# *Compounding Your Problems: Turning a Person into a Label*

## *by Peter Linnett*

*'The longer I live, the more convinced I become that one of the greatest honours we can confer on other people is to see them as they are; to recognise not only that they exist but that they exist in specific ways and have specific realities'* - Shiva Naipaul, 'The Illusion of the Third World'

*'Identifying with a group or a syndrome or a diagnosis is giving in to an abstraction. ... the mental health system labels people schizophrenics, alcoholics, and survivors so that it can bring some order to the chaos of life at home and on the street, but each person has a special story to tell, no matter how many common themes it contains'* – Thomas Moore, *Care of the Soul*

**From individual to psychiatric patient**

Do you think it could never happen to you? Many people have thought that.

Stephen Frost is 32 and works in the marketing department of a multinational electronics corporation's London office. An only child, he was brought up in a conventional, comfortably-off middle-class family in Hertfordshire. He likes to think of his childhood as being quite happy, at least at home; he was sometimes bullied at school. Stephen never mentioned it to his parents and forgot about it after leaving school. At university he gained a B.A. at university, and when he failed to find a job his father used his contacts to get Stephen a post in a public relations firm – a glorified clerical job. He found this environment stimulating, discovering that he had a talent for organisation and a way of charming people; he was soon promoted. From there he moved on to commercial marketing jobs in several companies, before landing his present 'marketing executive' post. It involves long hours and fitting in to a competitive, pressurised environment. He finds it exhausting, but likes to tell people he enjoys his work. Home is a flat in Wimbledon he shares with his partner Vanessa, who works in advertising. Stephen thinks of himself as being a pretty average guy.

The atmosphere in Stephen's department changes after his boss moves to another job. His new boss is a woman of Stephen's age, who tells the team bluntly that she intends to make changes. Things are too slack for her liking. She seems to target Stephen in particular, criticising his work in front of colleagues and ordering him to make changes that mean working even longer hours. Resistant to Stephen's charm, she implies on one occasion that his behaviour towards her is sexist. Before all this Stephen usually didn't get enough sleep, but now gets even less – partly because he stays late at the office and goes in early, but also because he's started to feel very anxious. The anxiety is accompanied by strange feelings he cannot explain. At times he even dreads going to work. Somehow this woman knows how to get under his skin; he feels she is doing it deliberately. Vanessa says he's simply being paranoid, which only makes him feel worse. He goes to his G.P., who prescribes sleeping pills.

No matter what he does, it's never good enough for his boss. She always wants it changed, and if this threatens deadlines she transfers Stephen's work to one of his colleagues. Their survival instinct comes to the fore, and Stephen soon starts to feel frozen out at lunchtimes and their habitual Friday evenings in the pub. Soon he takes to eating lunch at his desk, and makes excuses on Friday evenings.

He becomes obsessed with what he is doing wrong, and his work deteriorates. His behaviour towards his boss becomes more deferential. This only makes things worse. She makes it obvious she despises him - at a product launch meeting she says 'Stephen's proposals are rubbish', and throws the pages down on to the table. Some of them fall into the laps of two colleagues, who pick them up gingerly, as if afraid of being contaminated. Stephen's face turns bright red, he looks down at the table to avoid his colleagues' eyes: this is the turning point for him. After a few seconds he gets up and leaves the room. Silence.

He then goes to his desk, picks up his jacket and briefcase and heads for the lift. In the lift he finds himself shaking uncontrollably. Once outside he feels sick and disoriented, and wanders around for some time before finding his way to the tube station. Immediately on arriving home he goes to bed and is still there when Vanessa comes in at 9p.m. He is still shaking and will not or cannot speak to her. Next day he remains in bed, will not eat or talk to Vanessa. He lies there staring into space. Later he does talk - but to Vanessa and the G.P. she calls out, it only sounds like gibberish.

The rest of Stephen's story can be quickly summarised. He is sectioned, injected with anti-psychotic drugs, and given electro-convulsive 'therapy'. After a while it becomes obvious he cannot return to his job. His parents and Vanessa visit - as do some of his friends, for a time until their loyalty is tested too far by the radical change in Stephen and the dreariness of the ward. After a few months Vanessa's visits become less frequent. This was not part of her life plan. Stephen is released to a hostel unfortunately located not far from where he lived. His parents would like him to stay with them, but hospital staff are adamant he would be better supported in the hostel.

