Psychiatric Bulletin (1990), **14**, 296–297

Personal view

Paranoia – is it cost effective?

C. R. WHYTE, Consultant Psychotherapist, Humberstone Grange Clinic, Leicester LE5 0TA

The cost effectiveness of treatment has to be a major consideration in any well managed service. It is, therefore, the job of management to ensure that effective treatment is delivered efficiently.

Outcome depends upon many clinical factors, for example the accuracy of diagnosis, the severity of the disorder, the type of treatment and the skill of the clinicians. It also depends upon the setting in which the treatment takes place. For example, effective surgery needs well equipped operating theatres and sterile instruments. As managers have responsibility for the setting they are actually involved in the treatment process, and have a direct effect upon its outcome. Managers must therefore ensure that the setting itself is cost-effective.

Managing the setting means ensuring that the treatment is conducted in a therapeutic environment. Environments that are antitherapeutic result in poor outcomes and sometimes expensive mistakes. Buildings therefore need to be designed with the therapeutic task in mind. Equipment and support services need to be provided. Communication and information systems need to be developed. All of these are essential features of the setting influencing the outcome of treatment.

An equally important, but often overlooked, aspect of the setting is its corporate culture. This can be defined as the prevailing values and ethos of the organisation. In the NHS it includes attitudes towards sickness, death, suffering, care, treatment and cost. The corporate culture is pervasive and influences the performance of all staff, including clinicians. It therefore needs to be set in such a way that it induces a therapeutic and yet cost conscious set of attitudes. The objectives of the service are not helped by either those who want to care-at-all-costs or by those who are cynically commercial.

The task of management is to promote the development of a therapeutic culture which fosters attitudes that enhance the effectiveness of treatment. The central feature of this therapeutic culture is concern for the patient's welfare, including the ability to understand and tolerate the patient's anxiety. In such a culture staff are motivated to care out of concern. Unfortunately in some institutions a persecutory culture prevails in which staff are motivated to avoid criticism and disapproval. Such organisations run on anxiety rather than concern, and so to get things done managers and clinicians alike have to complain and protest. This results in a manager–clinician relationship that is based on fear and recrimination. A small-scale example will serve to illustrate the difference between a therapeutic and a persecutory culture. A department needs a photocopier to improve its efficiency. In a persecutory culture, the department would have to chase up its request by pestering the responsible administrators, several 'reminders' or even threats would be necessary before any action was taken. In a therapeutic culture, management would notice the need, ask if a photocopier would help and endeavour to get one. Alternatively the department would be given its own budget, enabling it to look after itself.

A persecutory culture runs on fear, it motivates with the stick. Success in organisations managed in this way depends upon the ability to generate paranoid anxiety in others, that is one has to badger, threaten and make a fuss. The good politician develops immunity to paranoid anxiety by inducing (projecting) it in others. The not-so-good politician falls victim to it. In such a culture clinicians tend to develop either a persecuting or a persecuted frame of mind; needless to say both are antithetical to a therapeutic attitude.

Management systems that run on paranoid anxiety are therefore detrimental to clinical work. In such systems those who are adept at projecting paranoid anxiety tend to be promoted to the positions of power. They assert control by inducing anxiety in their subordinates. The anxiety is passed down the ranks following the line of least resistance until it finally reaches the patient. A vicious paranoid spiral then results in which patients and staff are suspicious and wary of each other – a state of affairs which inevitably prejudices the treatment and results in a poor outcome.

Patients coming for help are in a state of anxiety which is liable to be made worse if they are faced with staff who are unable to recognise and respond to their distress. Patients need more than an accurate diagnosis; they need a clinician who can tolerate distress and who is understanding of the fears that illness

provokes. Clinicians who are already loaded with anxiety from the institution are in no state of mind to function in this way. Clinicians who are harassed and frustrated, who are tired and overburdened, and who are forever looking over their shoulder cannot do good work.

It may be a truism, but it is nevertheless a fact of human nature that people tend to treat others akin to the way they are themselves treated. In a persecutory culture clinicians are therefore in danger of passing their own anxieties onto the patient. This is detrimental to good clinical practice and undermines the aims of the service. It is not cost-effective. Managers therefore need to promote a culture in which a real concern for welfare prevails. In such a culture patients, clinicians and managers all feel that their plight is understood and met with sensitivity. When managers feel cared for they manage more effectively. When clinicians feel cared for their treatment is more effective. The central value of a therapeutic culture is care out of concern – staff can only give this to patients when they receive it themselves from the organisation.

To maintain a therapeutic attitude and thus do good clinical work, clinicians must feel trusted and supported, and need to find in their relationship with managers the care and concern that they are expected to give to patients. The effectiveness of treatment is dependent upon a therapeutic attitude and is seriously undermined in a persecutory culture. Management therefore has a responsibility to ensure that a therapeutic corporate culture prevails.

Lundbeck Teaching Fellowship

Fellows and Members of the Royal College of Psychiatrists, working overseas, are invited to apply for a Teaching Fellow from the UK to come to their country to provide a course of teaching in a designated specialist psychiatric subject. Overseas Fellows and Members may suggest a named teacher, but more importance will be given to the topic of their choice than to any individual.

A sum of £5,000 per year has been provided by Lundbeck Limited to cover the travel, living and incidental expenses of the Teaching Fellow who, it is envisaged, will complete the course over a period of 3–4 weeks. The host centre overseas will not be expected to provide any financial support.

Applications for the academic year 1990–1991 should be sent to the Dean, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. The Teaching Fellow will be selected by the Dean in collaboration with the College's Overseas Desk, and his/her appointment ratified by the Court of Electors.

Professor A. C. P. Sims
Dean

https://doi.org/10.1192/pb.14.5.296 Published online by Cambridge University Press