# From Generation To Generation:
The Personality Disorders Service and Kingston's Psychiatric Tradit

When I came to Kingston in 1995 to work in the Department of Psychiatry at Queen's University, I glanced over the contract, my eyes lighting upon my designated retirement date: 2010. My response was the same as my reaction to Orwell's book, *1984*, when I read it in 1960: How distant! It was more like science fiction than reality. Now both those dates have come and gone (although I have not, in fact, retired) without seeming strange or futuristic at all. I, however, seem more aware of the past than I used to be. The past does not seem as ancient and, well, historical, as it did when there was so much future ahead of me.

I am the clinical leader of the Personality Disorders Service, a primary role in my work as a Queen's faculty member. The Personality Disorders Service is by far the smallest program under the aegis of Southeastern Ontario's Providence Care Mental Health Services, treating people exhibiting the wide range of symptoms that are collected under the diagnostic category "Personality Disorder" or "Borderline Personality Disorder". Its six clinical staff represent four professional disciplines. Two nurses, two psychologists, and a social worker all lead groups; our psychiatrist assesses and consults two days a week. For 18 years, the Personality Disorders Service has been growing and changing in order to help suffering people in southeastern Ontario. The efforts we have been making for almost two decades to reach out inventively and effectively to human beings who are in states of confusion and pain echo similar struggles that have taken place
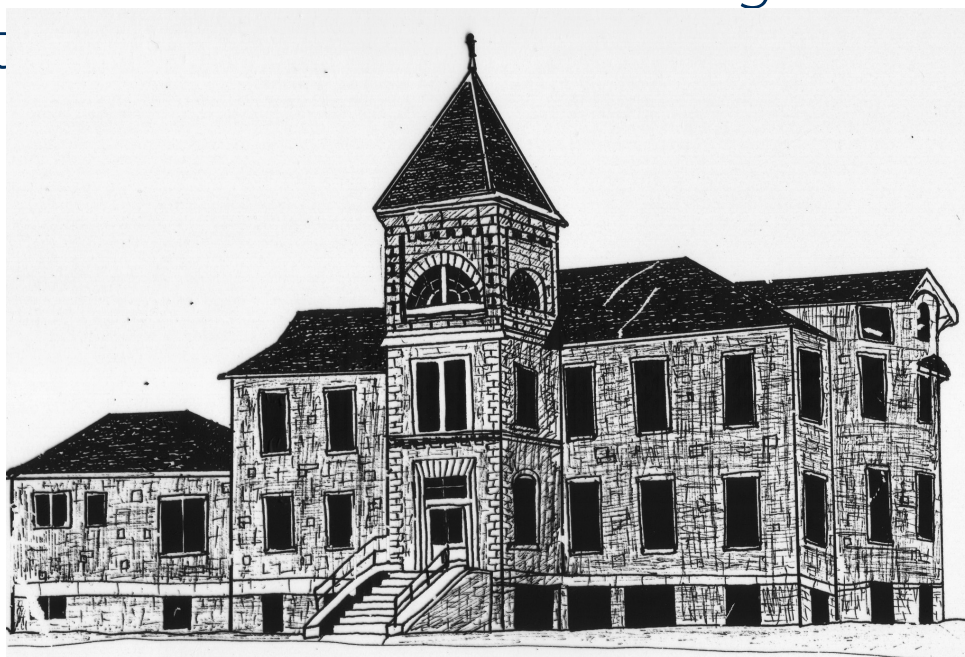
A drawing of Beechgrove Cottage by a Chrysalis Program participant. Used with permission.

in Kingston for a much longer period of time. It only takes a short walk through the grounds of Providence Care to remind me of this.

For the Criminally Insane, Built by Prisoners

Providence Care Mental Health Services is a large psychiatric treatment facility, which traces its roots back to the Rockwood Asylum for the Criminally Insane. Rockwood was commissioned by Province of Canada premier Sir John A. Macdonald and was built in 1859 by Kingston Penitentiary inmates. These inmates were imprisoned down the road from the asylum, in another example of Kingston's iconic lakeside limestone institutional architecture, and both Kingston Penitentiary and the Rockwood Asylum were designed by City of Kingston

architect William Coverdale. The penitentiary was opened in 1835, decades before Canada became a country, and the prisoners were conscripted to build the asylum to house mentally ill inmates. The institution began accepting non-criminal patients in 1868.

Rockwood's massive limestone edifice still stands, just down the hill from Providence Care Mental Health Services. In

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Welcome to the Fall/Winter 2013 edition of Synergy.

This issue presents three articles that show some of the breadth of the discipline of psychology. Two authors are academic psychologists here at Queen's University in Kingston.

Dr. Margo Rivera's extended essay puts the Personality Disorders Service in its local and historical context, providing a rich description of the programme itself, as well as its history and that of related endeavours in Kingston and Ontario.

Dr. Ron Holden's essay describes, and summarizes the literature (including his own pioneering research), on "Psychache," a phenomenon with growing empirical evidence to support its relevance and clinical use.

Finally, we have a book review, which, in itself, shows the breadth of psychology and psychiatry, as the book deals with behavioural economics, a field that might seem to have little relevance for the busy clinician, but one that is growing – even trendy perhaps – and may bear directly on how our patients fare.

We hope you enjoy the prose and, as always, welcome your comments.

SYNERGY **SUBMISSION GUIDELINES**

Synergy invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.

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Articles may be submitted in the form of a Microsoft Word document as an email attachment.

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Ongwanada

the last decade of the 19th century, two large limestone cottages were built on the asylum grounds to provide long-term patients with a more home-like setting. One of these, Beechgrove Cottage, rests on a cornerstone carved with the date 1893. This building became the home of the Personality Disorders Service and the Chrysalis Day Treatment Program a little more than a century later.

The Chrysalis Program Is Created

The Chrysalis Program was created by the staff of the Personality Disorders Service in May, 1995. In my first three months of practice in Kingston, I would visit my patients daily on Ward 15 in the Kingston Psychiatric Hospital (as Providence Care Mental Health Services was then called). A sub-group of inpatients, usually seven or eight young women who were diagnosed with borderline personality disorder (and sometimes major depression, bipolar disorder, anorexia nervosa, and a wide range of other Axis I disorders), would be found sitting in the wide hall, on the tiled floor, leaning against the walls, facing each other. They would chat together and laugh together; sometimes they would roll a rubber ball back and forth across the hall. Every now and then someone would yell or cry, and run to her room or into the bathing facilities. They might hurt themselves, or try to kill themselves, and the nursing staff would rush to deal with the crisis. On most occasions it was not long before they were back on the floor with their buddies, rolling the ball across the hallway, perhaps sporting an extra bandage or two.

