

Beyond biomedical models: a perspective from critical psychiatry

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The Critical Psychiatry Network

The Critical Psychiatry Network (CPN) first met as the 'Bradford Group' in January 1999. It is a group of psychiatrists that forms a network to develop a critique of the contemporary psychiatric system.

The first meetings of the group coincided with publication of the UK government's intention to undertake a root and branch review of the Mental Health Act 1983. The initial phase of this review involved a scoping exercise, undertaken by a small expert group chaired by Professor Genevra Richardson, to which CPN submitted evidence.

CPN has also responded at each stage of the subsequent consultation process leading to the draft Mental Health Bill 2002.

CPN's position statement in October 1999 made clear its opposition to compulsory treatment in the community, and preventive detention for people who are considered to have 'personality disorders'. A new response to the conflict between care and coercion was proposed that recognised the way values inform medical decisions. This ethical perspective resists attempts to make psychiatry more coercive.

CPN was an original member of the Mental Health Alliance, a coalition of organisations that share common concerns about the government's proposals to reform the Mental Health Act. The core members have subsequently been joined by the Royal College of Psychiatrists, but initially CPN was the only group of psychiatrists that was part of the alliance.

Critical psychiatry is partly academic and partly practical (Thomas & Moncrieff, 1999). Theoretically it is influenced by critical philosophical and political theories. Three main elements have been identified: (1) a challenge to the dominance of clinical neuroscience in psychiatry (although this is not excluded); (2) a strong ethical perspective on psychiatric knowledge and practice; and (3) the politicisation of mental health issues.

Over recent years, it has become popular to regard critical thinking as something that can be taught (Fisher, 2001). Critical thinking is seen as the art of taking charge of one's mind. If we can take charge of our own minds, the theory is that we can take charge of our lives; we can improve them, bringing them under our command and direction. Critical thinking involves getting into the habit of reflecting on our inherent and accustomed ways of thinking and leads to action in every dimension of our lives. Similarly, critical psychiatry wants to promote critical reflection on practice and research in psychiatry. More generally, critical psychiatry is supported by critical theory, which is a term that can be used quite loosely to refer to a range of theories which take a critical view of society (Macey, 2000). In particular, critical theory seeks to understand how systems of collective beliefs legitimate various power structures. In relation to psychiatry, this can be applied to appreciating why people are so ready to adopt the biomedical model in psychiatry. Critical theory has also distinguished itself through its critique of science as positivism. In other words, there is a tendency to believe that natural science is the only valid mode of knowledge and that progress continues to be made in uncovering facts through science. Psychiatry, for example, is said to have advanced over recent years in its understanding of the mind and mental illness. It suits

people's expectations to think that psychiatry has found the solution to mental illness. However, critical theory recognises that verifiable knowledge about the mind is as essential as natural scientific facts.

The Critical Psychiatry Network makes various statements in its March 2002

mission statement about its objectives. These include that CPN :-

is sceptical about the validity of the medical model of mental illness.

is opposed to the overemphasis on biological research and treatments in

psychiatry does not believe that psychiatric practice needs to be justified by

postulating brain pathology as the basis for mental illness believes that the

practice of psychiatry must recognise the primacy of social, cultural, economic

and political contexts minimises the use of compulsory detention and treatment

recognises the importance of working in alliance with service users to explore

approaches that give them control over their lives

believes that a combination of two types of expertise, expertise by experience

and by profession is a prerequisite for the highest quality mental health

services recognises the value of user-led research, independent peer advocacy, and the

employment of service users in mental health services.

attempts to find alternatives to drug treatment whenever possible.

The sceptical attitude to the use of psychotropic medication has influenced

contributions as a stakeholder to various guidelines produced by the National

Institute for Clinical Excellence (NICE). The scientific limits of the

possibilities of randomised controlled trials are acknowledged, as is the

general bias in the interpretation of the data.

