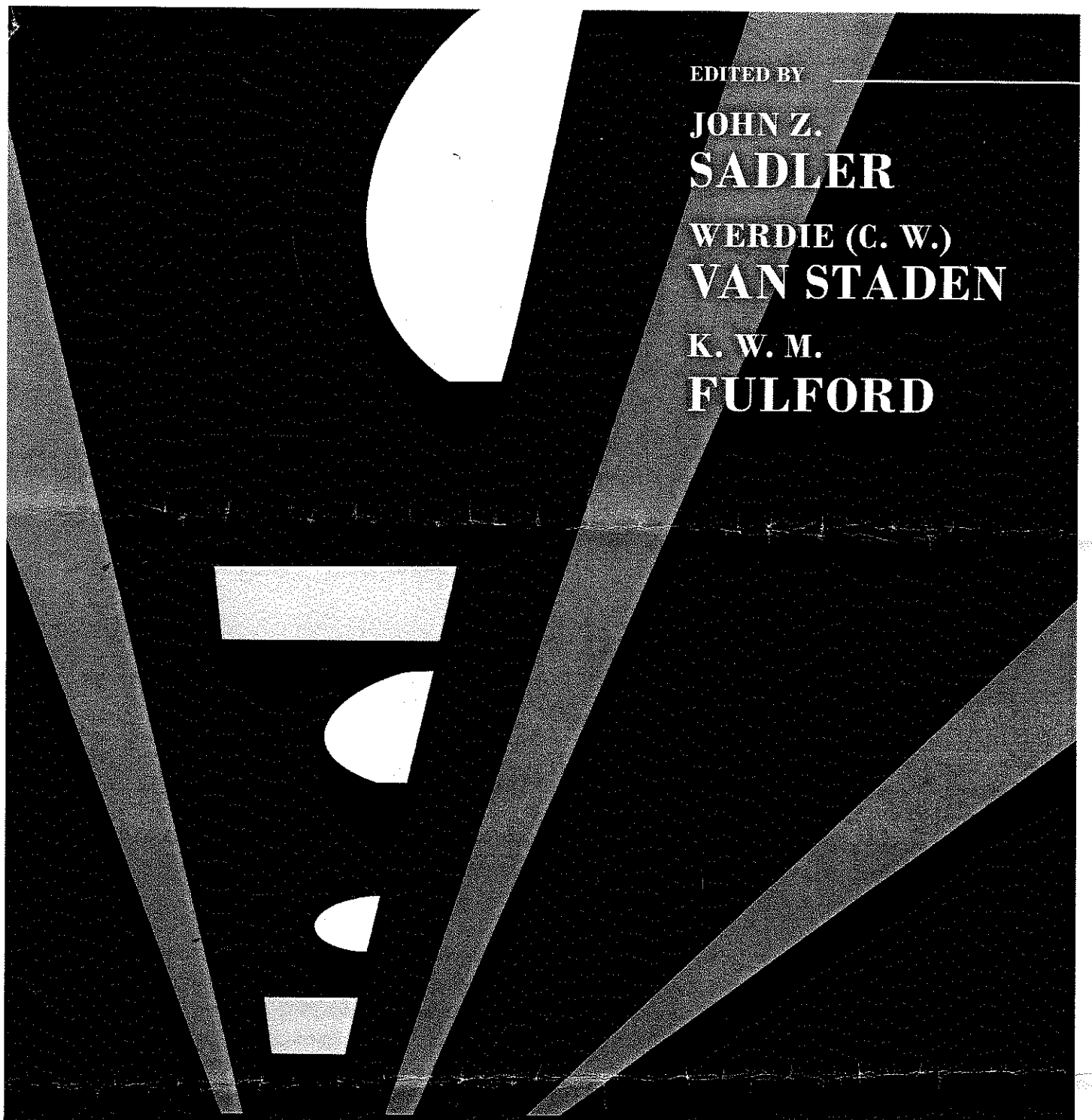

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The Oxford Handbook *of* PSYCHIATRIC ETHICS

VOLUME 1

CHAPTER 9

STEPHEN WEINER, PATIENT IN THE MENTAL HEALTH SYSTEM

SUSANNE PETERMANN AND STEPHEN WEINER

Over the course of several months in 2011, I interviewed Stephen Weiner, a person who is unusually articulate about his mental illness, and who retains an unusually precise memory of his long history in the mental health care system. Following are excerpts from what he told me.

I have never presented myself as being highly abnormal, so people don't know. They don't see it so they don't get it. Schizophrenia is so mysterious and unknowable, normal people can never understand the delusional mood [Ratcliffe n.d.].

