

# **Sense and Sensibility**

**The danger of Specialisms to holistic, psychological care**

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Increasing specialisation in healthcare is often equated with progress. Yet often, though subtly, specialisation is destructive of valuable aspects of healthcare. This article explores this theme, using the example of Specialist psychologists working with Acute Mental Illness.

*'Ten Lands are sooner known than one man'*

Yiddish proverb

## Prologue

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The use of technical language and understanding to designate and remedy the entire span of distress presented to healthcare workers is partly indispensable and inevitably expands. A burgeoning of Specialisms follows. Each of these, to survive, needs to develop its own distinctive language and models. The benefits of these, in some areas, have been dramatic and transformative. But such benefits become much more doubtful when problems are not primarily physical. This short essay is a response to another article proposing that the acutely mentally ill might be better served by a further elaboration of specialist services and vocabularies. The counter-argument, proposed here, is that such developments, when misplaced, often take us *away* from the kinds of personal engagement and understanding that are most likely to be healing and helpful. Neglect or abandonment of these may be inadvertent, but are insidious and growing threats to the quality and integrity of personal care.

As we get older, and when our turn comes, we are grateful for the sharp, narrow focus of specialisation. For the failing heart or eye, we welcome the territorially different skills, applied with strict topographic attention, mandating distinctions between cardiac valve and coronary artery, the lens cataract and diabetic retinopathy. We may challenge the competence of the specialist, but not his speciality.

We can call this process of progressive division of healthcare into smaller and smaller foci of activity 'Anatoatomization' (AA). This term signifies its derivation from the Medical Model (MM), a fault-in-the-machine paradigm. This, too, is based on anatomy and physiology; like foundation stones to a column of medical specialities, each successive layer becoming increasingly refined and confined.

MM and AA work so well in certain areas, that challenges rarely occur. The more anatomically located or acute the problem, the more true this is. Medical and surgical emergencies serve well as examples of near inviolability.

The *science* involved in such (MM and AA) defined activities proceeds via our conventions of clustering our observations by similarities: generic patterns. In contrast, there are other aspects to healthcare where, instead, the *art* discerns and navigates our innumerable (and less measurable) human variables; the personal and subjective – the dissimilarities that make each of us who we are. Such art and science are tensely counter-poised, but often symbiotic: an eternally recurrent test of balance and judgement for practitioners.

MM and AA, then, have well earned and well based pragmatic hegemony when dealing with physical disease: solid-state pathology. Adam Smith's doctrine of Division of Labour is here on very workable territory. But this hegemony is extended, then overextended, to other areas, and for other reasons. The language and model imply powerful blessings: for authority, definition, standardisation and measurability. This apparent conferral of clarity and control seems irresistible to planners, economists and managers. Adoption is eager and rapid. Scientifically sounding phrases then expediently bolster the language of governance: it becomes difficult to distinguish the scientific from

the scientific. Thereafter, in a cascade effect, these flow down as a kind of didactic Esperanto, instructing and defining the caring professions. The result is the 'medicalisation' of almost any problem of experience, learning, adjustment or relating. There are, too, larger cultural forces at work. For we, in our advanced industrial society, now rarely encounter the unpackaged and unlabelled. Our minds are now rendered disconcerted and distrustful by the feral and undesigned. Packaging becomes symbolic of safety.

Our medicalisation of non-anatomical problems can certainly (if transiently) seem to quell complex human uncertainties by a kind of rhetorical aura. Sometimes this is followed by real and sufficient help. Often, though, it turns specious from its assumed clarity and authority. This is because medicalised understanding is confined to generic patterns. It does not extend to individual struggle, evolution or meaning: the 'idiomorphic'. Within the ill-defined compass of Psychiatric and General Practice, in particular, practitioners who become unreceptive to the idiomorphic will miss and misconstrue much that they encounter. While 'treatment' may depend largely on objectification (MM), and thus be well-served by specialisation (AA), 'healing' runs counter to these: it requires approaches that are holistic, personal and interpersonal. Broadly speaking, treatment represents the convergence of '*science*', healing the divergence of '*art*' in encountering human distress.

I recently read an article: 'Where does Psychology fit in Acute Mental Health Wards?'<sup>1</sup> The writing was, I thought, a solidly competent contribution to the current thinking and culture of psychiatry and medically orientated psychology. But I was struck, and increasingly interested, by a central axiom: one deriving from, and then contributing to, our increasing tendency to an errant, fragmented specialisation. It was that psychology is a naturally divisible activity from, though an optional ally to, psychiatry. This premise produces more difficulties than it solves, for such assumed divisions will seriously obstruct possibilities of holistic personal understanding and care. This poses particular hazards throughout Psychiatry and Medical Practice. What kind of artless practice will remain if we do not include skilful address of the unobvious and the unspoken? The article's designated problem of acute mental illness, in particular, represents such inchoate territory: the breakdown of an

individual's functioning, integration and identity. What healing we can muster attempts to counter this with varieties of holistic reparation: good continuity and quality of personal contact are elemental and essential. To be personal, such contact must be bespoke and dextrous: this requires a wide repertoire of skills offered *in-vivo*. This kind of engagement is always a delicate dance and easily stymied,<sup>2</sup> for example, by any attempt to fragment personal suffering into academically abstracted sub-components, each to be sub-contracted *in-vitro*. (Presumably, eventually, algorithms would be designed to command this!)