For the most part these were patients who, after they were discharged, would haunt the emergency rooms of their local general hospitals in Belleville, Trenton, and downtown Kingston, begging for care of some kind so that they did not always have to feel so scared, so distraught, and so angry. Some health professionals they encountered felt sympathy, while others rolled their eyes and labeled them "frequent flyers" and "manipulative". They were prescribed medication, which rarely did much to ameliorate their volatile symptoms and relational turmoil. Sooner or later, they found themselves back in the psychiatric hospital, having hurt themselves or made serious attempts to kill themselves.

The staff of the Personality Disorders Service decided to try developing a program that would meet the obvious need of these individuals to gather as a group, and to add a dose of therapeutic treatment to their time together. We didn't do much planning; we didn't complete a needs assessment or a literature review. We invited inpatients and outpatients who seemed to have a similar set of problems – morbid fear of abandonment; unstable interpersonal relationships, affect, and sense of self; destructive and self-destructive behaviours; and constant self-sabotage – to participate in a two-day-a-week treatment program, which came to be called Chrysalis. I had treated trauma survivors for 25 years and had lots of experience leading groups with a psychodynamic approach; other staff were experienced in expressive therapy and in delivering treatment for people struggling with eating disorders. After attending the Chrysalis program for a few months, all of the participants stopped being admitted regularly to hospital, as their need for focused care and validation of their suffering and their struggles was met in the group setting by both staff and their co-participants. They participated in a range of psychotherapy groups, cooked and ate communal meals, expressed themselves through art and music, and went on three-day camping trips at the end of each summer. They played sports in the field at the bottom of the hill next to the old Rockwood Asylum that, though empty, still looms impressively over the lake.

The gigantic old building was opened for community use during the ice storm of 1998, and many vulnerable Kingston residents who were blacked out, cold, isolated, and fearful in their homes were housed there until the power grid was re-built and electricity was restored to Kingston. During those two challenging and memorable January weeks, the Chrysalis participants walked down the hill after their morning groups and spent the rest of the day serving and cleaning up after meals provided by the hospital kitchen, chatting with elderly people, entertaining children, and rocking fretful babies. That communal experience of helping others who were – at least temporarily – more needy than they were, reinforced the values of self-respect, compassion, and generosity that had been developing as core aspects of the Chrysalis Program.

After five years in the main building of the psychiatric hospital, the Chrysalis Program moved into Beechgrove Cottage in 2000. The move provided considerably more space, and additional programs were then offered to the community by the Personality Disorders Service. A decade later, in 2010, trading a beautiful, historical setting for a smaller, mold-free, and much more central location, the Personality Disorders Service moved to LaSalle Mews in downtown Kingston.

New Attitude Toward Mental Illness

In 1877, the Rockwood Asylum became part of the Ontario Provincial Asylum System, and Dr. William Metcalf was appointed its superintendent in 1878. Dr. Metcalf and his assistant (and brother-in-law), Dr. Charles Clarke, were both students of Dr. Joseph Workman, a mid-nineteenth-century psychiatrist and superintendent of the first asylum for the mentally ill in Toronto, which is still in operation today. Workman initiated an elaborate system of what was framed as *moral treatment*, an approach to the treatment of the mentally ill based on humane care that emerged in late 18th century Europe, deriving partly from psychiatry and psychology and partly from religious or moral values.

Workman, a founding member of the First Unitarian Church in Toronto, was a pioneer of liberal religion in Canada, and he incorporated his personal values into his professional practice.[1] "Unvarying kindness, never-tiring forbearance, and undeviating truthfulness," he declared in 1858, "are the cardinal moral agencies now employed in every well-conducted Lunatic Asylum."[2] These attitudes were coupled with worthwhile employment, social entertainments, and religious instruction – activities designed to divert the patient's mind from a preoccupation with morbid thoughts and emotions. Metcalf and Clark imported this treatment framework to Kingston, creating significant reforms at the Rockwood Asylum. The widespread use of restraints was abolished, the bedding was upgraded from straw sack mattresses, the food was improved, the tin cups and spoons used at mealtimes were replaced with plates and cutlery, and the patients no longer were required to wear the distinct canvas clothing stenciled with the word LUNATIC. A wide range of recreational activities, including outings into town and on the lake, enhanced the quality of life for both the patients and the many staff who lived in the institution. Among other things, there was a 25-piece orchestra that was celebrated throughout the Kingston area. Rockwood was also one of the first buildings in Canada to be outfitted with central heating.

In 1885, a patient attacked both Drs. Metcalf and Clarke. Metcalf was killed, and Clarke succeeded him as medical superintendent of Rockwood, a position he held until 1905. Clarke continued to make changes; clubs appeared at the hospital under Clarke's direction, with both staff and patients as members, including golf, sketching, photography, bird watching, bicycling, iceboating, bowling, and a glee club. Clarke also established the Rockwood Hospital Training School for Nurses in 1888, the first of its kind in Canada.[3]

The Personality Disorders Service, since it began offering group programming in 1995, has found a place in the psychiatric care system that strikes me as a worthy descendant of Dr. Workman and his nineteenth-century Kingston colleagues. Of course, each generation of professionals develops its own terminology; "Dialectical Behavior Therapy" and "Psychodynamic Psychotherapy" sound less strange to our ears than "Moral Treatment". But are they so radically different, after all?

Always Searching for the Cause

Workman and Metcalf and Clarke strived to create a community in which people suffering from mental illness could live in some degree of peace. They also struggled to discover what predisposed their patients to a state they termed insanity. They made considerable efforts to uncover the physical, psychological, and social causes of mental illness, just as many scientists/practitioners are doing today. Workman's research was meticulously recorded. He conducted 381 autopsies of patients who died in his hospital, during which he searched for lesions, tumors, and other abnormalities that would reveal, not only the cause of death, but also the predisposing factors that caused his patients' mental illness.[4] As well as struggling to uncover the physiological causes of mental illness, the titles among Workman's many published papers (for example, "Insanity from Hunger, Fear and Suffering"[5]) reflect his efforts to explore the social roots of the disturbance he saw in his patients. In the 1869 Annual Report of the Toronto Asylum, Dr. Workman writes about the subtle and complex etiology of mental and emotional disorders: "The time has passed away and can never return, when insanity was treated as a mere mental derangement, uncomplicated by bodily ailment. How instructive and humbling the thought that functional and structural changes in our organization, often so trivial as to be untraceable, may determine the entire difference between the philosopher and the madman…."[6]