CPN's campaigning on the reform of the Mental Health Act has emphasised the

importance of rights to advocacy and advance statements. It is also currently

campaigning against pharmaceutical company sponsorship of psychiatric conferences and educational activities. CPN has also organised and participated in various conferences, where papers have been presented which develop the notions on which critical psychiatry is based. Some of these papers have been published on the CPN website (www.criticalpsychiatry.co.uk), as have the other documents prepared by the group.

Critical psychiatry and "anti-psychiatry"

The Critical Psychiatry Network has never hidden its historical link with so-called "anti-psychiatry". However, the label anti-psychiatry needs to be understood for what it is. The terminology was disowned by both RD Laing and Thomas Szasz, two people who are probably most closely and consistently identified with the anti-psychiatry movement. The general view is that anti-psychiatry was a passing phase in the history of psychiatry and that it is no longer of any influence (Tantam, 1991).

In a way, the spectre of "anti-psychiatry" has functioned as a means of identifying and thereby marginalising psychiatry's critics. Anti-psychiatry is seen as disreputable, and part of this chapter's aim is to attempt to change that perception. There is an orthodoxy about current psychiatric practice which feels threatened by any challenge to its foundation (Double, 2001). Identifying psychiatry's critics as its opponents, therefore, allows them to be confronted and undermined.

Not all psychiatrists have seen the issue of anti-psychiatry in this way. For example, Kees Trimbos, one of the founders of Dutch social psychiatry, in his book *Anti-psychiatrie* warned against supposing that it was just a fad: "After all, anti-psychiatry is also psychiatry!" (quoted in Ingleby, 1998). The Critical Psychiatry Network also wishes to avoid the polarisation created by the

antagonism between psychiatry and anti-psychiatry. Being open to the uncertainties of psychiatric practice needs to be encouraged (Double, 2002).

So what is the 'anti' element in anti-psychiatry? Essentially, the biomedical model of mental illness regards mental illness as a brain disease. Hence it creates the tendency to reduce people to their biological base. Objectification of the mentally ill can make psychiatry part of the problem rather than necessarily the solution to mental health problems (Jones, 1998).

Anti-psychiatry had a popular, even romantic, appeal as an attack on psychiatrists' use of psychiatric diagnosis, drug and ECT treatment and involuntary hospitalisation. The apparently anti-authoritarian nature of anti-psychiatry obscures how much the ideas that amounted to anti-psychiatry predated its emergence.

This is the issue I wish to examine in this chapter. In particular, I wish to highlight the extent to which a biopsychological model of mental illness has been promulgated within mainstream psychiatry. Although the somatic hypothesis has always been the dominant model of mental illness, the view that mental illnesses have primarily psychological and social causes is not new. The essential importance of context for the understanding of mental health problems has been previously recognised. In particular, I submit that the most complete of such perspectives is linked with the name of Adolf Meyer.

The psychobiology of Adolf Meyer

Adolf Meyer (1866-1950) was an immigrant to the United States from Switzerland. He had an important role in American psychiatry and was arguably the foremost American psychiatrist in the first half of the twentieth century. His ideas came to Britain via psychiatrists such as David Henderson and Aubrey Lewis (Gelder, 1991).

His theoretical approach, which was called Psychobiology, has not always been well articulated. Although he lived in the United States for many years, Meyer had a rather convoluted style of communication in English. His ideas never really took hold as a systematic theory of psychiatry (O'Neill, 1980). Few references are now made to his writings in the literature. His collected works have been published, but are little read (Winters, 1951-2)

Essentially Meyer saw his views as an advance over the mechanistic notions of mental illness of the 19th century. He regarded the person as the focus for theory and practice in psychiatry. Psychiatric assessment should concentrate on understanding the patient as a person.

