Critical Psychiatry Network
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Critical Psychiatry

New Labour's 'new' look at mental health policy has some nasty surprises for those who believed that May 1st 1997 heralded a new dawn of tolerance, understanding and social inclusion for those suffering from mental health problems. The government is proposing changes that have serious implications for the human rights of people who use psychiatric services. Although the National Service Frameworks contain positive developments like home treatment, the government's priority appears to be increasing coercion and control for those using mental health services. The green paper reforming the 1983 mental health act includes proposals for compulsory treatment in the community, and is accompanied by a joint Home Office and Department of Health initiative on the management of people with so-called dangerously severe personality disorders (DSPD). If enacted, this would enable psychiatrists to detain such people indefinitely, even though they had committed no offence. We would be the only democracy in the World in which you could be locked up for life without having committed an offence. Compulsory treatment in the community and reviewable detention represent serious challenges to human rights, and this has fuelled concern inside the profession. In January 1999 the Critical Psychiatry Network first met in Bradford to discuss these concerns, and has since made clear its opposition to compulsory treatment in the community and reviewable detention for people with DSPD. To understand critical psychiatry we must consider the recent context in which medicine and psychiatry have been practiced.

In the last fifty years there has been growing disaffection with the medical profession. Until recently, the public was happy to defer to what was seen as the knowledge and experience of experts like doctors. What might loosely be called post-modernism has changed that, questioning the role of experts by challenging the authority of their knowledge. The assumption that science and technology can answer society's most complex problems has been thrown open to doubt. Science is no longer regarded as the saviour of mankind, but as the bringer of even greater problems. As medicine has become more influenced by technology and science, it has lost contact with basic human values of respect for the other person's beliefs and preferences. This is particularly so in psychiatry, where clinical neuroscience has driven a political agenda inflamed by distorted media coverage of high profile 'failures' of community care, in which risk reduction is of paramount importance. The result is legislation that attaches more importance to forcing people to take medication. Psychiatry has always been deeply split between care and healing on the one hand, and coercion and social control on the other. Government legislation, in shifting the balance away from care towards control, is making this split even clearer. No other medical speciality has the equivalent of the psychiatric survivors movement, confirmation of the coercive nature of psychiatry.

Critical psychiatry is part academic, part practical. Theoretically it is influenced by critical philosophical and political theories, and it has three elements. It challenges the

dominance of clinical neuroscience in psychiatry (but does not exclude it); it introduces a strong ethical perspective on psychiatric knowledge and practice; it politicizes mental health issues. Critical psychiatry is deeply sceptical about the reductionist claims of neuroscience to explain psychosis and other forms of emotional distress. It follows that we are sceptical about the claims of the pharmaceutical industry for the role psychotropic drugs in the 'treatment' of psychiatric conditions. Like other psychiatrists we use drugs, but we see them as having a minor role in the resolution of psychosis or depression. We attach greater importance to dealing with social factors, such as unemployment, bad housing, poverty, stigma and social isolation. Most people who use psychiatric services regard these factors as more important than drugs. We reject the medical model in psychiatry and prefer a social model, which we find more appropriate in a multi-cultural society characterised by deep inequalities.

The practice of critical psychiatry has important ethical implications. It is often difficult to work in the biomedical model in a way that really respects and engages with the patient's beliefs and preferences. What point is there respecting the patient's view if you believe that the main objective is to rectify a neurochemical imbalance in someone's brain? The social model, on the other hand, recognizes that the meaning of distress is culturally contingent, and so engaging with the person's belief systems and values is of paramount importance. This can only be achieved by listening carefully and respecting the person's beliefs. Critical psychiatry also brings a political perspective on mental health issues. The biomedical model locates distress in the disordered function of the individual's mind/brain, which relegates social contexts to a secondary role. This is problematic because it completely overlooks the role of poverty and social exclusion in psychosis. One of critical psychiatry's most important tasks is the creation of a new dialogue between survivors, mental health service users and psychiatrists, a dialogue that recognizes the value of different types of expertise. Psychiatrists are experts by profession, but service users are experts by experience. The best outcomes will only be achieved when these two types of expertise can work in alliance, something that critical psychiatry argues must happen now. The government already recognizes the importance of alliance between patient experts and health professionals in the area of chronic physical illness, by establishing an Expert Patients' Task Force to consider how professionals can work in partnership with expert patients. We believe that this model must be applied to the field of mental health, and we hope the government will not waste an excellent opportunity to act on this.