He has a psychiatrist, a community psychiatric nurse, and a support worker, plus a diagnosis of 'schizo-affective disorder'. No one seems particularly interested in what led to his present condition, or in helping him to gain redress. He says to his nurse, 'I don't know what's happened to me'. Sometimes when he goes out, children jeer at him, 'He's from that mad place – nutter, nutter!' He looks and feels defeated. In the hostel's living room, he wonders why he is here with these people. He feels a judgement has been made on him. Somehow, it seems final.

**Classified, categorised, labelled**

Sadly, Stephen's story is a common one. A person who has experienced injustice, abuse and humiliation has his life taken away from him, and is made to feel it is his fault. I think there is something more to be learned from his story.

Of course Stephen has been subject to 'stigma', 'discrimination', 'exclusion', all the things we read about endlessly in mental health publications. But what I call the 'social exclusion approach' does not inquire deeply enough. *Why* does this happen? How does a person reach the point of becoming subject to these attitudes? True, Stephen has been through a devastating experience. But it is possible to endure experiences just as shattering

without ending up the way he has. It is even possible to enter the psychiatric system without ending up the way he has. Stephen's loved ones did not know what to do when an emotional tidal wave crashed over him. They handed over responsibility to the professionals. Those responsible for caring for him stuck to their habitual rigid script to tell them what to do. The focus moved away from *the individual* and *what he had been through*. The result: a person was turned into a label. Stephen unwillingly became part of a group called 'psychiatric patients' or, in the jargon, 'users of mental health services'. And, unless he is very lucky, that label will define him for the rest of his life.

What makes it possible for Stephen to be 'stigmatised'? His being classified, categorised, labelled – socially, and visibly, thus denying his 'specific reality'. 'Psychiatric patient' is only one of numerous 'groups' within which thousands of millions of people are included: 'the elderly', 'people with learning disabilities', 'single parents', 'asylum seekers', 'inhabitants of the third world', 'the disabled', 'drug addicts', 'the working class' - and many more. This has profound consequences that are always ignored in favour of the more obvious ones. As societies become more complex, the greater is their tendency to operate in this way. The answers tell us a lot about modern societies, the ways we think or are made to think, and how we behave toward others.

**Your label, my label**

Communists and intellectuals used to refer to 'the masses' – 'the people' who would either rise against their class oppressors, or remain passive consumers and recipients of 'mass entertainment'. How patronising – those who used such terms doubtless considered themselves 'superior' and not part of any 'mass'.

'Communists' and 'intellectuals' are themselves groups, and not homogeneous ones either. The world is big and complex. It is impossible never to resort to lumping people together. If we insisted on seeing everybody in their unique reality, all the time, life would soon become impossible. To make it manageable, we have to generalise to some extent. Sociologists tell us we are moulded largely by class and institutions – that we are not as individual as we like to think. True, we live all our lives under the influence of these institutions. And designated 'groups' do have common attributes. Most 'single parents' have similar pressures and problems. So do most 'asylum seekers'. I am a writer: like most writers I work alone, but we find common cause in the difficulties facing us. For societies, institutions, organisations and associations to exist at all there has to be a recognition of our common humanity.

All this doesn't let us off the hook. Yes, we can only exist and realise our humanity within tribes or societies. 'Without the individual, the rest is nothing,' wrote Brian W. Aldiss. If individuality is suppressed, what are those tribes and societies except means of survival without a wider vision? Biologists tell us we are genetically unique individuals; creative geniuses change the world with works and ideas that could have come from no other individual, ever; societies stagnate when they are dominated by small groups that crush dissent and original thought.

I see our individuality as a radical form of freedom. It is too radical for us, so we fear it. We discourage it, suppress it, absorb it into a mass. In response to the new freedom of jazz drumming in the ‘60s, a drummer said: ‘You’re an idiot if you think I like it. Who is able to be free?’ Indeed: to be free is to see life’s possibilities *and* its limits more clearly than those who advocate unrestricted freedom or rigid control. That clear vision is too

painful for most of us.

