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The future of critical psychiatry

Abstract
The aim of this paper is to outline an agenda for critiques of psychiatry and other mainstream ideologies of mental health for the 21st century. While the heyday of anti-psychiatry was the period from the 1960s to the 1970s, new critiques of psychiatry, clinical psychology and psychotherapy continued to emerge throughout the last two decades of the 20th century. Some of these – not least those that emerged from the mental health service users' movement – echoed the themes of earlier critics such as R. D. Laing and Thomas Szasz by questioning the legitimacy of diagnoses and therapeutic interventions. Others focused on anti-racist and/or feminist perspectives. This paper suggests that, in the wake of developments in biological psychiatry and socio-biology as well as clinical advances in psychopharmacology and the rise of Evidence Based Psychiatry, critical psychiatry has a new role. This role is less adversarial than that of the so-called anti-psychiatry of the 1960s and 1970s and less concerned with challenging basic assumptions about the causes of mental distress. The critical psychiatry of the 21st century can best serve the interests of service users by ensuring that service users' rights to autonomy, fairness and freedom of choice are not overlooked due to a preoccupation with the science of Evidence Based Psychiatry.

Key words: anti-psychiatry, ideology, post-psychiatry, user perspectives

The historical context

This paper evaluates the impact which critical psychiatry has had on mainstream perspectives on mental health since the mid 20th century and attempts to develop a framework for critical psychiatry which

takes account of those developments and addresses the contradictions that are currently evident in prevailing ideologies of mental health and mental health care.

The heyday of critical psychiatry was the 1960s and the 1970s. It was during this period that the so-called anti-psychiatrist R. D. Laing became a key figure in the counter-culture of radical politics, civil rights and recreational drug use, while the self-styled libertarian psychiatrist Thomas Szasz was also at the height of his fame and popularity as a critic of psychiatry (Parker et al., 1995; Coppock and Hopton, 2000). Although both Szasz and Laing were opposed to coercion and compulsory treatment in psychiatry they differed inasmuch as Laing was primarily concerned with finding ways of understanding psychotic experience while Szasz's main concern was to demonstrate that 'mental illness' is a myth and that the medical model is wholly inappropriate for dealing with so-called psychiatric problems (which he reconceptualized as 'problems in living'). While Laing, Szasz and their associates were developing critiques of psychiatry and the concept of mental illness from within the psychiatric profession, some social scientists were developing similar critiques from outside the profession. For example, Michel Foucault suggested that psychiatry was more about surveillance and social control than about compassion for those in distress (Foucault, 1971, 1977), while writers such as Goffman, Scheff and Rosenhan were analysing the process of psychiatric diagnosis from the perspective of labelling theory (Goffman, 1961; Scheff, 1966; Rosenhan, 1973). It is important to recognize though that others followed the lead of such writers so that it became possible to speak of an intellectual movement that involved not only mental health professionals, but also representatives from the arts and the wider intelligentsia. While this is sometimes referred to as the anti-psychiatry movement, in this paper it will be referred to as the critical psychiatry movement. There are three reasons for this: 1) Szasz's right-wing perspective is in many ways very different from the broadly left-wing perspective of the Philadelphia Association; 2) many of the activists within the movement were to some extent uncomfortable with the negative connotations of the term 'anti-psychiatry'; 3) it is argued in this paper that critical psychiatry is not an historical curiosity but a living tradition.

In addition to social workers and psychiatrists, writers and artists were attracted to the ideas expounded by the likes of Szasz, Cooper and Laing (Cooper et al., 1989; Laing, 1994). For example, the Ken

Loach film *Family Life* and Ken Kesey's novel (later to be made into a major film) *One Flew Over the Cuckoo's Nest* reflect the themes of anti-psychiatry. However, it would be a mistake to dismiss anti-psychiatry as mere intellectual theorizing or a cult of personality based around high profile charismatic figures such as Laing and Szasz. Both Laing and Cooper attempted to apply their ideas to psychiatric care (Laing and Esterson, 1964; Cooper, 1970; Mullan, 1995), while other mental health professionals took up these ideas, elaborated upon them and also developed innovative approaches to mental health care (e.g. Boyers and Orrill, 1972; Radical Therapist Collective, 1974; Ingleby, 1981; Berke et al., 1995; Coppock and Hopton, 2000).