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PSYCHIATRIC IMPERIALISM: THE MEDICALISATION OF MODERN LIVING.

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Introduction

The institution of psychiatry grew up in the 19th century during the emergence and consolidation of industrial capitalism. Its function was to deal with abnormal and bizarre behaviour which, without breaking the law, did not comply with the demands of the new social and economic order. Its association with medicine concealed this political function of social control by endowing it with the objectivity and neutrality of science. The medical model of mental disorder has served ever since to obscure the social processes that produce and define deviance by locating problems in individual biology. This obsfucation lends itself to the perpetuation of the established order by side-stepping the challenge that is implicit in deviant behaviour and thereby undermining a source of criticism and opposition. During the 20th century, a fierce attack on psychiatry has condemned this misleading medical characterisation of the problems of living and the repressive measures that masquerade as psychiatric treatment. However, at the same time more sophisticated technology has enabled the psychiatric profession not only to weather the storm, but to strengthen its claim to the jurisdiction of 'mental illness.' Opportunities for social control and the suppression of dissent in the guise of psychiatry have increased.

In some respects psychiatry has never been as confident and respectable as it is at present. In the 1950s and 1960s a pharmacological revolution produced an array of drugs for use in disorders such as schizophrenia, depression and anxiety which enabled psychiatry to move closer to the paradigm of physical medicine of administering specific cures for specific conditions. Starting in this period also, psychiatric care relocated physically away from the discredited asylums and into general hospitals, in closer proximity to the rest of the medical community. This move embodied the attempts of the psychiatric profession to disentangle itself from the stigma of caring for the chronically insane and

instead to forge a role curing the acutely disturbed. Community care is the concession to the chronic and recurrent nature of psychiatric conditions.

Similarly, the endeavour to locate the biological origins of mental illness has been revitalised by the introduction of new technology for studying the brain and by the development of molecular genetics and the human genome project. Despite a disappointing lack of consistent results, the quantity of resources devoted to this research has, in itself, leant the medical model of mental illness further credibility.

However, the 20th century has also produced an influential critique of psychiatry articulated by academics and some rebel psychiatrists (famously, R.D. Laing, Thomas Szasz & David Cooper). Sociological theories of deviance, medicalisation and the organisation of professions helped to expose the political functions and processes involved in the institution of psychiatry. The paternalism of psychiatry was attacked and medical treatment was accused of being more oppressive than legal sanctions or punishment.

These ideas were expressed in concrete form in the activities of protest movements, patient advocacy groups and experiments in alternative care. In the early 1970s in the Netherlands and the United States, where protest movements were particularly strong, there were demonstrations against the use of electro convulsive therapy (ECT), university lectures were disrupted and some prominent biological psychiatrists had to have police protection. There were famous attempts to create therapeutic communities which renounced staff patient distinctions and hierarchies (such as R.D. Laing's Kingsley Hall and David Cooper's Ward 21in the United Kingdom) and in Italy a politically conscious democratic psychiatry movement instituted mental health care reforms. The patient advocacy movement, which took inspiration from civil rights organisations, was another important development. Although the activism has diminished, patient or survivor groups remain strong and individuals and groups of professionals continue to promote alternative approaches to the problems of the so-called mentally ill . The 'antipsychiatry' movement also had a significant impact on social policy resulting in increasing restrictions on involuntary confinement and treatment and a diminishing use of physical techniques such as psychosurgery and ECT.

However, recent developments in the definition and management of two major psychiatric conditions, depression and schizophrenia, illustrate that the social influence and formal powers of institutional psychiatry may now be expanding. The criticism that was first expressed over three decades ago may therefore be more relevant than ever.