Limitation of freedom does not come solely from dictators; it does not have to happen in a blatant way. By labelling, classifying and categorising, we limit our own freedom and that of others all the time. This undramatic process is hardly noticeable, and so is all the more insidious. Each label, category or classification is a restriction of freedom.

I would like to describe this process in terms of 'levels of labelling', and the restriction of freedom each label implies. At the first level are relatively innocuous labels/categories such as 'library users', 'pedestrians' or 'concert-goers'. These activities may be important to people, but they are not central to their humanity; negative attitudes are rarely inspired by them. Does this mean such categories are harmless? No – because they are part of a wider process, and they still use labels to describe people Still, they are labels that attach very lightly to people.

At the second level are occupational labels such as 'nurses', 'doctors', 'police officers', which categorise people who do the same work. These labels *appear* to be harmless – but they are much more central to individuals' humanity, because of the nature of their work and its dominating role in their lives. Once they were not nurses, doctors or police officers, and one day they will cease to be: they are assumed roles as well as jobs. We see the doctor, the nurse, the police officer; we can choose to forget the person. Their role becomes more important than their humanity, and so their freedom is reduced. Perhaps this is why they are so often criticised and blamed. Malpractice and wrongdoing should not be excused, but my impression in reading accounts of such situations is that the role or label has taken the place of the person.

To complicate the matter, 'role-holders' may sometimes be only too willing to let their role conceal their humanity. Their freedom is then reduced still further. But people *can* step out of this type of role, temporarily or permanently. When they go home and take off their uniform, they may be feeling drastically affected by their day's work – but they are no longer *visibly* what their uniform denotes.

It is at the third level of labelling that this process goes several stages further. So-called 'asylum seekers' are not always identifiable as such - but I can think of several ways in which they are or have been. In parts of London they can be seen queuing outside Refugee Council offices. At the time when the government was controversially giving asylum seekers food vouchers instead of money, I saw two women at a supermarket checkout vainly asking for change from their vouchers. Their presence is obvious in smaller towns – where they have usually been moved unwillingly – making them subject to prejudice, verbal abuse, and assault. Their already low status is made even lower by being visible.

At this level of labelling, people might just as well carry a placard round their necks saying 'asylum seeker'. Unlike 'refugee', this is not even a status: it describes something people don't have and are forced to apply for. But even this label can be discarded - if its holders are granted permission to stay. It takes extraordinary tenacity and relentless hard work merely to establish yourself as 'just another person', but it can be done. Redemption is possible.

Down at the lowest or next to lowest levels, redemption becomes even harder. The lowest level of labelling might be that of 'homeless person', whose status is sometimes blatantly obvious and accompanied by a pitiable level of degradation. But there is some sympathy

for people in this situation, and a greater understanding brought about by organisations such as The Big Issue. And many people do find their way out of homelessness. It is a label that can be discarded, even if the experience has long-lasting effects.

The worst labels and the hardest to shake off are those of 'psychiatric patient' or 'mentally ill person'. Within the mental health field, attempts have been made at turning such labels into a 'valued role' - for example, the idea of 'experts by experience'. But these have had no effect on public perception. Why do these labels stick so tenaciously, and what are the effects on the people concerned?

**Needing to see others as 'basically different'**

Public stereotypes of 'mental illness' function as what Thomas J. Scheff calls a 'contrast conception' – in his words, 'a reference point for making social comparisons and self-evaluations'. He adds, 'One clue to the existence of a contrast conception is a highly proliferated vocabulary of vernacular terms, ... Judging from the frequency with which references to mental disorder appear in the mass media and in colloquial speech, the concept of mental disorder serves as a fundamental contrast conception in our society, functioning to preserve the current mores. The displacement of such a convenient concept is probably resisted for this reason.' He was writing about the United States in the 1960s, but his idea is just as valid now: ' ... the average citizen resists changes in his concept of insanity – or, if he is in the middle class, his concept of mental disease – because these concepts are functional for maintaining his customary moral and cognitive world'.

