Psychiatry Beyond Current Paradigm

Jacqui Dillon

www.jacquidillon.org

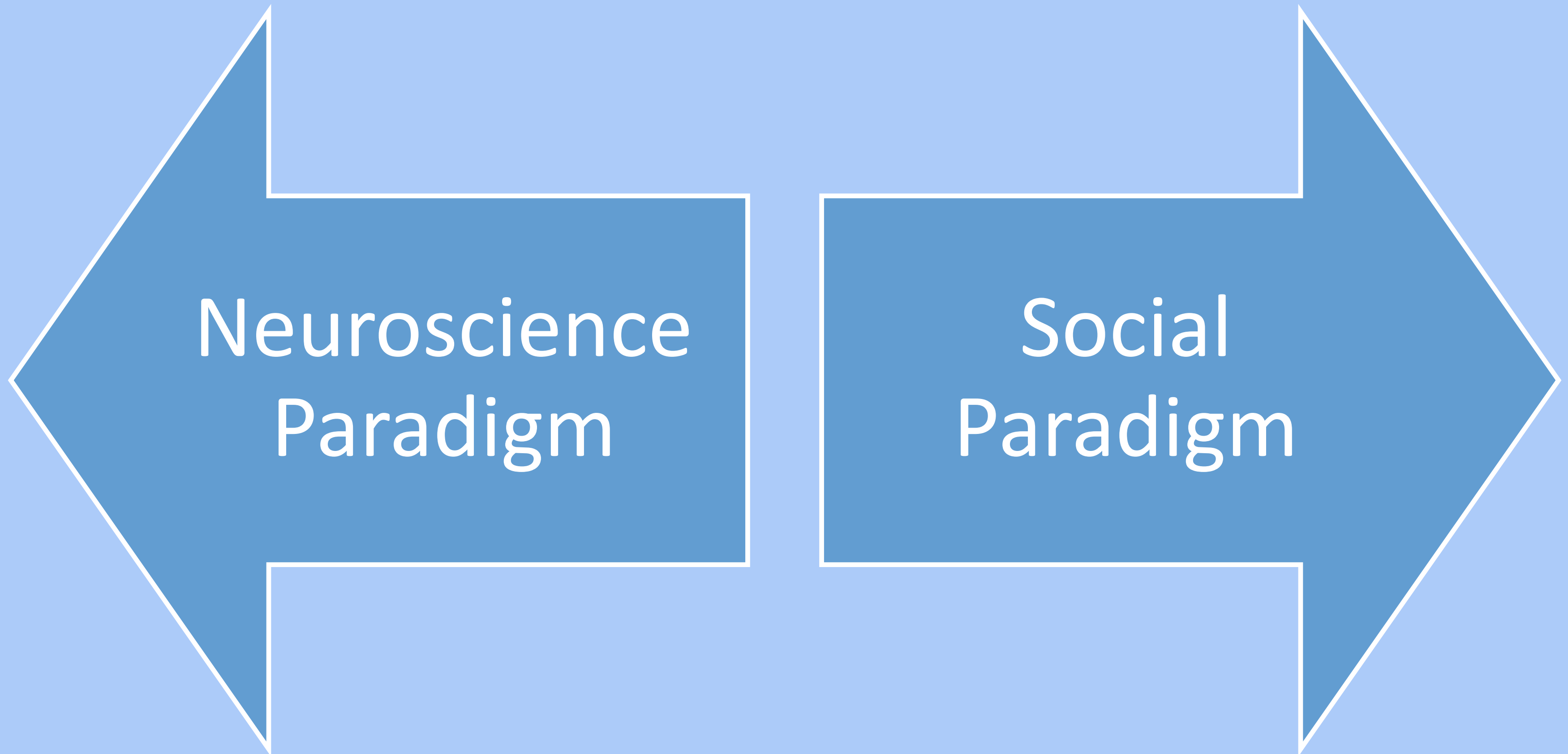
Psychiatry in Crisis

- The crisis in the profession of psychiatry has been looming for a while, as discussed in a series of articles in the British Journal of Psychiatry.

- Traditional psychiatric response to threat:
- Ignore
- Attack
- Assimilate

(Johnstone, Users and Abusers of Psychiatry, 2000.)

How is psychiatry re-positioning itself in response to the widely-acknowledged threat to its power and status?



The one thing that both wings agree on is that the profession faces a threat to its survival.