Depression: medicalising discontent

The Defeat Depression Campaign (DDC), launched in 1992 was organised by the Royal College of Psychiatrists in association with the Royal College of General Practitioners with funding from the pharmaceutical industry. The literature of this campaign suggests that around 10% of the population suffer from a depressive disorder at any one time, a third will suffer at some time during their lives and antidepressant drugs are

recommended for all those with moderate to severe symptoms. These claims seem to suggest that a large proportion of human unhappiness is biologically based and can be similarly corrected. The publicity surrounding the new antidepressant fluoxetine (prozac) has become only slightly more extreme with claims that it has personality altering and general life enhancing properties.

A recent collection of interviews with prominent psychopharmacologists who were involved with the discovery and introduction of modern psychiatric drugs provides an interesting historical backdrop to the DDC. In psychiatric hospital practise in the 1950s depression was a relatively rare disorder and there was no concept of a specifically antidepressant drug as opposed to a general stimulant. When antidepressant action of certain compounds was first proposed drug companies were initially reluctant to develop and launch such drugs. In an unconscious alliance of interests, influential psychiatrists developed and popularised the view of depression as a common biologically based disorder, amenable to drug treatment and as yet frequently unrecognised. This concept had the dual benefits of vastly expanding the market for psychiatric drugs and extending the boundaries of psychiatry outside the asylum. Since this time the psychiatric profession and the drug industry have continued to try and inculcate this idea into the consciousness of both the general public and other doctors. The DDC is the latest offensive.

Numerous biochemical mechanisms responsible for depressive illness have been proposed implicating a variety of biochemical and hormonal mechanisms, partly determined by fashion. The evidence for all these theories has been inconsistent and the consensus about the efficacy of antidepressant drugs remains the strongest support for the thesis that depression is a physiological condition. Perusing the psychiatric literature indicates that this consensus developed in the mid 1970s based on evidence from randomised controlled trials of the original and still widely used antidepressants, the tricyclics. However, early reviews of this evidence portray an ambiguous situation with a large proportion of trials failing to find a positive effect. In addition, more recently some researchers have suggested that antidepressants are not specifically active against depression but merely exert a placebo effect in a receptive condition . They appear to perform better than an inert placebo because their side effects increase their suggestive power and may admit bias into the assessment procedure by enabling investigators to guess whether patients are on the active drug or the placebo. A recent meta-analysis of placebo controlled trials of prozac found that the likelihood of recovery was indeed associated with experiencing side effects . A review of seven studies which used an active substance as a placebo to mimic antidepressant side effects found that only one showed the drug to be superior.

Variation in mood is a characteristically human way of responding to circumstances but unhappiness has become taboo in the late 20th century, perhaps because it undermines the image that society wishes to project. Medicalisation diminishes the legitimacy of grief and discontent and therefore reduces the repertoire of acceptable human responses to events and denies people the opportunity to indulge their feelings. At the same time it diverts attention away from the political and environmental factors that can make modern

life so difficult and distressing. It may be no co-incidence that the concept of depression has reached its present peak of popularity in western societies reeling from two decades of economic events and political policies which have been blamed for increased unemployment and marginalisation of a substantial section of the population.

However, it is also important to acknowledge that people have different propensities to experience intense moods and that, for those at the extremes of this spectrum, such as those with manic depressive disorder, life can be very difficult. Prophylactic medication is promoted by psychiatrists for long-term use in this condition primarily in the form of lithium. However, in a similar way to antidepressants, claims of the efficacy of lithium seem to have been based on insubstantial evidence and follow up studies of people with manic depression do not indicate that it has improved the outlook of the condition. It is possible therefore that prophylactic drug treatment constitutes a false hope held out to people who feel desperate, by a profession that feels helpless. But it may only further undermine the self assurance of people who are already vulnerable. Instead of aspiring to complete cure, natural remission of episodes should be encouraged by providing care and security, and attempts should be made to enhance people's confidence in their own ability to manage or survive their condition.