My first memory [relating to mental health issues] was when I was 6 or 7 years old [1957–1958], sneaking a glance at a behavioral report that said I had an emotional disturbance, or something to that effect. In those days the belief was that children didn't get depressed. I disagree. This raises the question about making evaluations of kids that early. I don't dispute the report's accuracy. I remember being disturbed in second grade by the new movie *I Want to Live*, a story of a gangster woman executed at San Quentin. I've always remembered identifying with her and being afraid I was going to be killed [like she was]. I mention this because it shows how miserable and emotionally unbalanced I was at the time.

The fact that I was not given a diagnosis, presumably because I was a child, made it harder for me to know how "objectively" to evaluate my condition. I knew I was very miserable but it took me decades to think of myself as clearly mentally ill. Now I wonder if it might not be wiser to tell older children a diagnosis.

At that time, probably little was known about the phenomenology of derealization and solipsism. So, when I told [my first psychiatrist] that I felt nothing existed, his response was unhelpful. He said many of the great philosophers have wondered about that too, and cited the song "Row, row, row your boat, life is but a dream," etc. I think he simply lacked the

training, which came later in the profession, to know how to acknowledge my issue and my suffering in a more helpful manner. I don't see this as unethical or a failure of empathy.

After graduating from college I decided to seek treatment by getting the deep and painful body work known as Rolfing. This was in Berkeley after the height of the counterculture movement and I was urged by many people, including my sister, a social work student herself, to look into alternative treatments for my growing and deepening depression and alcohol abuse. I now consider the Rolfing practitioner to have been unethical because he told me that all my psychiatric problems stemmed from the fact that I had a small penis. Even at that time, when Freudian influence was still quite powerful, many educated people would have disagreed with him. Even more objectionable is that when I asked him for the theoretical explanation of why Rolfing worked, he said, "We don't go for head trips here." My sister and I had many a laugh imitating him and deploring his anti-intellectualism.

To this day I have run for my life from any health practitioner who is unwilling to explain the scientific basis of their treatment. This experience inculcated much more skepticism than I had previously felt regarding psychiatrists and allied health professionals.

My mother was paying for my treatment with a psychiatrist named Dr. B. It must be complicated for a psychiatrist when a family member pays for the treatment. Dr. B was the first person I ever knew who called me a schizophrenic. One time I asked her something about myself and she said emphatically, but matter-of-factly: "Steve, you're a paranoid schizophrenic." I have questions about her presentation. I greatly prefer that diagnostic labels be used as adjectives rather than nouns. Also, my diagnoses were to change at various times with various psychiatrists. This is important because although diagnosis is an imperfect art/science, it greatly impacts the treatment of the patient in that it determines what medicines are used. In the end, probably all that anyone can know is that a sufferer suffers.

It was about this time that my condition worsened greatly. One day, walking down the street, it suddenly occurred to me that I might be murdering people in my sleep. I was too sick to be able to dismiss that as a fantasy. I lived in communal housing and began to fear that I was killing my housemates. Every morning when I woke up I would invent a pretext to knock on their doors, asking for something I had supposedly lost. I was checking to see that they were still alive.

Dr. B tried to reassure me that I wasn't killing anyone. She said if I did she wouldn't be able to help me any more. I'd be put in the criminal justice system. At that time there was a hanging in Delaware for a murder which I found very chilling. But a turning point came when I told Dr. B that I was suicidal, and she called my mother because it was her ethical duty. My mother, however, enraged me by coming to a session with me and Dr. B and ranting about me getting a job.

My worst memory ever was when my sister killed herself five years later, after my mother had given her a really hard time. I've never completely forgiven my mother for that, even after she died. I don't know how Dr. B could have handled it differently.

The drugs [I was being prescribed, Haldol, Navane and Stelazine] were of course just a few years old and those of us who took them in the fifties, sixties and seventies in effect were guinea pigs. Nobody in psychiatry intended it that way, but we were experimental subjects.

I don't think mental health professionals fully realized how deadening those drugs really were, but we, the patients, were loudly saying so even then.

Psychiatrists back then lacked training and awareness about my feelings of unreality or solipsism. No one raised it with me. You can't ask people to be ethical about something they are unaware of. As I look back I see they were still emerging out of the Freudian era, blaming the mother, etc. Another trend was toward biological psychiatry, which put a new emphasis on brain chemistry. That made people even less inclined to think about existential issues. In any event, will there ever be medication that could effectively treat solipsism and related states?

Most mental health professionals I saw supported me in my need to follow my own path in life and recognized my severe handicap, and that I was not going to be able to support myself and my daughter. My mother was fanatically devoted, dogmatic, and cold in her demand that I be able to work and be independent. I believe it is always ethical to stand up for a patient on his/her own terms, not the family's terms, even when/if the family is paying for therapy.

