Podcast Transcript

Online Professional Development for Mental Health Practitioners

In Conversation With… Mary O'Hagan and Dr Ruth Vine – Part 5

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Host (00:01):

Hi there. Welcome to Mental Health Professionals' Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary, collaborative mental health care.

Mary O'Hagan (00:17):

Welcome to this final episode of MHPN Presents: In Conversation With. My name is Mary O'Hagan, and I'm the inaugural Executive Director Lived Experience in the Mental Health and Wellbeing Division of the Department of Health in Victoria. With me today is Ruth Vine, psychiatrist, and Australia's first Deputy Chief Medical Officer for Mental Health. Hi Ruth, thanks for joining me.

Dr Ruth Vine (00:45):

Hello, Mary. It's lovely to be here again.

Mary O'Hagan (00:48):

Yes, and I look forward to our conversation today. Just to let you know, this is the final episode of the five episodes where we have been talking about issues of mutual interest from our respective lenses. My lens, as lived experience advocate, and yours, Ruth, as a psychiatrist, I recognise that psychiatry, and the mental health professionals, and the mental health system can be helpful. I've also been interested over my career in exploring critiques of the mental health system, and psychiatry.

(01:21):

We've talked a lot about compulsory interventions, and I think we've done them to death. So, I'm keen to know your response to some of the other critiques that I've come across of psychiatry. And the first one is the tendency for psychiatry, because of the medical background, to have medicalized explanatory theories of mental illness. Now, the critique claims that there is no real evidence that genetics or biochemical imbalances have a major role in causation, and that social determinants are more powerful. There's a consequential part of this critique, is that it is kind of reductionist, and renders powerful experiences as essentially meaningless. And this is something that I struggled with when I was using services, and going through some incredibly powerful experiences that I was told it was a biochemical imbalance. And I was left thinking, how do I explain these powerful experiences in terms of the story of my own life? And the other part of this critique, is that it leads to a narrow range of interventions, which can sometimes be harmful, can be ineffective, and even if they're effective, they're not enough to bring about a full personal recovery. And so, the system has been geared to provide this narrow range of responses, but even at very best people say, well, that was only 20% of my recovery, I needed other things as well. I just wanted to get your response to that critique.

Dr Ruth Vine (03:00):

Mary, it is indeed a whole cluster of things. So, I think the first thing is, there are some illnesses or disorders for which there has long been found to have at least a genetic component. And I'm talking here of way old studies about identical twins, and others in relation to illnesses like schizophrenia, but also things like alcohol abuse and bipolar affective disorder. So, for some illnesses there is a pretty strong evidence base around genetic components. Having said that, there is absolutely no doubt in my mind that there are also enormously potent forces that happen to do with a person's life experiences. Now, the two are not necessarily to be distinguished because, let's just say you grow up in a family where one or both parents suffer from alcohol abuse. That will influence your life experiences, it will influence their life trajectories. It will influence a number of socioeconomic determinants, like employment, and family engagement, and social connections.

(04:09):

And I think one of the pluses, if you like, of working in this area is that it is inevitable that you take into account more than what you're talking about as reductionist theories, and have to include a person's personal history, their life experiences, their family history. So, let me start with that. The second thing I think need to say, although you said quite a lot there, Mary, but that doesn't mean that one element of treatment might not involve biological means, just as it doesn't mean that psychological, or even social interventions on their own will be sufficient. Mary, I think of a couple of the, I don't know, the tragedies that I experienced in my clinical life. One was the death by suicide of a patient I'd been very involved with at a very early stage in my career. And when I reflected on that tragic, tragic outcome, part of me thought I'd been paying too much attention to the psychological, and not enough attention to the biological.

(05:13):

Another tragic event, that was a young woman with schizophrenia who died, probably related to the biological treatment she was on. It was an unexpected death. And in relation to that, I felt I had not given enough attention, enough, I don't think, credence, because we'd talked a lot about her symptoms

and her experiences, but perhaps not enough to her family life, and the importance of her engagement with her family of origin. So, I just don't think people working in this area wish to be reductionist. Just before I go on, I do also have to say that one of the really tragic things about psychiatry, at times, has been that there has been a psychological or even a social aetiology to what had an absolutely physiological or pathological origin. And I'm thinking there of things, diseases, like multiple sclerosis and various neurological conditions that can present with problems that look like they're psychological, but in fact have absolutely an aetiology in what's going on in the brain and nervous system. And that's why I think that absolute understanding of all of those is so important to bringing people the best outcomes.