Schizophrenia: disguising social control

The enormous investment in the investigation of the biological basis of schizophrenia has produced no conclusive information. Decades of increasingly sophisticated technological research has revealed a possible weak genetic predisposition, often much exaggerated by psychiatric commentators who ignore the shortcomings of the main studies . Molecular genetic studies have publicised initial findings implicating several different genes which then transpired to be due to chance when attempts at replication failed. The most recent pan European study boldly concludes that the genetic associations revealed are involved in the pathogenesis of the disorder. However, the gene implicated is common in the general population, it is only slightly more common in people diagnosed with schizophrenia and the similarity of the comparison group in this study was ensured only for ethnicity and not for other factors. As regards brain function and anatomy, the only consistent finding is the larger size of the lateral ventricle, one of the brain cavities, in people with schizophrenia. Again there is a substantial overlap with the 'normal' population and most studies have been conducted on people with long histories of drug treatment. However, the possibility that drugs may be responsible for causing the brain abnormalities observed has received little attention in the psychiatric literature .

Drugs variously termed 'major tranquillisers,' 'neuroleptics' or 'antipsychotics' form the mainstay of psychiatric treatment for schizophrenia. They have been claimed to have specific action against psychotic symptoms such as delusions and hallucinations, but critics suggest that they act in a much cruder way by producing a chemical lobotomy or straight jacket which inhibits all creative thought processes . Psychiatry applauds the role of these drugs in emptying the asylums but an alternative perspective suggests that they merely helped to replace expensive custodial care with long-term drug-induced control.

A consequence of the move towards community care is that public and political anxiety has replaced the concern for patients rights with concern for protection of the community and psychiatric treatment has become the panacea for this complex social problem. In response to a few highly publicised cases of violent or dangerous acts by former psychiatric patients, amendments were made to the Mental Health Act (1983) which came into force in April 1996 and which introduce a power of 'supervised discharge.' This power enables psychiatric personnel to have access to the patient if deemed necessary and to enforce attendance at psychiatric facilities. It does not confer the right to enforce medical treatment but it does require that an assessment for admission to hospital be conducted if the patient is uncompliant with aftercare arrangements such as refusing medication. The justification for this legislation is the assumption that medical treatment can cure disturbance and prevent relapse. However the evidence indicates that a substantial proportion of people with a psychotic episode fail to respond to medication at all, a further significant proportion relapse despite taking long-term medication (in clinical trials the relapse rates on medication is around 30%) and, like other people, they may behave antisocially when they are not actively psychotic.

The social control element of the changes to the Mental Health Act is only thinly veiled and they have been strongly opposed by civil and patients rights groups. Their significance lies in the introduction of a new precedent of control over people after discharge from hospital. The use of the former 1983 Mental Health Act for these purposes was successfully challenged in the courts in the 1980s. The exact form of the new provisions when implemented is uncertain and is likely to vary according to the predisposition of local professionals. Although there is much unease among psychiatrists about shouldering increased responsibility for the actions of people labelled mentally ill, many in the profession have called for stronger powers to enforce medical treatment in the community.

The medical model of mental illness has facilitated the move towards greater restriction by cloaking it under the mantle of treatment. This process of medicalisation of deviant behaviour conceals complex political issues about the tolerance of diversity, the control of disruptive behaviour and the management of dependency. It enables a society that professes liberal values and individualism to impose and re-inforce conformity. It disguises the economics of a system in which human labour is valued only for the profit it can generate, marginalising all those who are not fit or not willing to be so exploited.

Characterisation of schizophrenia as a physically based disease of the brain also forecloses any debate about the meaning of the experiences and actions associated with it. Attempts to render schizophrenic symptoms intelligible and to understand their communicative value help both to illuminate ordinary experience and to increase empathy for people with this condition. Other interesting findings point to the association of schizophrenia with features of social structure. Nothing resembling schizophrenia was described prior to the early 19th century, suggesting an association with the emergence of industrial capitalism. In modern societies schizophrenia is more frequently diagnosed in urban centres, among people of lower social class and in certain immigrant groups when compared to their country of origin, particularly second generation afro-Caribbean people

in the UK. Research in the third world has shown that people with schizophrenia have a better prognosis with a lower chance of relapse and functional decline than their counterparts in the developed world . It appears therefore that social conditions play a part in determining the expression of schizophrenic symptoms and so schizophrenia may be regarded as a mirror on the deficiencies of the current social structure.