Persons regarded as 'mentally ill', Scheff says, are seen as 'basically different' - even if they appear not to be. This perceived difference is not derived from a person's behaviour. Odd, eccentric public behaviour is not uncommon – especially in big cities – but unless it involves law-breaking or prolonged harassment of others, it will not have serious consequences. Stephen Frost's behaviour did not seem comprehensible, but seen in context it was entirely so. No one took the obvious step of looking at his experience and making the connections.

Stephen's labelling resulted from being *classified* and *placed* with others already categorised as 'mentally ill'. He was given a diagnosis and put in a shared environment – a psychiatric ward. *This* is what permanently compounded his existing problems - not his supposed 'illness', not his behaviour. He was turned into a label by being absorbed into a group and having his very particular experience ignored. He was publicly a patient within the world of the hospital, and became a unit in the psychiatric system; then, in the hostel, he became publicly identified as someone 'basically different'. Properly addressing the causes and effects of his original humiliation would have been hard - but it was possible. Reversing what he has now become will be almost impossible. His role is constantly reinforced by staff, by his environment, by other patients, and by people's reaction to him. His defeated demeanour bears sad witness to the reality of his situation.

I want to spell out the essence of Stephen's situation: *he has been placed with others regarded as being 'the same' as him*. This is a phenomenon so taken for granted we rarely think about it. In ordinary hospitals, ill people are placed together ostensibly because they can be treated most effectively that way. But even the shortcomings of this approach have become evident: the risk of infection, bad food, and a variable standard of

care may mean patients end up worse. How often do psychiatric patients end up worse?

## Maintaining distinctions

Dr Paul Tournier wrote: 'If we send the sick to hospital, the mentally sick to the mental hospital, the infirm to the old people's home, those with nervous complaints to the clinic, and difficult children to the reformatory, it is undoubtedly because they will be better cared for there. But it is also a little bit, whether or not we admit it, in order to remove from our sight these witnesses to human frailty. Civilised society does not like to see distress and poverty.'

Since the advent of 'community care', the segregation of 'psychiatric patients' has not ceased - it has just become more subtle and less obvious. (The unwieldy term for it is 'reinstitutionalisation'.) There are four main reasons for the persistence of this phenomenon. The most important is simply fear. People seen as 'basically different' need to be kept apart. If complete physical separation is not possible, then there will be partial separation – with people living in hostels, 'supported houses' and 'secure units'. Many of these are now run by private companies; there is money in it. People living in their own homes are not safe either. 'Assertive outreach teams' put pressure on those who, according to Priebe and Turner, 'have been “difficult to engage” or who – in plain English – want nothing to do with services'. 'Early intervention teams' target supposedly vulnerable non-patients with the aim of turning them into patients. The psychiatric state is nothing if not thorough.

The other reasons are less important, but still significant. Administrative convenience and economies of scale make it easier for services to deal with several or more 'service users' in the same place. The power of health professionals is reinforced by a concentration of patients or clients. Finally, as Tournier suggests, it may be that organisations and professionals genuinely believe people are best helped by segregating them. A genuine belief can still be self-serving.

The distinction between 'the sane' and 'the mad' must be maintained for the public's peace of mind. In many instances individuals will recognise our common humanity, but this is not enough to change attitudes across a whole society.

## Against segregation – a personal manifesto

Lunatic asylums developed as dumps for people society could not understand or cope with, and those who were rejected by their families or husbands. They also 'solved' the problem of fear of 'the insane' – being contaminated and upset by them. From the 19th century onwards, there have been dissenting voices. Pinel, the French pioneer of 'moral treatment', recognised the degrading effects of idle incarceration in large institutions. A 19th-century English reformer wrote: 'Asylums are manufactories of chronic insanity.' This was echoed by the American neurologist Weir Mitchell: 'Upon my word, I think asylum life is deadly to the insane.' This did not discourage the building of more and larger asylums throughout the Victorian era. The policy of segregation has set the tone for mental health services ever since.

I believe that herding people together on the basis of 'illness', diagnosis, condition or 'problems' is a fundamental violation of individual liberty. It is wrong not only to place

people together physically, but even to *think* about others in any way that ignores their 'specific realities'. The reasons or justifications I listed above may seem compelling. But they amount to excuses for the inexcusable. In the specific case of individuals who experience mental distress, just consider the consequences of this way of thinking.