Today we enjoy advances in biological psychiatry, particularly the development of psychotropic treatments for mental disorders, which have made a great deal of difference in controlling some of the symptoms of the most severe mental illnesses for many patients. A wide range of psychotherapeutic modalities have also been developed and found to be empirically supported for the treatment of psychological problems. However, the similarities in today's efforts and those of Dr. Workman's era are almost as striking to me as the differences. Dr. Workman's cry of satisfaction on successfully reaching a patient has been echoed by many of us: "On occasion I discover that which unlocks hidden doors and frees the prisoner from his anxiety. One such success makes worthwhile the hours of toil each day, and wipes clean the slate of failures and disappointments."[7]

The Chrysalis Program Evolves and Changes

When I was invited to become a member of the department of psychiatry at Queen's in 1995, and the locus of my clinical work moved from community to hospital, I brought with me a raft of convictions, including the moral certainty that labeling an individual as having "borderline personality disorder" was an artifact of countertransference, a punitive reaction to behaviours the clinician found particularly annoying. My righteousness about the unmitigated oppressiveness of Axis II diagnostic categories was challenged when, again and again, my hospital patients would point excitedly to the DSM list of criteria for borderline personality disorder, after being assessed, diagnosed with BPD, and referred to the Chrysalis program. They would exclaim – sometimes with tears in their eyes – something like, "Look, that's me! I do most of these things, and the pills I take don't help at all. Can your program really help me?" I have come to understand that – though stigma is certainly and sadly faced by individuals, disproportionately women, diagnosed with Borderline Personality Disorder – there can also be significant advantages to incorporating into an

overarching category the plethora of difficulties that plague these individuals, as long as this labeling leads to accessible and helpful treatment.[8]

At the same time as our Canadian treatment team was developing the Chrysalis Program, teams in the United States and Great Britain were also developing and researching specific treatments for individuals suffering from borderline personality disorder. Through the 1990s, the Chrysalis Program incorporated elements of other treatment approaches and tools as they emerged in the international literature. Two psychodynamic psychotherapies, which are evidence-supported for the treatment of borderline personality disorder, enriched the psychodynamic base of the Chrysalis Program: Mentalization-Based Treatment (MBT)[9] anchored in the growing science on attachment, and Transference-Focused Psychotherapy.[10] Skills groups informed by Dialectical Behaviour Therapy (DBT)[11] were soon introduced for the sub-group of Chrysalis clients whose emotion and behaviour dysregulation was so severe and dangerous that program participation was compromised. These DBT-informed skills groups, addressing emotion regulation, distress tolerance, mindfulness, and interpersonal communication skills[12] were found to be helpful to all participants, not just the targeted subgroup, and the program expanded to a three-day-per-week format to incorporate and integrate all the helpful and evidence-supported treatment modalities.[13]

Another subgroup of clients with particular needs combined borderline personality symptomatology with an Axis I diagnosis of Dissociative Identity Disorder. These individuals were frequently survivors of extreme childhood trauma, and they needed the same kind of help in resolving floridly dysfunctional behaviours and stabilizing their everyday lives as all the other group participants. But their perception of themselves as divided into separate people and, in some cases, their expectation of being treated as such, tended to create a barrier between them and other group members. The Chrysalis staff learned how to discourage these patients from highlighting the separateness of their internal states during groups, without invalidating their distress and the unique defenses they had developed to protect themselves. Instead, they are encouraged to use the language of *parts of self*, which is shared by most of the other group members. Most of the severely dissociative group participants engage in concurrent individual therapy, either with program staff or with community clinicians, where they can acknowledge, explore, and eventually resolve their dissociative states more fully and therapeutically.[14]

Chrysalis: Participants and Programs

Since 1995, over 460 individuals have participated in the Chrysalis Program; more than 90% have been women. A relatively small number of men are referred to the program, and many who are referred exhibit their disturbance in ways that exclude them from treatment with a group of women (for example, engaging frequently in physically and/or sexually assaultive behaviour). The men who do participate in the Chrysalis Program find it as helpful as the women do. The majority of Chrysalis participants identify as Caucasian (90%), with more Aboriginal participants than any other racialized group (5%). The majority of the group members identify as heterosexual, but individuals who identify as lesbian (14%), bisexual (3%), gay male (1%), and transgender (1%) have participated in the group. Many non-heterosexual individuals identify as "queer," a term which expresses their challenge to binary notions of sexuality and gender.

The histories and experiences of Chrysalis Program participants are consistent with those reported in the literature about individuals diagnosed with borderline personality disorder, wherein 60% percent report histories of childhood sexual abuse; 75% histories of childhood physical abuse; and 89% report histories of childhood emotional abuse. Of all Chrysalis Program participants, 25% have suffered from severe physical, sexual, and emotional abuse from earliest childhood through adolescence, as reported on the Trauma Antecedents Questionnaire and frequently documented in medical, child welfare, and/or legal records. 75% of Chrysalis Program participants have attempted suicide, an average of seven times each, before attending the program. Participants report a wide range of other self-destructive behaviours, such as self-injury, addictions, and severe eating disorders, and they have had extensive histories of psychiatric inpatient and emergency treatment. Many have participated in outpatient psychotherapy and inpatient hospital treatment prior to participation in the program, have been followed for years by psychiatry, and have been prescribed an array of psychotropic medications with limited benefit. The program is accessible to people with physical disabilities, and women who are moderately to severely physically disabled participate. Both guide and special skills dogs have been ongoing and much-loved program participants.[15]

Today participants in the Chrysalis Program attend a three-day-a-week program for 15 weeks to stabilize their lives and learn and practice basic emotion regulation and interpersonal effectiveness skills and to apply them to their lives. Tools such as Emotion Sheets and Pros and Cons Worksheets are frequently used by participants in their struggles to understand themselves, their co-participants, and challenging group dynamics – as well as to acknowledge and resolve their often profound ambivalence with regard to behavioural change. Individuals who have participated productively in the Chrysalis Program and still need the support of the program to maintain their stability and increase their capacity to build constructive lives are permitted to re-register for an additional semester, and some individuals participate in several semesters before they are ready to graduate.

New Programs Are Created

The Chrysalis Program was the first group created by the Personality Disorders Service. By the time the program moved from the main hospital building into a much larger setting in Beechgrove Cottage in 2000, it had become obvious that there were many individuals who experienced similar challenges but were not able to participate in a program that was as time-intensive (or, for that matter, as emotionally intense) as the Chrysalis Program. To meet the needs of a wider range of people in the large southeastern Ontario catchment area served by Providence Care, and also to create a therapeutic context in which more men were able to participate comfortably, the Personality Disorders staff began to offer weekly skill-building groups. These community groups are structured to be helpful for individuals struggling with any of the following challenges: low self-esteem, emotional instability, impulsiveness, unstable relationships, a variety of self-damaging behaviours including eating disorders and substance abuse, and suicidal thoughts and/or attempts. 1644 individuals have participated in the range of weekly community groups offered by the Personality Disorders Service. The first community group offered was Managing Powerful Emotions, a ten-week, 90-minute, modified DBT group, in which participants learn specific strategies to help them tolerate intense emotions, deal constructively with personal crises, and examine the pros and cons of enacting destructive behaviour. Now three weekly Managing Powerful Emotions groups, expanded to a 15-week format, are currently offered by the Personality Disorders Service. These are psycho-educational groups that teach participants to use practical tools to understand their feelings and exercise control over the emotional and behavioural outbursts that create significant difficulties in their lives. Currently, an electronic version of the Managing Powerful Emotions group is being piloted. Individuals can choose between participating in a live DBT skills-building group or learning those skills in an online format.[16] Completion of the Managing Powerful Emotions Group is a pre-requisite for enrollment in the Chrysalis Program.