However, by the dawn of the 1980s critical psychiatry was no longer a cause célèbre amongst the intelligentsia, and neither had it managed to establish itself as one of the mainstream ideologies embraced by the mental health professions. Nevertheless, it had not completely died. Szasz continued to publish articles and books articulating his particular standpoint on what he considered to be psychiatry's false claims and extending his critique to psychotherapy and social welfare (e.g. Szasz, 1979, 1994); while the Philadelphia and Arbours associations which had pioneered alternative approaches to mental health care inspired by Laing and Cooper continued to operate a small number of residential homes in London, England (Berke, 1979; Schatzman, 1980; Cooper et al., 1989). Nevertheless, the influence of these ideas was in decline and new critiques of psychiatry did not really begin to emerge until the late 1980s and early 1990s.

The main thrust of the new critiques was anti-racism, feminism, and user-centredness (e.g. Fernando, 1991; Ussher, 1991; Pilgrim and Rogers, 1993), although Jeffrey Masson stands out as a writer who attacked even the talking therapies favoured by many of the first wave of critical psychiatrists (Masson, 1990). The anti-racist and feminist perspectives essentially reflected the theoretical and political imperatives of the wider anti-racist and feminist movements. The user-centred perspectives, though had a two-pronged attack. In one sense, they reflected wider social concerns about the importance of self-advocacy, consumerism, stakeholding and self-determination (Sayce, 2000). However, they also implicitly echoed the concerns of the earlier critical psychiatry movement as service users, their allies/advocates and radical mental health professionals began to articulate new perspectives on issues such as self-harm and voice-hearing. These

new perspectives made claims that voice-hearing was not necessarily a symptom of schizophrenia and could sometimes be managed without resorting to psychopharmacology (Romme and Escher, 1993), and that repeated non-lethal self-harm was not inextricably linked to 'attention-seeking', 'manipulative' and anti-social behaviour but had complex origins and meanings (Pembroke, 1994).

Evaluating the impact of early critical psychiatry

Notwithstanding the echoes of so-called anti-psychiatry in the new perspectives on issues such as self-harm and voice-hearing, the work of Szasz, Laing, and still less that of their fellow-traveller contemporaries, rarely merits more than a footnote in textbooks on mental health published from the mid 1980s onwards (e.g. Lyttle, 1986; Reynolds and McCormack, 1990; Brooking et al., 1992; Gelder, Mayou and Cowen, 2001). In the sense that the transfer of mental health services to District General Hospitals began after the emergence of anti-psychiatry and the medicalization of mental distress/illness continued after its demise (Breggin, 1993; Jones, 1993; Kirk and Kutchins, 1999; Beresford and Hopton, 2002), perhaps this is unsurprising. On the other hand, the critical psychiatry movement of the 1960s and 1970s can be shown to have had a lasting (if subtle) effect on the way in which mental health issues are conceptualized and addressed. For example, even though the ideas of Szasz, Laing, their associates and fellow travellers were very much on the margins of mainstream psychiatry, some of those who entered mental health professions during that era became more receptive to such critical perspectives than many of their predecessors (e.g. Hinchliffe, 1990; Coppock and Hopton, 2000; Barker and Buchanan-Barker, 2002; Maitland, 2003). Similarly in British mental health nursing, while it includes no direct references to the influence of critical psychiatry, the 1982 syllabus for the training of Registered Mental Health Nurses was explicitly and deliberately based on a rejection of the medical model of mental illness (Nolan, 1993; Hopton, 1997). Thus, it might be argued that the early critical psychiatry of the 1960s and 1970s helped to foster an environment in which anti-racist, feminist and user-centred critiques of psychiatry, psychology and psychotherapy would be given serious consideration.