Tolerance of the diversity of human lives and a respect for the autonomy of all must be the foundation of a progressive alternative approach. Enhancing people's control over their lives means providing genuine choices and opportunities for people of all different propensities. It means creating a society where there are niches available that allow a diversity of lifestyles. It involves accepting that some people may chose to lead lives that appear bizarre or impoverished. Although some people with schizophrenia will find drug treatment useful, psychiatrists frequent complaints about non compliance illustrate that many chose not to take medication. Similarly, some people with chronic mental illness gravitate away from the structured, rehabilitating environment of the mental health services to homeless hostels and to the streets. It is commonplace to blame the underfunding of community care for this phenomena but research has found that most of the homeless psychiatrically ill had not come straight from closing hospitals but had been settled in adequate community accommodation before drifting away . An alternative explanation might be that the long-term mentally ill prefer the undemanding nature of the homeless situation to the intrusive demands of family, community and mental health services.

The management of disruptive and dangerous behaviour is a problem for every society. Involuntary confinement and treatment continue to be a major area of contention with opposition emphasising the need to respect people's autonomy and opposing the imposition of a relative set of values about what is normal and sane. It is argued that it should be possible to deal with behaviour that is genuinely harming or harassing other people using normal legal sanctions. It is an area which requires further and wider consideration. Whatever solution is adopted, it must be developed openly and democratically, with proper provision for representation and public scrutiny, so that measures taken can not be subverted to serve the ends of certain groups above others.

Conclusion

Despite the political and professional retrenchment of recent years, there are many developments which presage the ultimate transformation of the psychiatric system. The burgeoning patients rights movement and the anti-psychiatry critique are some of these. Rejection of paternalism is also embodied in the increasingly important role of consumers in medicine in general and the demand for justification of treatments and involvement in decision making. The medical profession is also placing more emphasis on objective evidence about the effectiveness of procedures and showing less inclination to support the principle of clinical freedom. Many individual psychiatrists are aware of the political conflicts that beset their practice and try to address these thoughtfully and with respect for their patients and philosophical debate, which inevitable touches on political issues, is flourishing within the profession at present. It is unlikely however that psychiatry will be

radically transformed without profound social and political change. The control of deviance and the enforcement of conformity are too central to the smooth functioning of the divisive and exploitative social system in which we live.

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- Modern-day psychiatry relies too much on the "medical model" and emphasises diagnostic decisions. If psychiatrists adopted a more social or therapeutic community approach treatments would be more effective.
- The categorisation of psychiatric illness is not as clear as most psychiatrists believe. Assessment of aetiology too often fails to take personal and social factors into account.
- There is too much emphasis on the scientific possibilities of randomised controlled trials. The evidence of these trials is biased.

Introduction

Psychiatry is open to criticism because of its power of compulsory detention and treatment. This issue could be avoided by psychiatrists restricting themselves to voluntary treatment, and psychotherapists indeed routinely do practise on this basis. However, the social responsibility of caring for the mentally ill is an essential function of psychiatry and should not be neglected. The question is how well psychiatry fulfills its role.

Critical psychiatry suggests that psychiatric practice is often inadequate for a number of reasons. This article will review this critique of psychiatry by examining its main constituents. Over recent years mainstream psychiatry has marginalised its critics by dismissing them as "antipsychiatrists". However, those identified as part of the antipsychiatry movement, such as David Cooper, Thomas Szasz and RD Laing do not represent a single view (Tantam 1991). Cooper was politically Marxist and the only one that accepted the designation "antipsychiatrist"; Szasz (1972) regards mental illness as a myth; Laing recognised the turmoil of mental suffering, whilst acknowledging that the term mental illness is used metaphorically. Arguably, the "antipsychiatrists" are only linked by their willingness to criticise psychiatric practice.