The assumptions of the biopsychological model are listed by Wilson (1993). Anyone can become mentally ill if exposed to sufficient trauma. The boundary between normality and insanity is therefore fluid. The cause of mental illness is postulated to be an untoward mixture of harmful environment and psychic conflict. Mental illness is conceived along a continuum of severity from neurosis through borderline conditions to psychosis. The mechanisms by which mental illness emerges in an individual are psychologically mediated.

Such a biopsychological perspective can be contrasted with the biomedical approach of Emil Kraepelin. For example, Kraepelin (1921) viewed the origins of schizophrenia (or dementia praecox, as it was then called) very differently to Meyer (1906). For Kraepelin (1921), dementia praecox, like manic-depressive illness, was a single morbid process. Meyer questioned the biological basis of Kraepelin's concept of dementia praecox. Meyer had a psychogenic understanding of dementia praecox, and believed that such psychological understanding should apply to dementia praecox as much as for any other psychiatric disorder. The reasons why people become psychotic are not understood by suggesting that such a process happens because of a condition behind the symptoms called dementia

praecox.

Typically, Meyer called speculation about the biological basis of mental illness 'neurologising tautology'. Thomas Szasz (1972) has been criticised for suggesting that mental illness is a 'myth'. Although Meyer would not have agreed with Szasz that the notion of mental illness is meaningless, he did concur with Szasz's contention that belief in mental illness as a disease of the brain is a negation of the distinction between persons as social beings and bodies as physical objects. To quote from Meyer (1951), "Very often the supposed disease back of it all is a myth and merely a self-protective term for an insufficient knowledge of the conditions of reaction."

Meyer's views are important because of the increasing hegemony of the biomedical model over the last 40 or more years. In fact, the drive to create a systematic biological perspective over recent years was at least partially driven by the wish to replace the perceived vagueness about psychiatric diagnosis blamed on the Meyerian perspective. Other factors were of course also important in encouraging the biomedical somatic hypothesis, such as the increasing development and marketing of psychotropic medication, related to biochemical theories of mental disorder.

I do not want to overestimate the differences in psychiatry 40 years ago compared with the present. The dominant model of mental illness has always been biomedical. The natural assumption has been to presuppose that mental illness is a physical disease and that the "answer" will be found in biological discoveries. However, I do want to highlight the relative pluralism of psychiatry of the past. Modern psychiatry has become so governed by biological psychiatry that we need to be reminded that biopsychological and social perspectives are not new.

Pluralism in psychiatry

In mid-twentieth century, there was little in the way of psychotropic medication. Although there was a certain enthusiasm for physical treatments such as electroconvulsive therapy (ECT) and insulin coma therapy, there was much interest in psychoanalysis and psychotherapy. A disparity existed between the relatively pessimistic situation regarding therapeutic options for serious psychiatric illness and increasing investment in outpatient work with neurotic and people with personality disorders. In the USA in particular, the highest calling was to go into psychoanalytic training. At the Maudsley hospital, the centre of postgraduate psychiatry in Britain in the early 1950s, and one of the best in the world, half of the trainees were in analysis (Clark, 2000). There were Freudian, Kleinian and Jungian trainees, all vociferously defending their schools.

Meyer ultimately rejected psychoanalysis but still encouraged a psychological understanding in terms of the patient's life history. More generally, psychoanalytic theories were re-evaluated by focusing on environmental factors and the critical nature of disturbances in human relationships.

For example, few people now recognise the name of William Alanson White. During the first third of the 20th century, he was one of America's leading psychiatrists. White played a major role in the introduction of psychoanalysis in the United States after 1910, advancing its role as a theory and treatment method. He was also mentor to Harry Stack Sullivan. The interpersonal approach of Sullivan focused on relationships and the effects of the individual's social and cultural environment on inner life (Barton Evans, 1996).

In the immediate post-war years, Karl Menninger's (1963) *The Vital Balance* represented a broadly conceived psychosocial theory of psychopathology (Wilson, 1993). As Menninger himself says, "As a result of Meyer's efforts and those of

William Alanson White, American psychiatrists began to ask, not "What is the name of this affliction?" but rather, "How is this man reacting and to what?". American psychiatry came to have a distinctively pragmatic, instrumental and pluralistic approach (Lidz, 1966).