While early critical psychiatry made valid points about coercion in psychiatry and the narrow-mindedness of a psychiatric profession that adhered rigidly to a medical model of mental illness which was then based on largely untested ideological assumptions, there have been a lot of developments since that time. For example, advances have been made in the fields of socio-biology, biological psychiatry and psychopharmacology which suggest that a medical model of mental illness is not necessarily wholly inappropriate. These include the use of light therapy in the treatment of seasonal affective disorder (Wileman et al., 2001), the clinical effectiveness of the selective serotonin reuptake inhibitor group of anti-depressants (Hedaya, 1996) and the apparent clinical effectiveness of clozapine in the management of 'treatment resistant schizophrenia' (Woodall et al., 2004). Alongside the development of these new and/or refined physical treatments, mainstream psychiatry has also embraced therapeutic approaches that are not dissimilar to those advocated by the critical psychiatry movement in the 1960s and 1970s. For example, there has been a growing acceptance that talking therapies such as cognitive-behavioural therapy can be an effective intervention in cases of psychosis (Haddock and Slade, 1996), and that the use of therapeutic community approaches can be effective in the management of personality disorder, a condition that many psychiatrists have traditionally considered to be 'untreatable' (Campling and Davies, 2003). Such developments would seem to imply a tacit acceptance that psychosis can be intelligible, and that creative thinking can lead to therapeutic success with individuals whose problems do not respond to psychopharmacology. Thus, at the level of appearances, it might seem that at the beginning of the 21st century, mainstream psychiatry has justified its claim that a medical model can (at least sometimes) be an appropriate conceptual and clinical approach to mental distress and has responded positively to ideas about the intelligibility of psychosis and the treatability of personality disorder.

Notwithstanding such developments, the later manifestations of critical psychiatry (which are in some cases contemporaneous with these developments) claim that misplaced faith in a medical model of mental illness has led to discrimination and oppression of sub-groups of mental health service users such as women and those from ethnic minorities. Similarly, service user activists have consistently argued that the medical model of mental health has led to the marginalization and oppression of service users who resist psychiatry's

diagnostic labels or who do not respond positively to medicalized treatments of their distress. Furthermore, many of these latter day critics of psychiatry have given clear examples of such discrimination, while the validity of some of these claims has been confirmed by official governmental enquiries (e.g. Ritchie et al., 1994; Sallah et al., 2003) and is implicitly accepted in policy documents such as the *National Service Framework for Mental Health* (NHS, 1999). Inasmuch as these developments echo the concerns of the early critical psychiatrists about the coercive dimension to psychiatry and the use of psychiatry in the social control and policing of social non-conformity and political dissent, even early critical psychiatry cannot be dismissed as a historical curiosity. However, critical psychiatry should be re-evaluated in the context of these developments and the emergence during the 1990s of the Evidence Based Medicine (EBM) movement (also known in this context as Evidence Based Psychiatry).

While in one sense, medicine has been evidence-based throughout modernity, the significance of this movement is that it reflects growing concerns about professional accountability, cost-effectiveness and resource allocation based on the systematic review and appraisal of relevant scientific clinical research. This is especially significant in the field of psychiatry where ambiguity about the aetiology of many psychiatric conditions has led to therapeutic interventions often being based on a combination of intuition, probability and inspired guesswork. However, within Evidence Based Medicine there is an assumption that there is a hierarchy in the credibility of research wherein evidence from randomized controlled trials is considered to be the most reliable form of evidence (Gelder et al., 2001). This inevitably presents problems for those mental health professionals whose clinical practice is based on (unquantifiable) humanistic approaches. Furthermore, within the field of mental health there are concerns about the role of pharmaceutical manufacturers in the generation of much of the available scientific research data about psychiatric drugs (e.g. Healy, 2001; Adams, 2001); the lack of regard for research approaches other than random controlled trials (Slade, Kuipers and Priebe, 2002); the lack of research evidence about the impact of drugs on the quality of life of service users (Faulkner and Thomas, 2002); and the possibility that, in the name of cost-effectiveness, research evidence might be used to justify coercive interventions with supposedly 'high-risk patients' (Cooper, 2003).