Mary O'Hagan (06:24):

Yes. So, I suppose syphilis was an example of that, wasn't it?

Dr Ruth Vine (06:27):

Syphilis was filling psychiatric hospitals, and yet someone found that the spirochete was at the basis of it, and decades of misery, decades of people with hideous illnesses that now with the discovery of the spirochete, but also of course the discovery of penicillin, just wiped that mental illness off the planet almost.

Mary O'Hagan (06:51):

So, Ruth, one of the issues I wonder about is, if you do psychiatry, you do years and years of medicine, and medicine is very much associated with the biological. And then you go into psychiatry, and there may be a more complex lens in psychiatry, but we end up in a system where psychiatrists are really just in the public mental health system. They just really deal with the pills and pillows end of the system. And that is really, often, all that people get.

Dr Ruth Vine (07:29):

But Mary, that's a damning of the system, not of the psychiatrist. And let's be very clear, again, I think we talked about this in an earlier episode, that as part of my psychiatry training, I had to do what was called a long case, which is a psychotherapy case, that was part of the deal. And I had to study Jung, and all those wonderful people who had all those deep thoughts about how people behaved and why. So, I think we do absolutely need to recognise that a system that, as you point out, is reductionist to the point of only giving people, and a very small number of people, I might add, you say pills and pillows, but a lot of people who might've needed inpatient care and the sort of support and opportunity to regroup couldn't get it, because of not enough pillows. And pills, there are good pills, and there are pills that need to be monitored closely.

(08:21):

So, I do think that's not how it should be, and it wasn't how it was during my entire career. I think there were times when there was a much broader thing. I think I mentioned in one of my earlier conversations with you, Mary, that when I started, I had this rather quaint job being a crisis registrar, and there was no pills there, that was about crisis intervention as informed by the work that came out of, I don't know if you remember it, but there was a fire in the Coconut Grove Club, going way back. Many people were traumatised during that event, and a whole sort of theory of crisis intervention grew out of that. So, that

was about psychological intervention. But I also would say that having done medical training, and in my case then a couple of years of physician training and other stuff, a bit of anaesthetics on the side, that does mean that you do think about physiology as well as what you're talking about, the socioeconomic determinants and the forces on our lives.

Mary O'Hagan (09:23):

I was saying before that one of the great struggles I had was I was told, Mary, you have bipolar disorder, you've got a biochemical imbalance. And I had some pretty powerful experiences with mood swings. My life's sort of pretty boring compared to what it was like back then. It's actually a lot better. With that conceptualization of it, I couldn't find, I said, does this mean these experiences are meaningless? And have you come across people with this kind of dilemma? And how have you talked to them about it?

Dr Ruth Vine (10:01):

Well, of course I have. I mean, I think you're right. I think experiencing things from a different perception of reality is enormously powerful. And I think there are times when, of course, that perception is so overwhelming that it does distort how you behave and how you interact. And that's when, more intensive treatments. But of course, in the longer term, talking through what that perception's like, and what that experience is like, I think is a really important part. It's also a really important part of explaining why on earth treatment is there. I briefly mentioned, I think in our last conversation, Kate Millet's The Looney Bin Trip. If you looked at it from Kate Millet's perception, she was having a high old time, and yet her family were incredibly concerned about her, and incredibly worried about her. So, I think that's one of the hallmarks, I think, of mental illness is an intense self-reflection. And of course, that can be very powerful at times, but also it does distort how you think other people might react. And so, I think that is part of the role of a psychologist or a psychiatrist or any mental health professional, to try and understand their patient's perception and understanding of the world, and also help them interpret that in a way that doesn't cause disruption and sometimes tragedy in their lives.

Mary O'Hagan (11:30):

One of the things that, and I'm going back to my own experience now, but one of the things that struck me was that when I was using services, there was no curiosity about the content of my experiences. There was a lot of interest in what the symptoms meant, and how they might fit into a diagnostic category. And also, no acknowledgement that, through having these experiences and learning to deal with them, I was learning things that other people never had to learn. And I was building up strengths and resilience that many of my peers didn't have to do, and all they saw was a person who was missing out on some developmental milestones, but who wasn't actually developing in other ways. And I just wonder what you think about that.