- *"Some… have questioned whether the psychiatrist is an endangered species… Urgent action is required to… ensure the future of psychiatry as a profession"* (Oyebode and Humphreys, 2011);
- *"British psychiatry faces an identity crisis… It is imperative that we specify clearly the key role of psychiatrists"* (Craddock et al., 2008);
- *"We believe that such a focus… has potential to strengthen our identity, give psychiatrists more societal relevance, and make psychiatry more attractive as a profession"* (Priebe et al., 2013.)

As these quotes suggest, the solutions are presented primarily in terms of their benefits to the profession, with little attempt to claim, for example, improved outcomes or greater acceptability to service users themselves.

- Present the profession of psychiatry as considering a wide-ranging selection of social and psychological factors in mental distress….BUT, it is swiftly noted that doctors are the only ones who do *everything* – psychological, social, medical, the whole lot.
- Open to acknowledge failings:
- 1) Medicine has no particular theoretical basis, and that is a good thing and
- 2) that medicine draws on every possible theoretical basis, social, psychological and biological, and that is an even better thing.
- No other profession measures up to our extensive range of skills. The message is: You need us in charge.

Are the Critical Psychiatry Network saying anything different?

"For the past 30 years, psychiatry has conceptualised human problems as illnesses and has promoted drugs as the only viable 'treatment' for these pseudo-illnesses. They have ruthlessly expanded their spurious, disempowering and stigmatising 'diagnoses'. They have developed corrupt and corrupting relationships with pharma….They have legitimised the widespread prescription of dangerous drugs, and have stood by complacently as clients succumbed to the most devastating side effects… Now, with their reputation in tatters, and the survivors of the 'treatments' in open revolt, they seek to rehabilitate themselves. But there's no apology. Not even an oops, sorry. Just 'We've messed up our own patch. Can we come over to yours? And by the way, we'll still be in charge.'"

(Phil Hickey at www.behaviorismandmentalhealth.com, May 8th 2013)

Huge range of vested interests in biological psychiatry with its function of pathologising and decontextualizing human distress:

Pharmaceutical companies:

Voracious appetite to nurture and protect the illness model of distress; fuelled by the morally blind economic imperative to increase profit for shareholders, and bonuses for themselves.

Political parties:

Gives politicians a perfect excuse to do nothing about reducing the social and economic problems underlying distress.

Society in general:

'The knowledge of horrible events periodically intrudes into public awareness but it is rarely retained for long. Denial, repression and dissociation operate on a social as well as an individual level' (Herman, 1992: 4).

Some families & carers' groups:

- Some families and carers groups (but not all) have an investment in the notion that their relatives' distress is caused by an illness, absolving themselves of culpability or responsibility.

Some 'service users':

- Protects both themselves and their families from painful truths.
- Having to take responsibility for the consequences of the deleterious effects of others' mistreatment or failures is a bitter pill to swallow.
- Abdicating responsibility for their own distress and recovery to an expert figure that can 'cure them' may be an unconscious attempt to receive 'care' that they may have never received.

Professionals:

All/some of the above +

- Sometimes it is just too hard to think or feel anything about the violence and injustices around us, let alone do anything about it all.
- Without systems that support professionals to bear witness to the pain of people who have endured terrible things, professionals may employ a number of self-protective strategies like ‘the silencing response’
- Denying the importance of life experiences and social context protects us from our own fear of going mad, or from acknowledging that we are already, from time to time, a bit bonkers.

‘Making the world go away, and how psychology and psychiatry benefit’

Psychiatry:

“It is no wonder that psychiatry is fearful of context and has to devise so many strategies to avoid it, because context constantly threatens to make emotional and behavioural problems intelligible or, to put it another way, it threatens to abolish psychiatry’s self-defined subject matter”.

(Boyle,2011): *Demedicalising Misery: Psychiatry, Psychology and the Human Condition.* Mark Rapley, Joanna Moncrieff and Jacqui Dillon

‘Making the world go away, and how psychology and psychiatry benefit’

Psychology:

“The first concerns psychology’s extreme insecurity about its academic and social acceptances as a science…So by minimizing or denying the importance of life experiences and context - by choosing not to expose the operation of power – mainstream psychology gains the double advantage of both appearing more ‘scientific’ and also avoiding the risk of offending the powerful by seeming to implicate them in causing distress to others; here, the powerful actually means any group that might make a public fuss over suggestions that they harm others and be taken seriously;”

(Boyle,2011): *Demedicalising Misery: Psychiatry, Psychology and the Human Condition.* Mark Rapley, Joanna Moncrieff and Jacqui Dillon

‘Making the world go away, and how psychology and psychiatry benefit’

Clinical Psychology:

“In following psychology in minimizing context, clinical psychology gains the added advantage of placating psychiatry…In fact, what we seem to have are three very insecure groups who have implicitly agreed not to expose the operation of power in return for academic and professional privileges. “

(Boyle,2011): *Demedicalising Misery: Psychiatry, Psychology and the Human Condition.* Mark Rapley, Joanna Moncrieff and Jacqui Dillon

What can be done?