A six-session psycho-education group, the Keep It Simple Skills Group, is an introduction to the four core modules of Dialectical Behaviour Therapy – Mindfulness, Emotion Regulation, Interpersonal Effectiveness, and Distress Tolerance. Both Managing Powerful Emotions and Keep It Simple Skills are self-referral groups. Individuals who are having trouble managing their emotions and/or their behavior and want to learn some new skills can call the central phone number of the Personality Disorders Service (613-542-8344 x 0), and ask to have their names placed on the waiting list for these groups.

Two other weekly community groups are also currently offered by the Personality Disorders Service; professional referrals and a screening interview are required for participation in these groups. Choices is a 10-week, 2½ hour group consisting of two parts: a structured psychotherapy group, followed by dialectical behaviour skills training. Participants' current dysfunctional patterns of thinking and behaviour are challenged through the review of weekly homework assignments, based on Dialectical Behaviour Therapy emotion regulation and distress tolerance tools. Completion of the Managing Powerful Emotions Group is a pre-requisite for the Choices group.

Seeking Safety, a weekly group that is six months in length, is structured to be helpful for people who struggle with the combination of substance abuse and emotion and behaviour dysregulation. The group is designed to teach participants a set of skills to manage their emotional suffering in a more constructive way than through the use of drugs and alcohol. Each participant makes weekly goals and is accountable to the group for meeting these goals.

All groups offered by the Personality Disorders Service, both weekly community groups and the Chrysalis Program groups, are highly structured. Clients are expected to participate in a respectful and disciplined way, even when the internal pressure to explode emotionally is extreme. This practice enables participants to build a much-needed capacity to consider their social milieu and the needs of others, even when their own feelings are very strong.

Empowerment and Respect

The treatment programs of the Personality Disorders Service generally place little emphasis on psychiatric diagnostic categories. In groups we use the language of "behaviour," "choice," "struggle," and "values," finding these words less pathologizing than the medical terminology that describes the array of symptoms the program participants exhibit. As one participant suffering from severe posttraumatic symptomatology explained:

Words are powerful symbols. I cringe each time I hear the term "disorder." I struggle to accept the means I used to survive absolutely horrendous sexual, physical and emotional abuse by my father and other family members. I struggle to celebrate the fact that I found a way to deal with the chaos without going crazy. Our language does not enlighten my struggle; it increases it. I am fully aware that what was once adaptive is now rather messy, to put it mildly. But I am not crazy. I am not ill. I am not a disorder. I am a human face who had to survive in a home that was totally crazy, very sick, and constantly disordered. Please do not define me in terms of their behavior.[17]

Many group participants arrive at the treatment program using diagnostic labels as an excuse for maintaining destructive behavioural patterns ("I cut myself and blow up at people because I have borderline personality. I can't help it." "I had to stay home from group yesterday because I have depression, and my mood was very low"). Most of these individuals are initially defensive and

reluctant to acknowledge the component of choice in their behavior – choices that are frequently not entirely conscious and may well have been adaptive for navigating in-validating environments but are now under-mining of a stable and constructive adult life. Most group participants, however, even-tually feel deeply understood when they hear some variant of, "You seem to be in ter-rible pain, and we can help you learn how to manage your intense feelings." Those who own and gradually come to understand and take responsibility for their own dysphoria and vulnerability – and develop more cre-ative methods of soothing themselves and relating responsibly to other people – even-tually experience a new sense of empower-ment. They often become enthusiastic about taking control over their lives, as ex-pressed by this young participant:

Prior to being in the Chrysalis Program…nobody helped me be responsible for my destructive behav-iour or for my refusal to take basic care of myself… The professionals I was involved with treated me as if I had no choice in these behaviours, and I did take advantage of this view. The Chrysalis Program's view that I was responsible for myself, in spite of my history and my inner struggles, allowed me to see clearly…that being self-destructive was in fact a choice. This enabled me to stop behaving in harmful ways and to start making decisions for myself in re-gards to my life. The result is that I gained a sense of self-respect which I was greatly lacking previously.[18]

All the group programming offered by the Personality Disorders Program combines the use of evidence-supported therapeutic approaches with the promotion of a set of values to establish and maintain a caring, respectful, and challenging community. This provides a framework in which par-ticipants are encouraged to engage con-structively with each other and the staff. The set of symptoms that are entitled "Borderline Personality Disorder" describes a disorder of relationship as well as a disor-der of individual personality. People who are diagnosed with borderline personality are attempting to meet their need for

human connection, both with people in their present-day life and through their in-ternalized relationships with significant people in their earlier lives. They are, how-ever, desperately trying to bond with signif-icant others, both external and internal, according to family rules that are fated to lead to failure and suffering. In the group programming, therefore, change is initiated and reinforced in the context of the build-ing of relationships – relationships in which all participants are challenged to be respect-ful and mature. One of the early groups of Chrysalis participants created what they called a "Program Covenant," which has been tweaked in response to evolving group dynamics over the succeeding years. Generations of participants have found this agreement helpful in defining what exactly are the values of the program that make it an environment of empowering and healing relationships (see Table 1).

From Generation to Generation

The nineteenth-century psychiatrists and nurses who worked so hard at creating a humane community at the Rockwood Asylum did not have access to the sophis-ticated and complex treatments we offer today, but their efforts to establish a respectful and enriched therapeutic environment – what they referred to as "moral treatment" – strike me as the histor-ical roots of the Personality Disorders Service's ongoing development of treat-ment community in Kingston. Now know-ledge achieved through the work of the Personality Disorders Service is being com-municated to psychiatry residents and psy-chology students from a range of academic programs and to the multidisciplinary staff of mental health agencies throughout Ontario. What we have learned regarding humane and helpful therapeutic commu-nity is being passed on to future genera-tions of mental health professionals, just as our predecessors passed what they learned on to us.