The foundation of the William Alanson White Institute can be seen as representative of this view. In the early 1940's Clara Thompson supported Karen Horney's departure from the New York Psychoanalytic Society. Not long after Erich Fromm joined Thompson, as did subsequently Harry Stack Sullivan, Freida Fromm-Reichmann and Janet and David Rioch at the William Alanson White Institute. They formed an unusual alliance, based more on respect for freedom of thought than unanimity of perspective (Lionells, 2000). What they did agree on was the importance of interactions between individuals and their interpersonal environment.

Contrast this pluralism with the current dominant emphasis on natural scientific causation, rather than psychologically meaningful experiences. This trend has been reinforced by factors like the therapeutic advances in psychopharmacology since the introduction of chlorpromazine and the development of brain imaging. These biological perspectives tend to lack the whole-person viewpoint of a biopsychological approach.

The attempt to make psychiatric diagnosis more reliable, combined with a return to a biomedical model of mental illness, has been called the "neo-Kraepelinian" approach (Klerman, 1978). I want to concentrate on the neo-Kraepelinian perspective as the modern representation of the biomedical model in psychiatry. I then want to move on to compare the neo-Kraepelinian position with the views of Adolf Meyer.

The neo-Kraepelinian approach in psychiatry

The modern explicit and intentional concern with psychiatric diagnosis contrasts

with earlier views, such as Meyer's, de-emphasising diagnosis in favour of understanding the life story of the individual patient. Psychiatric diagnosis became increasingly codified following the original paper by Feighner, et al (1972) and the introduction of the Research Diagnostic Criteria (Spitzer, et al, 1975), through editions of the latter revisions of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III, DSM-III-R and DSM-IV) (American Psychiatric Association, 1994). Symptom checklists and formal decision-making rules for psychiatric diagnoses were produced. This operationalisation of diagnostic criteria was developed specifically to respond to criticisms of the basis of psychiatric classification.

This development promotes many of the ideas associated with the views of Emil Kraepelin, often considered to be the founder of modern psychiatry.

Psychiatry is regarded as a scientific, medical speciality that qualitatively differentiates mentally ill patients, who require treatment, from normal people. Scientific psychiatry's task is to investigate the causes, diagnosis and treatment of different mental illnesses, which are seen as discrete from each other. Biological aspects of mental illness are regarded as psychiatry's central concern. Diagnosis and classification are intentionally viewed as important. Belittling of the value of psychiatric diagnosis is discouraged. Mental illness should not be seen as a myth. Instead diagnostic criteria should be codified and research should attempt to validate these criteria, using statistical techniques to improve reliability and validity.

The most visible product of the neo-Kraepelinian movement was the third edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III). The change in diagnostic classificatory systems between DSM-II and DSM-III was dramatic (Blashfield, 1984). This can be seen if only from the size of the manual. The chapter related to psychiatric disorders in DSM-II is a thin

pamphlet. In contrast, DSM-III it is a large textbook.

Robert Spitzer chaired the task force that produced DSM-III. Spitzer was particularly concerned about the reliability of psychiatric diagnosis (Spitzer and Fleiss, 1974). What especially perturbed him was a study by Rosenhan (1973), called *On Being Sane in Insane Places*. Rosenhan was a sociologist who was interested in the labeling effect of psychiatric diagnoses. In a classic study, he arranged for normal accomplices to be admitted to psychiatric hospital, by presenting themselves saying they were hearing a voice, saying a single word. There were three variations in the trial: the pseudopatient said they were hearing the voice say either "thud", "hollow" or "empty". This was the only symptom they had. There were no other indications of mental illness such as delusions or thought disorder. The only complaint was of a simple hallucination, and even then just one word, which is not in itself particularly characteristic of mental illness.