Biological bias in psychiatry

Detaining the mentally ill creates the potential for abuse. From the 1950s, attempts were made to make psychiatric hospitals more therapeutic by unlocking the doors (WHO 1953). The maltreatment of patients in hospital was exposed in several scandals that gave an impetus to the dehospitalisation of patients (Martin 1984). Conversely, inquiries over recent years, particularly following homicides by psychiatric patients, have expressed

concern about neglect of patients in the community (Peay 1996). Psychiatric services have to find a precarious balance beside abuse and neglect.

Accordingly it can be difficult to sustain interpersonal relationships. One temptation is to retreat into objectification of those identified as mentally ill, insisting on the somatic nature of their illness. An advantage of this strategy is that it protects those trying to provide care from the pain experienced by those needing support. Notwithstanding some intuitive understanding of mental illness as a disorder of the mind, it is simpler to concentrate on its bodily substrate. Such a biological bias is not new in psychiatry, although psychopharmacological developments following the discovery of antipsychotics and antidepressants have reinforced this emphasis. As expressed by John Haslam (1798) over two centuries ago: "[T]he various and discordant opinions, which have prevailed in this department of knowledge, have led me to disentangle myself as quickly as possible from the perplexity of metaphysical mazes."

Both the dopamine theory of schizophrenia (dopamine overactivity in schizophrenic brains) and the amine hypothesis of depression (amines depleted in depressed brains) arose following the introduction of psychotropic drugs, at a time when only few neurotransmitters had been discovered. Despite the subsequent discovery of a vastly more complex neurotransmitter network, psychiatrists still use such simplistic notions in their everyday management of patients when they explain that mental illness is due to "chemical imbalance".

The evidence for the organic basis of functional psychiatric conditions such as schizophrenia is not as considerable as certain claims suggest. Functional imaging of receptors has produced equivocal results. Structural and functional cerebral abnormalities in schizophrenia are at best subtle rather than gross (Chua & McKenna 1995). In contrast, the identification and cloning of genes and the elucidation of chromosomal abnormalities has led to major progress in the molecular biology of genetic neuropsychiatric disorders, such as Huntington's disease, in which the abnormality of triplet repeat on chromosome four has now been demonstrated.

Taken to its extreme, the danger is that people with mental health problems will be reduced to purely physical terms wherein their brain chemistry needs correction. Moreover, the biological hypothesis is used to give justification to medical control in the treatment of mental illness. In relations of power, it suits psychiatrists to keep other mental health professionals thinking that they may be missing vital knowledge about bodily processes. The authority of the challenge to the biological hypothesis is thereby undermined.

Diagnosis

Single-word diagnoses fail to give an adequate understanding of a person's mental health problems. The modern explicit and intentional concern with diagnosis and classification disguises uncertainty about psychiatric disease entities.

In particular, over recent years, psychiatric diagnosis has become 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 DSM-III, DSM-IIIR and DSM-IV (APA 1994) and ICD-10 (WHO 1992). Robert Spitzer, who chaired the DSM-III Task Force, was particularly concerned about a study by Rosenhan (1973), which raised the fear that unreliable diagnoses may invalidate the whole process of psychiatric practice (Spitzer & Fleiss 1974). Rosenhan demonstrated that normal people could gain admission to hospital and acquire a diagnosis of schizophrenia by merely feigning a mundane, simple hallucination, saying they were hearing a voice say "thud", "empty" or "hollow". He concluded that professionals were unable to distinguish the sane from the insane. Operationalisation of psychiatric criteria arose as a response to the perceived need for objectification in diagnosis.

The US-UK Diagnostic Comparison Study demonstrated that American psychiatrists were using the term schizophrenia more inclusively than their British counterparts (Kendell et al 1971). This finding also contributed to a tightening of diagnostic criteria, particularly a restriction of the use of the term schizophrenia. Concern about stigmatisation has made psychiatrists much less ready over recent years to use a diagnosis of schizophrenia which tends to imply poor prognosis.