In my twenties and thirties I was figuring out that older men rarely approved of me—this was my feeling anyway—because they were so unlike my bohemian, idealistic father, whom I loved and admired. The problem was that most of the psychiatrists and professionals were men. Another handicap was that none of them knew enough, or cared to find out enough, about my communist left-wing background. My expectations about myself and career success were different than for most people. I had just graduated from Stanford, and success was expected of me, which caused puzzlement and in some cases offense.

As stated by Radden and Sadler [2010] in *The Virtuous Psychiatrist*, the psychiatrist should make more effort than others to step out of their own background and learn something about the patient's existential experience and personal history.

The switch to a biological model as the dominant paradigm in psychiatry was mostly good but created new difficulties for patients. For instance, I got labeled with a slew of unflattering personality disorder diagnoses because these were being used by inpatient hospital psychiatrists who had no history or long-term knowledge of me. Later [some of the diagnoses were] flatly contradicted by several other psychiatrists. These diagnoses never felt completely accurate to me because I am not the loner classically described in schizoid personality disorders, nor do I have the relationship instability of a borderline personality. In fact I am very social and have longstanding friends.

Psychiatrists are in a terrible position. Most people who walk through their doors bring with them all their previous life experience. Of course I've finally realized that that's the nature of human interactions, and that modern psychotherapy doesn't create this but merely intensifies it. But the stakes are higher in psychotherapy because people are miserable and trying to get help. They are vulnerable and so dependent on their psychiatrist. The modern therapeutic setting encourages honest talk about otherwise taboo topics, therefore there's an extra burden on mental health professionals to get to know the client in depth and not make snap judgments until enough data have been gathered.

One psychiatrist, Dr. W, was correct in her assessment of a lot of my problems as OCD. However, she closed her practice abruptly with a phone call to each of us. It was shocking in

the extreme. She had undergone cancer surgery and apparently had been near death. That's a pretty extenuating circumstance, but what she did to terminate her practice without providing for transfer to other doctors, was indeed unethical. I heard later that she had been censured by the County Medical Society for that. The phone call in which she informed me of her decision was so shocking that I had one of the most intense experiences of derealization that I had had in years. I remember everything going very still and quiet and seemed ready to disappear physically.

I started seeing Dr. S but soon realized I didn't like him. I think he'd been a military psychiatrist. He seemed to think his function was to repair patients enough to be shredded again by the world. He infuriated me by taking family phone calls during sessions. One time, during such a call, he discussed what kind of French bread to have for dinner that night. I fired him.

I switched to Dr. A. I was trying to overcome my phobia of the very nearby state penitentiary that carried out executions. Insane as this seems to me now, I seriously half-believed that if I saw this prison which was very visible from this county's main freeway, it would mean that I had committed murders previously in another state. I would do everything possible, as I stood at the bus stop, without being conspicuous, not to see the prison out of the corner of my eye. I kept this up for nine years. It was torture.

I am quite sure I discussed this phobia/delusion with Dr. A; I was powerless to completely eradicate it. He and I worked on strengthening my more rational self. He never tried to desensitize me by telling me to look at the prison or tour it. For this reason I consider him to have been highly ethical. He offered relief, palliative care. I think it was the right thing for him to do since propping me up, in a sense, enabled me to hold a full-time job for three years, take care of my father for eight years until his death, and work on establishing a relationship with my daughter who was living nearby.

Steve Weiner, interviewed by Susanne Petermann

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Psychiatrists have written much about the explosive expansion of scientific knowledge of the brain which developed over the late 20th century and the early 21st century. Comparatively little has been written within the field of psychiatry about the changes in society and world culture over this same period, and even less on the scope of psychiatric ethics that would account for these changes. Yet psychiatric ethics is an excellent framework in which to examine social changes in the field over the past 25 years, changes which are dramatic in nature and profound in impact.

Some of these social changes include multiculturalism and its associated diversity of values; the transition to the digital era with its new demands on confidentiality, clinical boundaries, and privacy; the empowerment of psychiatric service users as full participants and co-producers of care; the development of new technologies of assessment and treatment, varying in their invasiveness and risk; the recognition of expanded social roles for psychiatrists, and the associated virtues of psychiatric citizenship; and the development of new practice models, settings, participants, and oversight, all of which represent profound challenges and opportunities for the ethical practice of psychiatry.

The Oxford Handbook of Psychiatric Ethics is the most comprehensive treatment of the field in history. Written and edited by an international team of experts, this landmark book provides a powerful and important review of psychiatric ethics in the 21st Century.

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