All of the pseudopatients were admitted to hospital. After admission they stopped feigning their symptom of hearing a voice. Some of the real patients detected that they were pseudopatients, because they saw them writing notes about their experience.

All of the pseudopatients apart from one received a diagnosis of schizophrenia; the other was diagnosed as manic-depressive. There is some qualification to this process because although the pseudopatients had acquired a psychiatric diagnosis they were noted to be in remission, improved or asymptomatic. Specific reference to this designation in psychiatric hospital discharge summaries is generally unusual.

The response of the psychiatric establishment to this study was disbelief.

Rosenhan therefore informed the staff of a research and teaching hospital that at some time during the following three months, one or more pseudopatients would

attempt to be admitted. No such attempt was actually made. Yet approximately 10% of real patients were apparently suspected by two or more staff members to be pseudopatients.

Rosenhan concluded from his work that psychiatric diagnosis is subjective and does not reflect inherent patient characteristics. Spitzer (1976) was one of the main critics in the literature of his study and its conclusion.

Spitzer was so panicked that psychiatric diagnoses may be unreliable that he made every effort to ensure that they were clearly defined. The inherent vagueness in category definitions, which could be linked to Meyerian views and other pragmatic perspectives, was blamed. Although careful analysis of the evidence presented in reliability studies of psychiatric diagnosis may not be as negative as is commonly assumed, the commitment to increase diagnostic reliability became a goal in itself (Blashfield, 1984). Transparent rules were laid down for making each psychiatric diagnosis in DSM-III.

In retrospect, what could be seen to have happened is that the response to the attack on psychiatric diagnosis, for example by the labeling theorists such as Rosenhan, also served to undermine the Meyerian perspective. The neo-Kraepelinian approach provided an argument for mainstream psychiatry to re-establish the reality of mental illness, seen as under threat from anti-psychiatry. (Roth & Kroll, 1986).

Meyerian ideas, if they are restated, now may appear tainted with the unorthodoxy of anti-psychiatry. It is almost as though they are held responsible for allowing the threat of anti-psychiatry to be taken so seriously. The underlying assumption seems to be that if psychiatry had not allowed itself to become so imbued with the vague and woolly ideas of Meyer about diagnosis, anti-psychiatry would not have been able to take such hold and to have had such credence. The biomedical model, reinforced in its neo-Kraepelinian form by the

operationalisation of diagnostic criteria, has again become dominant in current psychiatric practice.

Comparison of Meyerian and neo-Kraepelinian approaches

I have previously compared Meyer's perspective and the neo-Kraepelinian approach and concluded that Meyer would have been profoundly critical of the emphasis and assumptions of the neo-Kraepelinian approach (Double, 1990). I argued for a neo-Meyerian revival. Klerman (1978), who originally stated the neo-Kraepelinian principles, had expected such a reaction, but it seems slow to have been formulated.

Spitzer (2001) maintains that DSM-III takes a neutral approach to causation and that it is not covertly committed to a biological approach to explaining mental illness. There is truth in this observation. The link between DSM-III and biological aetiology is merely associative, not logical causal. A classificatory system in itself is not necessarily biomedical. This is illustrated by the fact that DSM-I was influenced by the reaction types proposed by Adolf Meyer, despite Meyer's concern about the general over-emphasis on psychiatric diagnosis. However, the biopsychological model of mental illness, is undermined by a specific focus on diagnosis, as in DSM-III. For Meyer, the first aim of the psychiatrist should be to get at the facts of the case rather than to make a diagnosis. Indeed if the facts do not constitute a diagnosis, the patient still needs to be managed without a clearcut diagnosis being made. Meyer understood the craving for certainty in classification but thought that there were dangers in one-word diagnoses, which gave a false impression that matters are known and understood better than they really are.