I have found a safe place I never dreamed existed – a place where I've been given permission to acknowledge the rage I carry and to use that rage constructively to explore and question the beliefs that regulate my life….I'm being encouraged and challenged….I am being shown it is okay to have a voice of my own…. For the first time in my life, I now know I have both the right and the power to make my own choices.[19]

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Rockwood Asylum ca.1910s. 1021.44-1, on loan to the Providence Care Archives from the Archives of Ontario. Used with permission.

TABLE 1
Chrysalis Program Agreement

Show respect for myself and for others':
- Differences
- Struggles
- Opinions
- Beliefs
- Confidentiality

Take responsibility for:
- being aware of how my actions and words affect others
- not judging others based on race, religious or cultural beliefs and backgrounds, sexual orientation or gender identity
- showing tolerance towards co-participants, recognizing that everyone's struggle is difficult
- not acting out destructive and self-destructive behaviours in program; that is, no physical violence towards others, no verbal lashing out at others, no self-harm
- learning how to speak about my experiences in groups in a way that does not upset or scare other participants; for example, no graphic details of traumatic experiences, past or present, speaking instead about my feelings and my struggles
- not dumping my problems on the laps of others; not asking that others rescue me from myself
- encouraging others to be responsible for themselves rather than rescuing them
- being rigorous about confidentiality; not disclosing any information from program to non-participants
- being open in group about my own struggles and asking for help when I need it, rather than waiting for someone else to notice that I am in trouble
- bringing grievances and disagreements with others out directly in the group
- being willing to listen with an open mind, even when what is being said is difficult to hear
- being open to challenge and constructive criticism
- meeting weekly goals whenever possible and acknowledging openly when this is not happening rather than waiting for someone else to point it out
- attending all groups for which I have signed up and arriving at groups on time with homework completed
- paying attention to what others have to say in groups, rather than fidgeting, doodling, sleeping, etc.
- understanding that anger and power struggles with staff and other participants are to be learned from, not suppressed or acted out
- not socializing with co-participants during my first semester
- not engaging in any sexual behaviour with other program participants
- bringing back to group anything I am concerned about that occurs or is said in social situations with other program participants
- not gossiping or spreading rumors
- being discrete about taking medications
- notifying the program anytime I have to be absent, so that others do not worry about me
- sharing computer time, telephone access, and other program resources fairly with others
- doing my share to maintain a clean and pleasant physical environment

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Psychache as a Cause of Suicide

RONALD R. HOLDEN

Introduction

Imagine the worst pain that you have ever felt in your life – physical or psychological. Maybe it was associated with childbirth, maybe it was associated with the death of a family member, maybe it was associated with a horrific accident such as a fire or being impaled. Take that pain, multiply it many times over, and, now, experience it rather than imagine it. Further, know that it won't go away! You are beginning to understand the magnitude of the essence of what Shneidman termed "psychache".[1]

Psychache is an emotional experience difficult to capture in words. A visual representation such as Edvard Munch's "The Scream" (although "The Shriek" might be a better Norwegian-to-English translation) is a possibility, as is the sketched Figure 1 below. The state of unbearable anguish, despair, and desperation is central to the phenomenon.

Figure 1 – The Anguish of Psychache. Reprinted with Permission.

What do I think of when I try to imagine the pain that is akin to psychache? I think of an event in my teenage years when I had a serious health issue that was causing me to move slowly, but steadily, towards death – my heart and lungs were gradually being constricted to the point where, untreated, I would die. For me, fortunately, there was a treatment and, with great trepidation, I underwent surgery at the Hospital for Sick Children in Toronto. The surgery was long, the recovery took years, and the associated pain was only bearable because of extensive pharmacological intervention. Shortly after my surgery, despite an intention to keep me unconscious by sedation for the first post-operative week, I awoke one night screaming – the pain was unbearable, unbelievable, I was well past the point of even being able to cry, and I was certain that I was rapidly descending into Hell. Of course my screaming brought an immediate intervention and I was sedated and returned to unconsciousness for a week or more. For three decades after that event, I could not just remember the agony, I could re-live it. For the past 12 years, I can still remember the pain but, thankfully, no longer re-live the experience. Yet, somewhere in the recesses of my being or my soul, I know that this pain still lurks. To me, this must be what the agony, the forever-lasting black forsakenness, the Inferno, the Hell of psychache is like.

Definition of Psychache

Psychache is a term that was coined by Edwin Shneidman, who is regarded as the father of suicidology and was one of the founders of the Los Angeles Suicide Prevention Center in 1958. Psychache refers to the free-floating, non-situation-specific state of unbearable psychological pain, anguish, horror, terror, despair, or more generally, extreme mental perturbation. It is an affective phenomenon that is conceptually and empirically distinct from cognitive states such as depression or hopelessness.

Why is Psychache Important?

Almost four thousand Canadians die by suicide each year and, worldwide, approximately one million suicides occur annually. Shneidman asserts that psychache is the *cause* of suicide. Suicide is an escape from the unbearable pain of psychache. All other factors that are associated with suicide are only related through psychache. For example, according to Shneidman, the well-established links of depression and schizophrenia with suicide exist only because of the mediating effects of psychache. No psychache, no suicide. Psychache is a necessary condition for suicide to occur. Research has established and repeatedly confirmed significant links between psychache and various suicidal manifestations such as suicide ideation, suicide motivation, suicide preparation, and previous suicide attempts. Further, the significant relationship between psychache and suicidal behaviours is maintained even when other risk factors such as depression or hopelessness are statistically controlled. These findings have been demonstrated in multi-year longitudinal studies that are still ongoing.

How to Measure Psychache or Mental Pain?

Three self-report scales are most commonly used to measure psychache. First, inspired by the Thematic Apperception Test, Shneidman's Psychological Pain Assessment Scale was published in 1999 and is primarily a projective test though some structured components are included.[2] Second, in 2001, Holden and his colleagues published the 13-item structured Psychache Scale (see Table 1).[3] Items are responded to using 5-point ratings. Third, Orbach and his associates published the Orbach and Mikulincer Mental Pain Scale in 2003.[4] That scale comprises 44 items responded to on 5-point ratings and scored on nine subscales.

TABLE 1 **The Psychache Scale** (Holden et al., 2001)

The following statements refer to your psychological pain, NOT your physical pain. By circling the appropriate number, please indicate how frequently each of the following occurs.

