was a physical costume of the role we inhabited, which I put on, performed the role in and at the end of

the day, I took it off and I was me again. The powers-that-be got rid of them, claiming they were an infection hazard and so I began work just walking around in my own clothes. I felt strangely naked without my coat after five years of wearing it and felt I had to dress up a certain way to look 'the part', and this was instigated and reinforced by all kinds of attitudes, codes and policies (implicit and explicit) about who a doctor was, and what they looked and acted like. This performance of the persona of a doctor made it easier to bring less of myself into relationship with people I served; even my assessments became stereotyped and formulaic, and I often felt I was proceeding with the doctor's agenda and not responding to what was happening in the moment. I reflected on this often and because I had started practising paying attention in 2009, I found it easier to notice when it was happening, even remembering little things that seemed like clues as to what was really happening. I reminded myself that, even when I wore the white coat, the persona's mask, I was always me underneath it. Even with the 'right' clothes, shoes, handbag, car, voice and speech pattern, I never stopped being me, a person, and those things were mere affectations of a character. When they became burdensome and interfered with what mattered, I dispensed with them and found that the elimination of the image of a doctor did not make me less of a person (who happens to practice the art of medicine).

I started to think that the same was true of the 'patient' whose experience of being was described as 'illness', a morally 'bad' thing. I decided that there was no 'patient' and no 'doctor' but only two (or more) people in a room, being together, at least one of whom was in some kind of distress and seeking help with it from me. If I was also in some state of distress, seeking something to help me with it from the other people in the room, I was better able to notice that, too. The panicked reaching for solutions to prove my worth as a doctor vanished. Having nothing to prove, my head was pleasantly empty and free to pay attention to what was happening, what I was being told, verbally and non-verbally by the person suffering. I could sit with my helplessness, powerlessness, smallness, my own distress, making space for things to ebb and flow, and in time and with practice, grew spacious enough to contain the distress of the others who came to me, too. After a consultation, I felt energised rather than drained, and people were happy with me, pleased to have me as a doctor and a colleague. I enjoyed going to work, which I hadn't for a long time. I was also able to notice when I was full and needed time to empty and rest, so I could fully show up, ready and open for someone again. The standard way of working in the National Health Service does not allow a lot of flexibility for that, understandable in some ways because it is a national service. The primary consideration is the service as a whole and how it supplies and meets demand, as a whole —the needs

of the individual people are easily subsumed by the priorities of legibility, consistency and cost effectiveness.

I love plants and find most of my analogies making reference to them. The fertile ground of a good education, enough sunshine and plenty of rain, with obligatory cold snaps to inure to hardship ensured the seed my parents planted grew well as a doctor, as a person, in my six years of training as a psychiatrist and the four subsequent years I have worked as a consultant psychiatrist. It reminded me of the reason I became a doctor: to understand these painful experiences of being human, including the experience of death and dying in all its forms. It has been hard, with near deadly conditions at times, but this little sapling has managed to survive (with a lot of help from bigger, older and more robust trees). Along the way, I learned that there was nothing wrong with my upbringing, in which emotional experiences (especially painful ones) were not really talked about; I eventually figured out for myself that it is not always necessary to put them into words. Words are highly convenient, wonderful but imperfect tools because they mean different things to different people (even ourselves) at different times, and sometimes there are no words one knows for what is happening. 'It's good to talk,' said Bob Hoskins in an advert from my childhood, and it's true but sometimes it feels cheapening and reductive to use words to describe something so huge and intensely personal. There are, however, always other means of expression which can induce in a witness a feeling of empathy, of connection across the isolating bubble of private experience, which is perhaps why music, singing, dancing, massage and touch, painting and drawing, sculpture, story-telling and non-verbally based relationships with other living beings like plants and animals are so profoundly satisfying. It is also perhaps why I can conjure so easily the feeling of being in that young woman's flat, or by the side of a woman dying fearfully in the hospital, apart from her family who sit at home believing she will join them soon, her worst fears coming true despite the promises of her doctor, her last wishes unfulfilled. Our bodies, our whole being speaks for us then.

I sometimes think about the people I have met through work; there are well over ten thousand of them by now, and I can't remember every individual but the ones who I can conjure up eidetically are the ones whose experience connected with something I had also felt at some point: terror and numbness that leaves one sobbing like a child; haughtiness which comes with insulted pride; the meanness that accompanies a desire for revenge; sorrow tinged with relief that makes one feel guilty; aloneness and a desire to scream one's existence and be noticed; tearful gratitude for some small, insignificant act of selfless kindness; peace and belonging; outrage at injustice tinged with self-

righteousness, to name a few examples. I don't remember what we called their problems, but as that great storyteller of human experience William Shakespeare wrote for his Juliet to say, "what's in a name? That which we call a rose, by any other name would smell as sweet." We are all humans being, and the types of experiences we have, though uniquely expressed, I suspect are universally felt; perhaps to some degree and in some way felt by all living things as the love of life which drives the desire to be alive. Some experiences and ways of expressing them may be deemed socially acceptable, others criticised and censured, even punished but I believe that there are no right and wrong ways to be— we have what we have. My privilege is to be present while it is happening, for it means that I am alive, the greatest gift I have ever received (even when sometimes, its challenges and hardships have one searching for the gift receipt).

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