Spitzer (2001) concedes that biologically orientated clinicians, who generally regard psychiatric diagnosis as crucial to their work, are positive about the development of DSM-III. For example, Samuel Guze (1989), a central member of the

neo-Kraepelinian movement, has suggested that there can be no psychiatry that is not biological. For Guze, it is inescapable that psychopathology is the manifestation of disordered brain processes.

Meyer also, of course, did not fail to recognise the neurobiological substrate of mental states and behaviour. His emphasis on the person, however, meant that mental illness was understood as a maladaptation in terms of the patient's life experiences. Although he maintained an interest in neuropathology, biological considerations hardly ever arose in dealing with everyday psychiatric problems. In contrast, modern psychiatric practice tends to focus on the biomedical hypothesis.

It is not unusual in current practice for patients to be told that they have a "biochemical imbalance" in the brain. To give the pharmaceutical industry its due, statements that it makes about the biochemical hypothesis are generally couched in appropriately cautious terminology. The stance taken tends to be that research has shown that mental disorders could be linked to a chemical imbalance in the brain. The hypothesis is not necessarily taken as proven. The clinical error is introduced by doctors and other mental health practitioners acting as though the conjecture is true. Meyer recognised this fallacy and modern biological psychiatric practice needs to be repeatedly reminded of it.

Much psychiatric research has had the aim of looking for a physical lesion. Yet if the premise is wrong, is it surprising the work has ended in so many blind alleys? This statement may be thought to show my prejudice about psychiatric research. The general impression has been created that there have been many research discoveries that have produced great advances in psychiatric knowledge over recent years.

In practice, initial enthusiasms have commonly been shown for the speculations that they are. To give an example: investigators have periodically claimed that

they have found the location of genetic markers for mental illness. There were highly publicised announcements that chromosome 5 is linked to schizophrenia (Sherrington et al, 1988) and that chromosome 11 is linked to bipolar disorder (Egeland et al, 1987). Although not confirmed to be the case, it is widely believed that such markers for schizophrenia and bipolar disorder have been proven. Despite the hype, accurate prediction may never be possible because of the complexity of the genetics of common disorders (Holtzman and Marteau, 2000).

Let me give another example of current research biomedical hypotheses, just picking a study arbitrarily from the literature. Over recent years, carbamazepine and valproic acid have been added to the pharmacological armamentarium in bipolar disorder (manic-depressive illness), even though they were originally introduced into the pharmaceutical market for their anti-epileptic activity. Their mechanism of action in bipolar disorder remains unknown. Rapoport & Bosetti (2002) have recently proposed that lithium and antimanic anticonvulsants, like carbamazepine and valproic acid, act by targeting parts of the "arachidonic acid cascade," which may be functionally hyperactive in mania.

Let's see how long this speculation lasts! I doubt it will. It has been published in a prestigious psychiatric journal, but it is as likely to languish for lack of evidence or disconfirmation as have many other shortlived biomedical speculations. As these words are in print, people will be able to look back to see if my prediction proves to be correct or whether Rapoport & Bosetti's hypothesis that the overactivity of the arachidonic acid cascade is implicated in the aetiology of mania is confirmed. I very much doubt whether their conjecture will be of any lasting value, either scientifically or clinically, but its promotion in a prestigious psychiatric journal adds to the impression that great progress is being made in scientific psychiatry.

Meyer would have shared my concerns about a positivistic view of science, in the sense that he did not believe that what we need is simply more scientific 'findings'. For example, at the time he was practising, he regarded the advent of insulin shock therapy as a resurgence of medical emphasis where humane psychological interest should have prevailed. Biological psychiatry has continually perpetuated the illusion that just round the corner lies some vital new discovery that will settle the arguments once and for all. For Meyer, there is already a wide range of facts, usually left to untrained common-sense. The job of the psychiatrist is to organise this information as a body of "facts" and methods of study and therapeutic procedures. For biomedical psychiatry, such a view is too unscientific. To quote from Roth & Kroll (1986): "Such a closure of the model at the level of vague statements that all factors are important and must be taken into account threatens to interfere seriously with the continued progress of medicine" (p. 64).