1 = Never; 2 = Sometimes; 3 = Often; 4 = Very Often; 5 = Always

1	I feel psychological pain.	1	2	3	4	5
2	I seem to ache inside.	1	2	3	4	5
3	My psychological pain seems worse than any physical pain.	1	2	3	4	5
4	My pain makes me want to scream.	1	2	3	4	5
5	My pain makes my life seem dark.	1	2	3	4	5
6	I can't understand why I suffer	1	2	3	4	5
7	Psychologically, I feel terrible.	1	2	3	4	5
8	I hurt because I feel empty.	1	2	3	4	5
9	My soul aches.	1	2	3	4	5

Please continue this inventory using the following scale:

1 = Strongly Disagree; 2 = Disagree; 3 = Unsure; 4 = Agree; 5 = Strongly Agree

10	I can't take my pain any more.	1	2	3	4	5
11	Because of my pain, my situation is impossible.	1	2	3	4	5
12	My pain is making me fall apart.	1	2	3	4	5
13	My psychological pain affects everything I do.	1	2	3	4	5

FIGURE 2 **Distribution of Psychache Scale Scores for Various Groups**
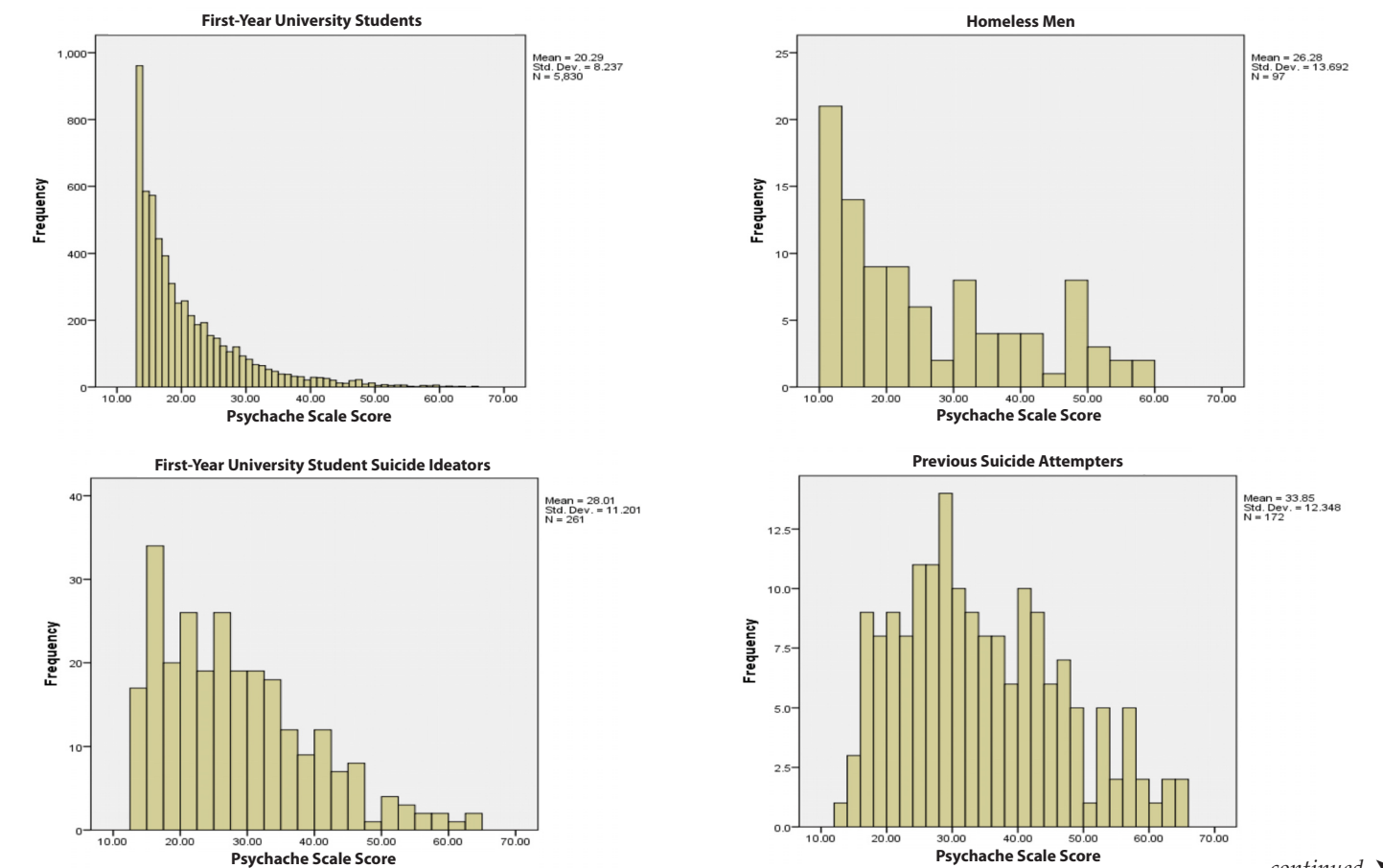
How Common is Psychache?

According to Shneidman, psychache is not a psychiatric issue, per se, but rather a problem in everyday human functioning. Psychache is a result of unfulfilled or thwarted psychological needs. As such, psychache is present to some degree in every person and may be viewed as existing along a continuum where an individual's location depends on the size of the discrepancy between the current self and the ideal self on relevant psychological needs. Figure 2 displays the nature of this continuum as observed in various populations and as quantified by scores on Holden et al.'s Psychache Scale. Samples were selected to represent populations manifesting different amounts of suicidal behaviour. Within each of the samples, psychache scores demonstrate considerable variation along a range. For a relatively low suicidal risk sample such as first-year university students, Psychache Scale scores (mean score of 20) tend to cluster near the lower bound, although there are a few individuals displaying more than a small amount of mental perturbation. For homeless men (mean score of 26) and student suicide ideators (mean score of 28), Psychache Scale scores, although showing a central tendency toward the lower end of the distribution, are significantly higher than for the low risk general student group. For individuals with a history of a suicide attempt (mean score of 34), the central tendency of the Psychache Scale score distribution is clearly elevated from the lower end and the difference from the other groups represents a substantial effect size.

What Causes Psychache?

Shneidman indicated that psychache is caused by unfulfilled or thwarted psychological needs. His approach to suicide was particularly based in the psychodynamic personality theory of Henry Murray. Shneidman viewed discrepancies between the actual self and the ideal self as the catalyzing agents for psychache. In assessing this basis for psychache, Shneidman focused on 20 psychogenic needs proposed by Murray: abasement, achievement, affiliation, aggression, autonomy, counteraction, defendance, deference, dominance, exhibition, harmavoidance, inviolacy, nurturance, order, play, rejection, sentience, shame-avoidance, succorance, and understanding.

How to Treat Psychache

If psychache is caused by frustrated psychological needs, the appropriate treatment is to identify the particular relevant need for an individual and then to address the gap or discrepancy that exists between that person's current actual and ideal standing on that dimension. For a particular client, the assessment question is this: Which one (or more than one) of Murray's 20 psychogenic needs is the basis for generating the resultant psychache? Once the specific thwarted need is identified, then, theoretically, possible therapeutic interventions could include: (1) Altering the current standing of the client on the relevant dimension; (2) Adjusting the client-perceived ideal level of the dimension; (3) Having the client learn to live with the psychache generated by that thwarted need, or; (4) Making that dimension less relevant for the client. That being said, support for these various approaches to treatment has yet to be demonstrated empirically.