Occasionally I hear people express a bizarre nostalgia for the old psychiatric hospitals. They were 'home' to many people for so long, it seems a shame they had to close; they weren't all bad, they were a kind of community; patients understood each other's problems, and supported each other; the routine and lack of responsibility helped you to focus on what was distressing you; some people need a haven... No doubt there is a measure of truth in some of these observations. The same things might be said of any psychiatric set-up, especially when it closes and there is supposedly 'nowhere' for those people to go.

I invite people who think like this to go to a psychiatric ward, a hostel, a supported house, a day-care centre; to talk to the people there; and to ask: W*hy are these people here? Why are they here together? What (and whose) purpose is being served?* They will find it very hard to say honestly that the best interests of those individuals are being served. Certainly, interests are being served – the government's, the community's, the organisation's, the workers'. Organisational rhetoric insists that the interests of 'service users' are paramount, but it is a lie.

I do not believe that anyone would freely choose to enter any psychiatric institution - *if* they had full prior knowledge of what such a step entailed. At the one time in my life when I felt so disturbed I might have landed in a psychiatric ward, I avoided it – because I knew what was happening, and I knew what steps to take to find relief and support. The *very last thing* I wanted and needed at that time was to be placed among others equally or more disturbed. It would have had the most destructive consequences. Even if the ward had been luxurious – and I need hardly add that no NHS ward is like that – it would have made no difference. I did not need to be diagnosed, labelled, and categorised – to be completely removed from normal life, and to be put among others supposedly 'the same' as me. Campaigners for 'improvements' in psychiatric hospitals do not realise the essence of these institutions is always destructive: superficial changes will never alter that.

Would other patients have understood and supported me – or me them? This is very unlikely – most patients are too deep in their own misery and confusion to make genuine contact with others. I know it does happen – but why should people have to enter the dismal environment of a psychiatric ward to get this support? It reminds me of Camus' note about military camaraderie, 'the sordid and sticky fraternity in face of death in battle'. Why do you have to risk death to find camaraderie? Why do you have to descend to the lower depths of society to find understanding? If people always got genuine support from those trained and paid to give it, things might be better. But so often they do not get it.

You may object that things must be better in a more 'normal' or 'community-based' environment such as a 'supported house', a hostel, or a day-care centre. There is nothing normal about them. I lived in a 'supported house' for a year – a very long year. The anti-social and self-destructive behaviour of others went unchecked, and there was certainly no support. I felt terribly unsafe in the house, and this contributed to the worst breakdown I have ever had. My existing problems were greatly compounded: I live with the consequences to this day.

Some 'supported houses', hostels, day-care centres may be considered good by the

people who live in or attend them. They may say they have been helped. I say there is always a hidden cost – not only to those people, but to everyone involved. The clients' individuality and liberty have been diminished, and staff have had their own humanity diminished by categorising others and forgetting that they each have 'a special story to tell', in Thomas Moore's words.

All psychiatric institutions exist because of decisions made by governments, organisations and professions. People are then coerced into entering them, or encouraged to: either way, choices have been made for them. When others make choices for you, your freedom is being taken away.

I know I am being Utopian: there will always be people who need help and support. All I ask is that such help impinges as little as possible on the person's individuality and liberty. If organisations herd people together – either physically or in categories - I want them to be honest about their reasons. Let things be seen as they are, behind the smooth front that mental health organisations and psychiatrists present to the public.

Stop compounding people's problems by breaking them to fit into a category.

**Note on sources**

The following authors and publications were valuable sources for this essay:
Shiva Naipaul, *An Unfinished Journey*; Thomas Moore, *Care of the Soul*; Brian W. Aldiss, *This World and Nearer Ones*; Nat Hentoff, *The Jazz Life*; Thomas J. Scheff, *Being Mentally Ill: A Sociological Theory*; Dr Paul Tournier, *The Meaning of Persons*; Stefan Priebe and Trevor Turner, 'Reinstitutionalisation in Mental Health Care', *British Medical Journal*; Albert Camus, *Selected Essays and Notebooks*.