- Much of the work around human rights begins with accurately and aggressively reframing the status quo as an outrage.
- Change the language and you've begun to change the reality or at least to open the status quo to question.
- What protects an outrage are disguises, circumlocutions, and euphemisms:
- “Enhanced interrogation techniques" for torture
- “Collateral damage" for killing civilians
- “The war on terror" for the war against you, me and our civil liberties and human rights.

(Solnit, (2012): Words are the greatest weapon for political activists*. The Guardian)*

Just saying it as it is

Names matter; language matters; truth matters

- Deconstruct biomedical model & the traditional relationship of dominant, expert clinician and passive, recipient patient
- Share power; advocate and practice mutually respectful collaborations between experts by experience and experts by profession
- Take a stand: have the courage to bear witness to and name taboos, injustices, outrages…
- Stop using scientifically meaningless, stigmatising words which focus on deficit and chronicity, like ‘schizophrenia’ and medicalising terms like ‘mental illness’
- Decolonise medicalised language of human experience:
- E.g. - While ‘auditory hallucinations’ is the preferred jargon within psychiatric literature, the term ‘hearing voices’, which uses ordinary, non pathologising language framed subjectively, has been reclaimed
- Reframe and reclaim ordinary language which restores meaning and context and is firmly rooted in peoples lived, subjective experiences

What is to be done?

- Psychiatry, along with colleagues from all professional disciplines, needs to work in genuine partnership with people with lived experience of diagnoses, in order to find less damaging and more humane ways of making sense of, and responding to, madness and distress.
- Ensure service users are involved in the management of, and training about, mental health services
- Ask service users about their past and how they think that relates to their current problems - reject the ‘can of worms’ fallacy
- Help your colleagues focus on recovery not pathology
- Form alliances between progressive professional organisations and groups of service-users and family groups
- Stop using scientifically meaning, stigmatising words like ‘schizophrenia’ and medicalising terms like ‘mental illness’
- Refuse to accept drug company money. Publicly name attempts by drug companies to influence mental health services, research and policy

What is to be done?

- Support psychiatrists, psychologists and other mental health staff who are trying to change but are under pressure from their colleagues to conform
- Help psychiatrists share the responsibility for managing risk
- Inform yourself about and use the research literature about psycho-social causes and treatments, and about the limitations and dangers of psychiatric drugs
- Moving beyond the current paradigm will involve re-thinking methodology in research from quantitative to qualitative research methods which will help promote people's voice
- Lobby for change: governments (local and national), mental health service managers, etc., and in the media (write letters)
- Join a group of some kind with similar goals (eg HVN, CPN, ISPS) or form your own local group to connect with others who share your values - you will need the support!

the
elephant
in the
ROOM

The master's tools will never dismantle the master's house.

Audre Lorde.

Do we need psychiatry?

A.K.A Post, post psychiatry

- If madness & distress are not medical problems…
- What is the role of psychiatry?
- Rule out organic causes…(neurology)
- Advise on meds… and helping people come off meds… (pharmacology)
- Is psychiatry the best use of (a lengthy and expensive) medical training?

Beyond Psychiatry

- Have a 5-10 year plan to gradually reduce the country's dependency on technical fixes for human distress: phase out psychiatric medication and close remaining psychiatric hospitals and invest the money in:
- Public education about the psychosocial causes of much distress and work on prevention (poverty, abuse, racism, social inequalities…).
- Non-medicalised coping strategy workshops where people actually live, work and play (rather than quasi hospital sites).

Beyond Psychiatry

- A range of self help support (e.g. books, groups, etc).
- Survivor-run crisis houses and non-medicalised Soteria Houses for those in most distress.
- Phase out expensive and separate mental health professionals and move towards integrative and generic training following a 'barefoot doctor' model.
- Train them in non-medicalised therapeutic approaches like Open Dialogue…