Psychiatry is a form of hermeneutical science in that it recognises the importance of interpretation in establishing objective facts. It is part of the human sciences, not natural sciences. Biomedical psychiatrists to buttress their case should not abrogate the authority of science. There is a perceived certainty about the biological viewpoint, which is highly valued and gives an apparent justification to the biomedical hypothesis. As there are difficulties in deciding a priori between the legitimacy of the biomedical and biopsychological models of mental illness, factors like this do sway heavily.

In summary, Meyer and the neo-Kraepelinian approach find different ways of accommodating to two main conceptual issues (i) the mind-body problem and (ii) the application of scientific method to the study of human nature. Meyer sought an integration of mind and body, whereas biomedical psychiatry postulates an underlying physical lesion as the cause of mental illness. The neo-Kraepelinian

approach encourages a positivistic view of mental science, whereas Meyer recognised the interpretative nature of human knowledge.

Post-psychiatry and critical psychiatry

Bracken & Thomas (2001) have recently outlined a new direction for mental health, which they call "post-psychiatry". This approach emphasises the significance of social, political, and cultural contexts for the understanding of mental illness. Whilst recognising the importance of empirical knowledge, it gives priority to interpretation and to meaningful experiences. It argues that mental health practice does not need to be based on an individualistic framework centred on medical diagnosis and treatment.

Post-psychiatry is about creating a space in which a new debate can take place.

There is a need for an open, genuine and democratic debate about mental health.

Bracken & Thomas (2001) suggest that post-psychiatry is the post-modern deconstruction of modernist psychiatry. Following the Enlightenment, or the Age of Reason as it is called, the concept of psychiatry developed as a separate area of medical endeavour. Foucault (1967) views the associated emergence of institutions in which mad people were housed as the 'The Great Confinement'.

According to Bracken (2001), modernist psychiatry is made up of three elements; (1) technical reasoning and a belief in science; (2) exploration of the individual self; and (3) coercion and control of madness. Post-psychiatry sees this agenda as no longer tenable because of various post-modern challenges to its basis. These include questioning simple notions of progress and scientific expertise. The rise of the user movement, with its challenging of the biomedical model of mental illness, is seen as being of particular importance. Recent government policy emphases on social exclusion and partnership in health are viewed as an opportunity for a new deal between professionals and service users.

Post-psychiatry is, therefore, context-centred and takes its philosophical foundations from 'hermeneutical' philosophers such as Wittgenstein and Heidegger and the Russian psychologist Vygotsky (Bracken, 2002). Such approaches give priority to meaning and interpretation rather than causal explanation.

Post-psychiatry also emphasises the importance of values rather than causes in research and practice. This theme chimes with the so-called "new philosophy of psychiatry" (Fulford et al, 2003).

Post-psychiatry proposes a new relationship between society and madness and challenges doctors to rethink their role and responsibilities. For example, in relation to the proposals for reform of the Mental Health Act, decontextualising the biomedical model weakens the argument for relative medical control of the detention process.

Post-psychiatry, therefore, is probably the best articulated form of critical psychiatry. However, critical psychiatry covers a broad span of approaches.

Those interested may wish to consult the Critical Psychiatry website (www.anti-psychiatry.co.uk). The internet has tended to provide a forum for more marginalised views, such as critical psychiatry. Some of the best articles explaining the basis of the approach are only available on the internet. Links to four articles by David Kaiser are at <http://www.critpsynet.freeuk.com/Kaiser.htm>. They were originally published by Mental Health Infosource, an internet based continuing medical education resource. Those interested in reading books on the theory behind critical psychiatry may wish to consult Lucy Johnstone's (2000) *Users and abusers of psychiatry*.