Critical psychiatry in the era of evidence-based practice

Notwithstanding such concerns about Evidence Based Medicine in relation to mental health, for ethical and political reasons, research evidence about mental distress and therapeutic interventions cannot be ignored. Evidence Based Medicine has generated a lot of data about a range of clinical interventions. This represents a sharp contrast with the early critical psychiatry movement which provided very little in the way of evidence to support its claims for the efficacy of the therapeutic interventions that it advocated. Indeed, for the most part, all we have by way of a record of the supposedly pioneering work of R. D. Laing and his followers are a variety of anecdotal, autobiographical accounts and a minute number of detailed case studies of individuals whose clinical presentation was atypical (Barnes and Berke, 1971; Boyers and Orrill, 1972; Radical Therapist Collective, 1974; Schatzman, 1980; Sedgwick, 1982; Mullan, 1995). Furthermore, many of these accounts were written some time after the events described had actually occurred so even if they are not tainted by nostalgia or personal-political agendas, they may be affected by the limitations of human memory (see Ainsworth, 1998). Thus, 20 to 30 years later there is little justification either for championing the approaches used by the so-called anti-psychiatrists or for attempting to replicate the kind of clinical work that the early critical psychiatrists were engaged in. Nevertheless, this lack of clinical credibility does not necessarily invalidate the questions that underpinned the work of the critical psychiatry movement.

The key questions posed by the early critical psychiatry movement concerned the validity of the medical model, whether psychotic thought could be 'decoded' and rendered intelligible, and whether there was a real need for compulsory powers of psychiatric detention and treatment. The work undertaken clinically in locations such as Villa 21, Kingsley Hall and other establishments later run by the Philadelphia and Arbours associations posed further questions about the need for psychiatric medications and how best to mentor a person through acute psychotic episodes. Later on, the second wave of critical psychiatry continued to ask such questions and also generated new questions about the historical emergence of psychiatry as a distinct branch of medicine in an era dominated by ideologies of patriarchy,

eugenics, imperialism and faith in professional expertise (Coppock and Hopton, 2000). According to such analyses this historical coincidence led to gender biased and culturally biased assumptions about normal and abnormal behaviour becoming intertwined with official discourses of so-called mental illness.

One of the key new themes that has emerged from the second wave of critical psychiatry is that such ideological contamination continues to interact with structural inequalities in ways that result in mental health services being tainted by institutionalized racism, sexism and the marginalization of service users' own perspectives on mental illness/distress. However, while the questions arising from the first wave of critical psychiatry continue to be valid and while there continues to be evidence that supports the allegations of the second wave of critical psychiatry (e.g. Sallah et al., 2003), there have also been developments that suggest that progress has been made and continues to be made in responding constructively to such critiques.

There are at least three ways in which developments have occurred that in some way render the analyses of the critical psychiatry movement problematic. First, there is the perspective of modern biological psychiatry and socio-biology which holds that behaviour is the product of a complex inter-relationship between biology and environment (Ridley, 1993; Hedaya, 1996). Secondly, there are new developments in medicine in general such as the Expert Patient Programme (Department of Health, 2001) as well as new concepts and initiatives emerging within psychiatry such as the current connotations of the term 'recovery' and the introduction of Primary Care Graduate Mental Health Workers (National Institute for Mental Health in England, 2004). Thirdly, there is the growing emphasis on empowerment, partnership and stakeholding throughout the entire public sector.

Notwithstanding such developments, critical psychiatry continues to have intellectual and socio-political value. For example, critiques of psychiatry and mental health services can be used to interrogate any claims made under the banner of Evidence Based Psychiatry. Thus, critical psychiatry's scepticism about the value of Evidence Based Psychiatry leads to consideration of the reservations of those service users who are suspicious of interventions such as Assertive Outreach, alongside the evidence that points to its effectiveness and reports widespread user satisfaction (Smith and Morris, 2003). Similarly, critical psychiatry has a role in posing the kinds of questions that can

lead to consideration of a wider picture than that provided by random controlled clinical trials. For example, there is evidence that potential problems of dependence/withdrawal were originally overlooked when the effectiveness of selective serotonin reuptake inhibitor antidepressant drugs (especially paroxetine – also known by its trade name of Seroxat) was being evaluated (Medawar, 2003).