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Lessons from Behavioural Economics

ERIC PROST

Sendhil Mullainathan and Eldar Shafir. *Scarcity: Why Having Too Little Means So Much* (Times Books, 2013); 288 pages; CAD$32.00, hardcover.

1. If you visit Kampala, you can take a 4x4 west to see lions and hippos in Uganda's national parks. Or you can visit a high quality craft market to buy shawls and beads and the same wild animals carved out of gleaming dark wood. More interesting, however, as an inroad into the minds of Ugandans – even more so than interviewing the mentally ill at the hospital where I worked – is to stroll up the road where I lived to the local market, a collection of stalls selling chickens, livers, intestines, onions, phone cards, used sneakers, and rides into town. This last provides the insight, or the bafflement really, concerning local economic thought.

At the corner is a taxi stand. Taxis are not usually metered in Kampala and are not yellow with an illuminated sign atop. They are private cars driven fulltime by men who will decide on a price with you depending on your destination. Eight or ten such cars and their drivers are always parked at the market in a pack. When I lived in Kampala, I did some research to discover how this economy works because it seemed to contradict all common sense and even the little economic knowledge I have. I even bought an economics textbook to find if it was I or the taxi drivers who were most daft.

Here is the economic case study. You are a poor African taxi driver. Business is bad, as most of the inhabitants of your city cannot afford private taxis (especially in a non-expatriate neighbourhood like mine). You must buy fuel and parts for your car and make periodic repairs. In short, you have business expenses. You also have personal expenses which come with regularity: food and clothing bills, a little alcohol (or a lot), and school fees each term for your seven children. Your taxes are not so high as to punish earners above a certain income; in fact, you don't pay any taxes at all. Your daily goal in an economy like Canada's might be to get as many fares in a working day as possible as long as the agreed upon price for each ride made you a profit. You could then pay your business and personal expenses as well as maybe even save a bit so that the school fees weren't upon you unexpectedly yet again next term.

Now you cease to be the businessman and become the consumer of services at the local taxi stand. You are the only foreigner who ever comes to the market and you are not new to the neighbourhood. You know that none of the taxis at this particular stand gets priority for the next customer; they all wait bumper to bumper in a small square lot.

You approach Driver A (Moses) and say: "I want to go to Nakasero [another neighbourhood]."

"OK. Get in. Get in."

"No, how much to Nakasero?"

"15,000 shillings," says Moses.

"I never pay more than 12,000 from here," you honestly respond.

Moses shakes his head. *No Sale.*

I've found in my economics text that Supply and Demand can have some complicated concepts attached to them such as the adjectives *elastic* and *inelastic*. But nothing I have read detracts from the observation that when ten taxis are waiting, supply is big, and

when one foreigner is paying, demand is small. How can Moses not even try to bargain? How can he just shake his head: No Sale?

Predictably, I turn – not even walk across the street – but just pivot 180 degrees on my heels, and say to Driver B (Emmanuel), "How much to Nakasero?"

Emmanuel has heard the first exchange: "12,000."

Explanations. (1) Moses' car is such a gas-guzzler that he must always charge 15,000 to Nakasero just to cover expenses. Why then didn't he start at 25,000 and try to bargain with me to finally reach 15,000 or even 20,000? (2) Moses' income for the year just reached an income tax threshold and he doesn't want to exceed it unless by a huge amount; in short, that Uganda has a tax code that at some income level acts as a disincentive to higher earnings. No. Moses pays no taxes. (3) Moses is too proud to bargain. (4) Moses is sure another wealthy customer will come along who will pay 15,000. Unlikely. He could have gone and come back from Nakasero and be ready to take that next potential wealthy passenger as well. The taxi park is not very busy. (5) The drivers are in cahoots. Even 12,000 is far too high to Nakasero and Moses and Emmanuel will split the overpriced fare and both have a good laugh later. (No, it's a reasonable price.) (6) Emmanuel is far more intelligent than Moses.

How will Uganda prosper if the laws of supply and demand don't even apply? The answer is *I don't know*. I do have one other explanation for the odd little economic case study though.

The late economist, Robert Heilbroner, has a theory to explain economic behaviour – or really non-economic behaviour as we know it – before Adam Smith and what he calls "the economic revolution" in the 16th- and 17th-centuries. He believes that the idea of "making a living" didn't exist before then, that work was an end in itself, and that its being merely a means toward the end of making money and then spending (or saving) it was unknown. Europeans did not function on the profit motive, which we may now take for granted, and the idea of gain for its own sake didn't exist. He argues that the idea of bettering one's life, saving for the future in order to leave a different life for one's descendants, or striving so that one's offspring can be in a different financial state are all strictly modern notions; moving upwards economically was synonymous with moving socially, and the vast majority didn't do it. He quotes a 17th-century polymath, Sir William Petty, who "claimed that when wages were good, labor was 'scarce to be had at all, so licentious are they who labor only to eat, or rather to drink'". If someone is not accustomed to ever-rising standards of living and a market economy, when wages rise, he will not work harder but will simply take more time off.[1]

This can be seen in the nearby fishing villages outside Kampala where we did medical outreaches: if the men catch some fish, they come home and sell them, spending the money largely on booze and prostitutes (hence the need for the medical outreaches). They don't fish for the complete day in order to catch yet more in case tomorrow is a rainy day and they can't go out on the lake in their little boats. If you give a man a fish, you will feed him for a day; if you teach a man to fish, you will also feed him for a day as well as pay for his drink and his sexual satisfaction; if you teach a man to fish, you may even feed him for a lifetime, but you will not be contributing to his rising standard of living or even to his slowly accumulating savings as you might have thought.

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I asked a Ugandan friend about the politics of the local taxi park. He confirmed that it was a first-come first-served basis and that Moses and Emmanuel were both fair game to bargain with. I asked him why Moses hadn't bargained with me and had let Emmanuel get the fare when supply so clearly outweighed demand.

"He probably had already had a fare that day," my friend said.

He'd made a bit of money already. Work was the end, not the means to advancement or savings. There was no planning for the next term's school fees or the next week's emergency brake or muffler job.

2. My Ugandan story is a *behavioural* economic case study: it shows the social and psychological factors that may explain economic decisions. Consumers and spenders and earners and investors in Uganda and Canada do not make economic decisions based only on the value of a dollar or on supply and demand or other rational and seemingly predictable laws. They are, after all, human beings who are exchanging the money and taking out the payday loans and forgetting to save for college, not computers with classical economic theories programmed within.