More basically, in most of our many forms of interpersonal care, we are best served when we are imaginatively receptive. For human vulnerability usually ushers a complex of unarticulated fears and encoded needs. To meet these we will need to navigate the cryptic – often delicate questions of engagement and encounter: whether to? what? when? how? who? We can call all this 'vernacular psychology': an unschooled ancestor of current spawnings of systematic, academically-shepherded, formally packaged 'Clinical Psychology' and 'Psychological Treatments', with which most healthcare workers are now inculcated. Such vernacular psychology is guided by a quest for personal understanding, rather than any kind of 'objective' designation. Such understanding proceeds by asking questions: What is it like to be this other person, to have lived their life? What is the meaning and significance, for them, of this distress? What is the meaning and significance, for them, of me, now? What needs do I need to address that they might not (yet) be able to articulate?

The language of such non-specialist forms of understanding can only succeed when fresh and personally meaningful. Unlike designatory language it can only be effective when our intelligence is fuelled and directed by resonance and imagination.<sup>2</sup> Procedural and technical language are, thus, often intrusive and antithetical to the vernacular; for languages not only communicates thought, it controls it. Vernacular psychology, with freedom of language and metaphor, seeks understanding before and beyond the shackles of our more administrative systems. When apposite it is a powerful element in the art of Medicine and Psychiatry. This is particularly well-illustrated in our best responses to those disabled by anguished dilemmas and unstable situations: the victims of Life's shakings and tearings – the bereaved, the ravaged, the

dispirited, the overwhelmed, the dying, the acutely mentally ill. These sufferers are different from those with stable and habitual patterns of distress: for such stability of distress is more likely to be receptive to our stability of approach – our reassuring and familiar structures: Treatment Planning, regular sessions, good-enough statistics, a premeditated and pre-packaged therapy, and so forth.

Across the wide span of palliative and curative activities, it is often vernacular psychology that best guides the kinds of empathic, compassionate approach that may enable containment and healing in the other. Being unschooled, it can be learned, by experience and apprenticeship, but probably not taught schematically: it is more the product of self-propelled education, rather than institutional training. This poses difficult conundrums for planners, managers and academics: it is easier to provide managed instruction than nurture nuances of culture.

It is worth reflecting on how important and widespread is our need for skilled, but unsystematised, psychology in our care of others. It is necessary even with the unconscious in ICU. Shockingly, they are often much more conscious than we can bear, and they will remember.

There are many kinds of sufferers who are too dislocated and disintegrated by their distress to be able to attend to, or retain, our professionally systematised, management-modulated approaches: our 'Treatments'. They are, however, deeply influenced by sensible, sensitive understanding: communication that is bespoke, empathic, and prepared from fresh ingredients. These fresh ingredients are prepared to meet the (often) unarticulated and primitive needs of the sufferer. Rawly anguished, we all are likely to need some composite form of these: for validation, containment, comfort, encouragement, recognition, expression, understanding, catharsis or touch.<sup>3,4</sup> In such encounters, each matched cluster of responses will never be exactly repeated. These intimate choreographies are thus not susceptible to standardisation or measurement; they cannot be quantitatively researched, or mass-managed. Policy-makers, managers, eventually clinicians in the current quantification-centred culture, may become expediently neglectful, then oblivious.

With high levels of chaos or distress, the acutely mentally ill are usually unreceptive, or even obstructive, to our conveniently pre-packed, management-purchased, NICE-endorsed Shibboleth Therapies (CBT and MBT were cited in the article). Aspects of any of these *may* be helpful, but only if evoked as part of a developing dialogue. Not if we administer them, as a bolus, a prescribed procedure. A maze of semiotics here awaits us, for the extremely anguished are often beyond words: our dialogue has to be finely-tuned and respectfully empirical with the implicit. To enter this ever-evanescent realm of healing art we must be prepared to be delicate with ambiguity, improvisatory with our choreography: an exquisite and disciplined eclecticism. These, in turn, must aspire to an imaginatively accurate sense of what kind of explanations, language, metaphors and dialogue the sufferer is receptive to, and can bear. Such comprises much of healing, but how do we subsume it to 'Treatment'?

To end this article we should return to the beginning, to its title and that of the article that encouraged this enquiry. Can we best encounter the acutely mentally distressed by further administrative subdivisions, by further specialisms? What happens to holism, to sense and sensibility?

Clinical psychologists are no more qualified to enter this fragile and feral fray than any other clinicians. Frustratingly and fascinatingly, this is an area of marshland where our tarmacked roads quickly sink: we must find lighter ways to traverse. Psychologists can certainly contribute to these lighter ways; they can offer their slant of analytical thinking to protean processes. Our success usually depends upon our awareness and responsiveness to the vicissitudes of human complexity and paradox. This is a difficult and different stratum of activity and thought to that executised by the prescribed, planned and packaged.

We must beware, for the discounting of vernacular psychology, then its dismemberment, then colonisation by Specialities, risks impoverishing or displacing the common compassion and emotional intelligence of us all.

Tennessee Williams starkly captures what so often eludes our over-organised and presumptuous encounters with others:

*I don't ask for your pity, but just your understanding – not even that, no – just your recognition of me in you, and the enemy, time, in us all*

Tennessee Williams, *Sweet Bird of Youth* (1959)

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<sup>1</sup> McGowan, John and Hill, Rosalind (2011) 'Where does psychology fit into acute mental health wards?'. Submission to *The Psychiatrist*, spring

<sup>2</sup> Zigmond, D (1987) 'Three types of encounter in the healing arts: dialogue, dialectic and didacticism'. *Holistic Medicine*, Vol 2, 69-81

<sup>3</sup> Frank, J (1972) *Persuasion and Healing*. New York: Schocken

<sup>4</sup> Zigmond, D (Sept. 2010) 'Why would anyone use an unproven therapy? Treasures in the mist'. *Journal of Holistic Healthcare*. Vol 7. Issue 2 17-19

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