Critical psychiatry may also be useful as a basis for challenging attempts by policy makers to consolidate or extend coercive psychiatric practices such as compulsory detention and treatment. A good example that shows that this is a real threat is the response given to service users and critically minded mental health professionals who challenged the content of a draft mental health bill in 2002. While the Prime Minister, Tony Blair claimed to understand the concerns expressed by these stakeholders, it seemed to many that he was responding more to the concerns of those members of the public who worry that 'some people who tragically have a severe mental disorder can pose a danger and threat to the public' (Harper, 2002: 4) than to the evidence which suggests that such concerns are largely unfounded (Taylor and Gunn, 1999). In the face of such political attitudes, a critical psychiatry movement has an important role to play in providing the evidence that counters the media frenzy that often surrounds high profile but exceptional cases such as the murders of Jonathan Zito by Christopher Clunis and of Lin and Megan Russell by Michael Stone.

Developments such as the Expert Patient Programme, the emergence of Primary Care Graduate Mental Health Care Workers and the emerging concept of 'recovery' are in many ways progressive. Such initiatives can be ambiguous though. The rationale behind the launch of the Expert Patient Programme is that people with chronic health problems often know more about how to manage their condition than health professionals. However, there is also a suggestion that people need to be trained in order to become expert patients. While it is axiomatic that this will be true of newly diagnosed patients and while it is feasible to have user-led education programmes for such individuals, there is nevertheless a possibility that the ethos behind this initiative might eventually become corrupted into a 'nurse/doctor knows best' kind of approach via the training programmes devised to enable people to become 'expert patients'. Similarly, the fashionable concept of 'recovery' can be a two edged sword. On one level, it represents a step away from the once prevalent idea that mental illness

is something that you have to learn to live with, and that only compliance with medication will prevent a relapse. On the other hand, it also seems to have medical overtones and seems at variance with the view of organizations such as the Hearing Voices Network that, for some people hearing voices can be just a way of being in the world and does not necessarily require 'treatment'. Again, critical psychiatry has a role in keeping alive debates and discussion about what should be the meaning ascribed to such phrases as 'recovery' and 'expert patient', and so act as a safeguard against gradual erosion of principles of user-centredness.

It is also the case that since the early 1990s, concepts such as empowerment, partnership and stakeholding have been at the forefront of any debates about improvements in health and welfare services. The original impetus for this (at least in the British context) seems to have been the preoccupation of the New Right in the 1980s with challenging professional authority within the welfare state via consumerism but regardless of its origins, the ideology of user involvement has become so entrenched that it is unlikely to disappear. Nevertheless, there is a wide variation in how user involvement is conceptualized and put into practice (Maguire, 2005). Furthermore, even official policy can overlook the needs of specific sub-groups of service users. This is particularly evident in the case of ethnic minority users of mental health services. For example, when the government established an External Reference Group on Mental Health Policy in the late 1990s, none of the eight sub-groups initially established had a remit to consider race and culture, even though race and culture had been highlighted as a major issue in relation to mental health since the early 1980s (Fernando, 1998; Rack, 1982). It took an open letter from a group of prominent mental health professionals to Frank Dobson (then Minister for Health) to remedy this oversight. More recently the inquiry into the case of David Bennett raised concerns about institutionalized racism in British mental health services (Sallah et al., 2003). The continuing existence of critical psychiatry is vital if progress is to be made and substantive user involvement and truly user-centred/user-led services are to become a reality, as critical psychiatry represents an independent voice, supporting the demands of service users through professional and academic research and publications. Critical psychiatry also has a similar role to play in highlighting the plight of those long-term users of mental health services who do not benefit from the latest

clinical advances and whose enduring severe mental distress might prevent them from expressing their concerns in the right forums (Rethink, 2004; Maguire, 2005).

Conclusion

At the beginning of the 21st century critical psychiatry has come a long way from its roots in the work of the right-wing libertarian Thomas Szasz and the left-wing intellectuals of the Philadelphia Association in the early 1960s. Nevertheless, it continues to pose similar questions about the origins and management of mental distress, and the validity of compulsory treatment and other forms of coercion. Additionally it raises new questions about fairness, social justice and equality of access to mental health services. Admittedly it is not such a broad church as it was in the heyday of anti-psychiatry in the late 1960s and early 1970s when it was as likely to include artists, dramatists and other assorted intellectuals as mental health professionals. These days, it is largely a movement of mental health professionals, academic psychologists and social scientists working in conjunction with the agendas set by the mental health service user movement which emerged during the late 1980s and early 1990s. In this sense, it should not be seen as antagonistic to mainstream concepts and practices such as Evidence Based Psychiatry, recovery, new developments in psychopharmacology etc., but complementary to them; by encouraging practitioners of mental health care to look behind the science to see the wider picture. Similarly, Evidence Based Psychiatry can be shown to have validated some of the claims of critical psychiatry.