For the purpose of this chapter, what I want to look at again is the more general link to what I have been calling the pluralistic emphasis in psychiatry of the past. In many ways, post-psychiatry is not a new direction. In my view,

critical psychiatry does not need to be tied to post-modernism. In this way, critical psychiatry avoids philosophical critiques of post-modernism, such as that it tends to retreat into the irrational.

What is crucial is that psychiatric practice is not taken for granted. It needs to be self-conscious, self-critical and non-objectifying. Its world-view, collective beliefs and attitudes need to be examined. This is why I prefer the term critical psychiatry.

On the other hand, I do have some reservation that the term "critical" may be open to misinterpretation. It tends to have a negative connotation and imply antagonism. This meaning may be the first one that you will find in dictionaries. In this sense, critical means "inclined to find fault, or to judge with severity." However, critical also has other meanings, such as being "characterised by careful, exact evaluation and judgement." Also, it may have something to do with a crucial turning point, in this sense meaning "of the greatest importance to the way things might happen." It is in these later senses that I am using the word "critical" in relation to psychiatry.

Critical psychiatry could be accused of caricaturing psychiatry as a reductionist, biomedical behemoth, crushing all dissent and interested only in drug treatment. In fact, modern American psychiatry studied by participant observation appears to be "of two minds", in that there is a divided consciousness created between the practices of drug therapy and psychotherapy (Luhrmann, 2000). Psychopharmacology may be the dominant force in contemporary psychiatry, and psychiatrists may tend to act as though psychiatric illness picks out real disease processes in the body, but there is a general recognition that this model impoverishes the sense of human possibility. The professional split between biological psychiatry and psychotherapy represents this dilemma. Not that psychotherapy monopolises the benefits of attempting to understand a

person's problems. It too can degrade and cause harm.

Critical psychiatry is clearly not saying that all that is required is a combination of drug treatment and psychotherapy, as tends to be the position of those that criticise critical psychiatry for its apparent overstatement. The disadvantage of such an eclectic solution is that it suggests that to explain mental illness all one needs to do is to select the approach from the various alternatives of biological, psychological or social that seem most reasonable at the time. A fusion is created without necessarily resolving conflicts. Critical psychiatry is seeking a new synthesis. This synthesis is a continuation of the pluralism of the past. In terms of theory, it could be seen as a restatement of the position of Adolf Meyer in a post-antipsychiatric age.

The critical issue in modern psychiatry is the apparent benefit of psychopharmacology, which has grown since Meyer's time, following the introduction of chlorpromazine in the 1950s. How much is this advantage due to the placebo effect? People have always sought to bolster and restore their health by taking medications. They have not always taken a rational approach to this key problem of life. Quackery was profitable because sufferers believed in the cures for their ailments. The difference now is that large international pharmaceutical companies make the profits rather than the travelling vendor. The safety and effectiveness of modern medicines is regulated, but there are biases towards the interests of industry and trade against the interests of patients and public health.

We may want a placebo solution to our problems, because it seems easy and quick, but more longlasting benefits may emerge from the difficult task of dealing more thoroughly with our problems. The way we conceive of mental illness as a society does matter.

Conclusion

What I have tried to do in this chapter is to describe how critical psychiatry wishes to change the dominant paradigm in mental health practice from a biomedical to a biopsychological model. This interpretative model recognises the centrality of social perspectives. What is not always clear is that mainstream psychiatry has always had elements that have acknowledged these perspectives. I have attempted to elucidate the relationships with so-called anti-psychiatry, and its history in the pluralism of mid-twentieth century psychiatry before the development of psychopharmacology.

What I hope I have demonstrated is that critical psychiatry cannot easily be dismissed and its strength should not be underestimated in the current mental health debate. Objectification of the mentally ill in the biomedical model can make psychiatry part of the problem rather than necessarily the solution to the problem of mental illness. For this reason, the Critical Psychiatry Network has supported and seen itself as an essential member of the Social Perspectives Network (www.spn.org.uk).

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