Sendhil Mullainathan (an economist) and Eldar Shafir (a psychologist) in their book, *Scarcity*, provide a particular behavioural economic explanation for some of the world's problems and then briefly sketch some solutions. Their thesis is this. Scarcity means "having less than you feel you need". And this scarcity "captures the mind," allowing us to be intensely focused and efficient, but at a cost: we are then unable to make good choices outside our tunnel vision since our minds are occupied with whatever we lack. Measurements of intelligence and executive function decline because we have less "mind" to spare for life outside our preoccupation with scarcity.[2] For example, the starving have a scarcity of food and thus are obsessed with it. In experiments cited in the book, starving participants read recipes, thought about food, and were attracted to the food scenes in films – to the detriment of other cognitive pursuits.[3]

Mullainathan and Shafir focus mainly on the scarcities of money and time. They devote pages to the problem of poverty and how a scarcity of money leads the poor to appear to possess lower IQs or flawed characters when really they are simply focused on the problems of paying bills or buying groceries and are not capable of making measured decisions outside this because their "bandwidth is taxed" severely. Scarcity taxes bandwidth: this is the thesis in the jargon of behavioural economics.

Several studies are explained in detail and they make for fascinating reading. Farmers in India are wealthy post-harvest, and score the equivalent of 10 points higher on tests of IQ than the same farmers do when they are pre-harvest and, therefore, poor.[4] They behave more impulsively and appear less intelligent when money is scarce. When American mall patrons were asked to ponder how they might negotiate the decisions around a $300 car repair, both the rich and the poor appeared "equally smart" on a component of an IQ test after thinking through the vehicle maintenance. However, when the scenario was changed to a $3000 car repair, the poor did significantly worse on subsequent IQ tests. In fact, they did worse than participants in sleep studies who were forced to stay awake all night and then perform an IQ test, leading the authors to conclude that "simply raising monetary concerns for the poor erodes cognitive performance even more than being seriously sleep deprived".[5]

Equally interesting studies about the effects of time scarcity are described. The positive effects are clear: being closer to a deadline means, for many, that focus is enhanced and time is used more efficiently. For example, the "midcourse correction" in meetings means that halfway through the time allotted for the meeting the participants realize that time is running out and they must get serious and get through the agenda.[6] (Shorter meetings seem like an obvious correction for this, possibly allowing for a focusing of the mind on the time scarcity from the outset.) The deleterious effects of time shortages are apparent, too. The very busy – those with schedules that are packed back-to-back without slack – are frequently poor longer-term planners and, when an unexpected delay occurs, end up pushing tasks on into the next day's schedule with little foresight that this will only cause worse problems tomorrow (like clinicians who schedule too tightly and then make patients wait and leave paperwork and charts for the morrow).

It is not clear why Mullainathan and Shafir focus almost exclusively on the scarcities of money and time. (Maybe their respective bandwidths were too heavily taxed to entertain more.) The lack of either money or time certainly affects many in both the developed and developing worlds even in the 21st century. Can their theory though be applied to other scarcities? Would a scarcity of friends (the authors allude to this), health care, power, influence, sex, or spirituality lead its victims to appear to possess but borderline intelligence? This is not addressed.

3. While the authors take care in their introduction to remind us that the "book is not meant to be the final word," but rather "a front-row seat to a process of discovery," it is still difficult to close the book and not think its explanations and conclusions a little too tidy.[7] The simplicity of an explanation is surely its glory, and any theory that is new and creative yet sensible and supported by evidence will prompt the reader to think, "Why didn't I think of that?" or "There must be more to it!" Perhaps Mullainathan and Shafir have struck upon simple but fresh ideas, marshaled statistics to prove them, and then presented them in clear and chatty prose. Who can fault them for that? Would that more academics were guilty of this. But the findings are presented as laws – "scarcity taxes bandwidth" – just as old economic theories in textbooks are worded as laws – "the quantity demanded and the price of a commodity are inversely related" – while others explanations are avoided.

In my Ugandan case study, the authors of *Scarcity* would have explained Moses' behaviour in refusing to bargain in terms of simply, well, scarcity. Halfway through the book they define the "scarcity trap". It is not only true that scarcity causes problems as diverse as impulsivity, forgetfulness, and insomnia. It goes farther: once someone is lacking something, he often is unable to change. An extended example of street vendors in Chennai, India who could get out of poverty if they saved a few rupees a day by foregoing tea illustrates this for the authors. When you are poor and busy (when both money and time are scarce), you simply do not have time to save. You are occupied with your business, your many expenses, your children, and with simply making ends meet. Even if someone comes along and explains how you might grow your business little by little and gives you a small loan to eject you out of the scarcity trap, it will only be temporary. A major expense like a wedding present will send the Indian vendor back into debt and the trap.[8] There is

likely a similar explanation for Moses' behaviour at the taxi stand in Kampala. What is for certain though is that the scarcity model would not have considered the historical explanation for the taxi driver's behaviour, which I explained above – that a mindset of work as an end in itself and not as a means of making, let alone saving, money may still exist.

4. If Mullainathan and Shafir are wrong, or their conclusions too simplistic, we can either ignore them or complement their theories with other explanations. What is problematic for psychiatry is if they are right.

If there are reasons for poor attention, poor concentration, impulsivity, slowed cognition, and faulty executive function that are not attributable to mental illnesses such as mood disorders, schizophrenia, high anxiety, or ADHD, then we better acknowledge it and discharge some of our patients to the behavioural economists and their solutions.

The common pathway of many mental illnesses is cognitive problems, whether psychomotor retardation in depression, processing speed in schizophrenia, or indecision in generalized anxiety disorder. Perhaps these symptoms are not caused by mental illness at all but by scarcity in the patients' lives? The common pathway of so many of the authors' scarcity case examples would be depressive *symptoms* and anxiety *symptoms*. Treating them with SSRIs, though, would be like throwing money at the problems of the developing world and wondering why the problems persist.

As psychiatrists and other mental health clinicians, we pride ourselves on being practitioners of holistic health care where we consider the whole person and her biopsychosocial needs. Maybe we shouldn't be proud of this. There is no glory in being half-baked, no reason for celebration in treating symptoms when the causes are out of our expertise. Rather than welcoming more and more patients with or without actual psychiatric diagnoses, maybe we should narrow our profession to what we can actually accomplish and leave the rest to the credit counselors, the time management specialists, and the economists.

5. Mullainathan and Shafir have written an engaging book. You might find yourself trying to apply their ideas to your own life or profession. You might agree with them completely, or disagree on much. But if scarcity is a mindset of "having less than you feel you need," which leads to poor performance on cognitive testing, we could state a law this way: Discontentment makes you look dumb. Sages have been saying that for millennia.

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