Evidence Based Psychiatry has led to a reduction in the use of electroconvulsive therapy (ECT) which has long been a bone of contention between critical psychiatry and mainstream psychiatry. In 2003 the British National Institute for Clinical Excellence, having reviewed the available evidence, recommended that this controversial therapy should henceforth only be used in cases of severe depression and where other treatments had been tried and found to be inadequate (Fleischmann, Rose and Wykes, 2003). While this does not go as far as many representatives of critical psychiatry might like, it nevertheless represents clear advice to clinicians that ECT should only be used in clearly restricted circumstances and prevents clinicians from

justifying its use on nothing more than their 'professional judgement' or 'professional experience'. Similarly, there are those who see no inconsistency between a rejection of the concept of 'mental illness' and the use of medication to overcome a crisis (Coppock and Hopton, 2000; Chadwick, 2003). Inevitably people who take that view would prefer to take the drug that would be most effective and would have the least side effects and Evidence Based Medicine is likely to facilitate the identification of such medications. More generally, the anti-racist and feminist strands of critical psychiatry have highlighted how 19th century psychiatry became contaminated by prevailing discourses of patriarchy, imperialism and eugenics and how some of these assumptions became institutionalized within psychiatric assumptions. Ongoing concern to develop Evidence Based Psychiatry should contribute to the elimination of any such assumptions that may still survive.

In summary, the role of critical psychiatry in the 1960s and 1970s was to question the basic common sense assumptions about 'mental illness', its management and psychiatric expertise and to argue the case for more autonomy and therapeutic choices for people suffering from mental distress. In the wake of the New Right's assault on professional arrogance within the welfare state; new political ideologies of stakeholding, citizenship and identity politics; cultural influences such as New Age spirituality, alternative medicine and post-modernism, these ideas are no longer radical or revolutionary. Nevertheless, the draft Mental Health Bill on the reform of the 1983 Mental Health Act contains proposals to extend powers of compulsory treatment to community settings and to encompass people who are considered to have 'untreatable' personality disorders; while concerns have been raised about patterns of prescribing of apparently clinically effective new drugs such as paroxetine. Such developments clearly demonstrate that there is still a role for critical psychiatry at the beginning of the 21st century. However, its role now is less to challenge the underlying assumptions of psychiatry and more about using research findings to challenge demands for more coercive psychiatric initiatives, while at the same time offering critical perspectives that highlight the limitations to research influenced by Evidence Based Psychiatry, which might otherwise be overlooked due to a preoccupation with measurable data.

Possibly some of the more radical elements within the mental health service users' movement (and the wider critical psychiatry

movement for that matter) might consider a retreat from challenging the underlying assumptions of psychiatry to be a betrayal. However, other parties within the user movement are more concerned about the way in which the medical model of mental health has been used to legitimate coercive psychiatric interventions than the theoretical assumptions which underpin medical psychiatry per se. Nevertheless, there may be a risk that the kind of engagement with Evidence Based Psychiatry that has been proposed here could result in tipping the balance of power back towards a more paternalistic approach to the management of mental distress and the provision of mental health services. Indeed, even some of the early literature of critical psychiatry (not least that produced by Laing and his associates about their work at Kingsley Hall) reflects a benign paternalism wherein distressed persons' experience is presented and interpreted by self-proclaimed 'experts' rather than by distressed persons themselves. On the other hand, the progress made by the mental health service users' movement over the last 20 years should be sufficient to ensure the continuance of reasoned public debate wherein service users' anxieties are addressed constructively so that no such shift towards paternalism occurs within the critical psychiatry movement itself. For example, even within the mainstream, service users are now routinely consulted about developments in mental health policy while service user activists give keynote speeches at mental health conferences and are employed as university professors in social sciences. As long as critical psychiatry sustains a constructive dialogue with such representatives of the users' movement and continues to lobby for mainstream mental health services and mental health professionals to sustain a similar dialogue with them, any backsliding towards paternalism should be avoidable.

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