Dr Ruth Vine (12:22):

Well, the first thing I'd say is, I'm sorry that that was your experience. I'm very sorry. And I'm sure that your experience was not the only person who experienced that. And as I said, I absolutely accept that there are practitioners who are less curious or less empathic than others, and that there are systems and times that are less able to listen to that. When you were talking, I was reminded of one of, I think it's just a terrific book, but Sandy Jeffs's book, and her experiences of going in and out, and indeed her experiences or her reflections of what her friends thought when she was going through this. And indeed, Sandy's poetry and writings are fantastic. So, they've given great depth to her. And I would count, think

of Sandy as one of the, a wise person who is able to interpret her experiences and understanding of mental illness.

(13:16):

So, there's lots of creative writing and lots of fantastic stuff that's come out of people's understanding of their mental illness. We could think of the description of Septimus Spool, I think his name is, in Mrs. Dalloway by Virginia Woolf. I mean, a fantastic example. And you just know that Virginia got that from her own experiences, and understanding of what it was like to feel the demons around you. So, I'm sorry, Mary, that your experience was not one of curiosity about, not only what you were experiencing, but also what you were doing with it in your mind, and how you were incorporating it into your understanding of your world. I think that's, it doesn't mean to me that mental illness doesn't cause distress, and that treatment is not important, but it does add, for me, the need for understanding. And it's more than curiosity, Mary, because it's curiosity about how you're incorporating that, and how you're making sense of that, and then what that's done to your subsequent thinking, and your subsequent engagement with people.

Mary O'Hagan (14:24):

Yeah. One of the pieces of the puzzle that had been important to me, over the years, is to rethink the concept of mental illness, and I don't use that term. Now, I'm quite happy for other people who have had a diagnosis of mental illness to use that term. But one of the problems with that term, or that concept, is that it tends to increase stigma and discrimination, if you call it mental illness. Whereas if you call it something else, like psychological distress, then it's not so othering, can be part of that whole cluster of experiences or severities that come under the banner of psychological distress. And I think there's some problems with the concept of mental illness, and one of them is the almost invalidating of the experience, I mean, and the reductionism that's associated with it. What do you say to people who say, well, you call it a mental illness, but I don't want to call it that. I really refer to my experiences as existential crises. What's your response to that?

Dr Ruth Vine (15:46):

Well, Mary, I have a very big problem with referring to what I think of as severe mental illness as psychological distress, because I might have psychological distress when I get a car parking ticket, or I lose my wallet, or I have a fight with my sister. But that, to me, is diametrically different from a severe enduring illness, that if you think about an illness like schizophrenia or major depressive episode, many, many, a large proportion of those people will, with the best of treatment and the best of recovery, will still struggle to sustain employment, will struggle to sustain family life. And so, I think to refer to that as psychological distress is diminishing. The second thing I think I'd say is that we see discrimination against people with mental illness. We see stigmatisation of those who might present with mental illness all over the place, and in all sorts of different ways.

(16:46):

And, I would say, we also see it in other areas. So, we see it in areas of intellectual disability, the other, the otherness. But I think that if we were to not recognise the importance of and the impact of illnesses, OCD, we talked about that the other day, or a really severe anxiety disorder, if we didn't recognise that that is more than psychological distress, I think we are not being fair to those who are experiencing that, or their families. And I think we are not being fair to the health system to say, you've got to give it lots of

attention to this, and funding, and research, and treatment, and amenities, which is not to say, Mary, absolutely not to say that the socioeconomic determinants are not important. So, a person's experiences in their first three years, their experiences of trauma during their upbringing, their experimentation with drugs during adolescence, all sorts of things impact how you respond and how you're able to tolerate your own emotions. But I think that sits alongside some of these other presentations, which without being reductionist, Mary, I think one day, one day we'll find a neurophysiological or a neurodevelopmental or whatever it may be, I think one day, in the same way as we've discovered so many things, you mentioned syphilis before, but we could add Parkinson's, or multiple sclerosis, or lots of other, I think one day we'll discover a lot more about those illnesses that we currently refer to as the psychotic illnesses, and therefore find interventions that can prevent or cure.

Mary O'Hagan (18:27):

We've been waiting a long time for that day, Ruth.

Dr Ruth Vine (18:31):

We have Mary, but a lot of those other treatments are very recent. If you think about advances in oncology and urology and others, they are very recent, and we are making great strides. I'm not sure where the solution will be found. I'm not a researcher, but I don't want people to stop looking because of that.

Mary O'Hagan (18:51):

Yeah, I mean, I wasn't meaning to diminish the profound experiences people have who experience severe mental distress at all, but I'm wondering why do we need to portray it in medicalized terms? That's my argument.

Dr Ruth Vine (19:11):

Well, I guess Thomas Satz, of course, he was not going to have a bar of mental illness. He just said they're all bad. If they do bad things, they're bad. And I don't think that's very fair either. And in illness, I mean, I don't have a problem with thinking that there can be significant illnesses that have ramifications on a person's broader functioning, including interpersonal functioning, or memory or whatever. So, I think you want to not have a medical paradigm. And I understand that pills and pillows is very reductionist. I would just say don't ditch the lot of it, Mary.

Mary O'Hagan (19:50):

No. And I certainly have never advocated no psychiatry, or no pills and pillows, but what I've always said is that there's a plethora of those, not for everyone, not everyone can get them, but virtually all the funding goes into those interventions and not into other ones.

Dr Ruth Vine (20:13):

Alright. But sorry, Mary, I have to again challenge you a bit there, because if you, I'm sure a lot of money is spent on pills and pillows, but I would say probably not enough. If you look at Australia, if you look at the growth in mental health spending, particularly from the Commonwealth perspective, a lot of that's

been in Better Access and Headspace, which is absolutely all about psychology, and not about beds and pillows. And most private psychiatry, and private psychology is absolutely not about beds and pillows. It just happens to be that the federal system in Australia means that state funding goes more to those who cannot or are unable to access primary care in other places. And that means,

Mary O'Hagan (20:58):

Yeah, that's true. And it's a different story in New Zealand, but we won't go into that.

Dr Ruth Vine (21:02):

It's very different in New Zealand.

Mary O'Hagan (21:05):

Yeah, yeah. So look, another thing is related a bit to what we've been talking about, is the critique about diagnosis. And you're probably very familiar with this, that diagnosis in psychiatry is unlike diagnosis in the rest of medicine because it's usually tagged to some physical indicator. It might be a tumour, or a blocked artery, or a fever or something like that. And I've read critiques of the process of creating the diagnostic manual that have said, this is a political process, it's not a scientific one. So, I just wonder what you think about that, because actually the diagnosis doesn't always lead to specific treatments either, because the drugs used in psychiatry, if you think about anti-psychotics, there's more used on older people in rest homes than there are on people's psychosis. So, I just wondered what your thoughts were about the process of diagnosis, and how, in scientific terms, does it have validity or reliability and really what does it lead to in the end anyway?

Dr Ruth Vine (22:13):

Mary, I think that's a little unfair question when we are right at the end of our conversation, because you've opened up about three new scenes, so I'm going to have to be really, first thing I'm going to say is, I'm no lover of DSM, but I think DSM and ICD have brought, to some extent, a degree of rigour and comparability, and people talking the same language is useful. So, I'm not going to go into that. I think the other thing is that you mentioned, I think in one of our earlier conversations, about that old study now, but the international study of schizophrenia, I can't remember the name of the study, but basically it was looking at prevalence in different parts of the world. And what that demonstrated was that people in America called schizophrenia something very different than people in the United Kingdom. And so, I think a common language is a really important thing. You then, I think, suggested that there might be too many, use of too many anti-psychotics in old age people. And that's a whole nother thing, Mary, and it's done for different reasons.

Mary O'Hagan (23:13):

That was an example of how the drugs aren't really specific to a diagnosis.

Dr Ruth Vine (23:19):

No, indeed. Indeed. Anti-psychotics are used in anxiety. They're used in delirium, they're used in drug withdrawal, they're used in bipolar. I think we mentioned steroids the other day. Steroids are used in a

whole gamut of illnesses because, so Mary, I can't answer that because I know we're running out of time and I just want to tell you, it's been a delight to talk with you, and I can only say we'll have to catch up for coffee.

Mary O'Hagan (23:44):

Okay, we will do that. I had a couple of other critiques, but I won't ask you about those. Thank you very much, Ruth, for taking part in these conversations. I've enjoyed them. On the landing page, you'll find a link to a feedback survey, and MHPN really values your feedback, so please follow the link and let us know whether you found this episode helpful. Provide comments or suggestions about how MHPN can better meet your needs, and you can also provide a star rating. Stay tuned for further episodes in the series In Conversation With, and listen to other MHPN podcasts. Thank you for your commitment to and engagement with interdisciplinary, person-centered mental health care. It's goodbye from me.

Dr Ruth Vine (24:34):

And indeed, from me. Thank you, Mary.

Host (24:37):

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