The movement to create explicit diagnostic criteria has been called neo-Kraepelinian, as it promotes many of the ideas associated with the views of Emil Kraepelin, often seen as the founder of modern psychiatry (Klerman 1978). Adolf Meyer was regarded as extremely influential in American psychiatry in the first half of this century, and his influence came to Britain via Aubrey Lewis and David Henderson (Gelder 1991). Meyer (1951/2) is remembered for his opposition to the preoccupation of the Kraepelinians with diagnosis. Although he accepted that there may be a place for classification, he argued that if diagnosis was meaningful, it was secondary to the assessment of the patient as a person (Double 1990). He may be held responsible for helping to create a trend which depreciated the role of diagnosis, which the neo-Kraepelinian movement deliberately countered. Psychoanalysis was strong in academic psychiatry in the post-war period in America and also appears to have played a role in de-emphasising the importance of diagnosis and classification..

It is illegitimate to postulate an underlying disease entity just because mental disorders may seem unintelligible. Assessment should concentrate on the "facts of the case", as Meyer was fond of saying, and diagnosis usually does justice to only part of "the facts". Even if "the facts" do not constitute a diagnosis, clinical management has to act on them. Meyer favoured a psychogenic explanation of mental illness and regarded it as not completely foreign to normal experience. In particular, he explained schizophrenia (dementia praecox) as a maladaptation that could be understood in terms of the patient's life experiences. Psychiatric assessment too often fails to appreciate personal and social precursors of schizophrenia by avoiding or not taking account of such considerations.

Social therapy

Several experimental attempts have been made to provide a more therapeutic milieu than the traditional hospital environment. For example, Harry Stack Sullivan established a small ward for schizophrenic men that was staffed with hand-picked attendants, set apart from the rest of the Sheppard Pratt Hospital in the 1920s (Barton Evans III 1996). He gave his staff autonomy to operate on their own with patients. As Sullivan (1962) stated:

> [W]e found intimacy between the patient and the employee blossomed unexpectedly, that things I cannot distinguish from genuine human friendship sprang up between patient and employee, that any signs of the alleged apathy of the schizophrenic faded, to put it mildly, and that the institutional recovery rate became high.

Sullivan's experimental ward could be seen as a precursor of the therapeutic community movement, whose influence came to be integrated with mainstream psychiatry (Jones 1952, van Putten 1973). This emphasis on the social aspects of treatment, though, is much less obvious in the current climate of risk assessment and psychotropic drug management (Clark 1974).

The "antipsychiatrists" also experimented with institutional alternatives. For example, David Cooper set up Villa 21 in Shenley Hospital, although Cooper's positioning as an antipsychiatrist makes it difficult to appreciate the similarity with ventures like that of Sullivan. Cooper's (1967) "experiment in antipsychiatry" failed to change the ward staff's role-bound behaviour. Laing's Kingsley Hall was outside the hospital system and was perhaps more like a commune. Criticism of its laissez-faire ethos should take account of Laing's own concession - that he had failed to find "a tactical, workable, pragmatic . . . . sort of thing that could work for other people" (Mullan 1995).

Scepticism about therapeutic efficacy

Historically doctors have prescribed medications which are now regarded as useless and often dangerous. Non-specific placebo effects can be powerful (Shapiro & Shapiro 1997). Uncontrolled evaluation of the efficacy of treatment was eventually replaced by clinical trials and the acceptance and use of the double-blind method. However, randomised controlled trials are commonly flawed in practice and the most rigorous trials are associated with less treatment benefit than poor quality trials (Moher et al 1998). The recent emphasis on evidence-based medicine with initiatives such as the Cochrane Collaboration has also focused on methodological issues.

The double-blind method is not infallible because frequently the double blind can be broken (Fisher & Greenberg 1997). Patients and doctors may be cued in to whether patients are taking active or placebo medication by a variety of means. For example, they may notice that placebo tablets they have been taking taste differently from medication to which they have previously become accustomed. Active medication may produce side effects which distinguishes it from inert medication. There is evidence even of deliberate deceit in clinical trials so that randomised allocation is not concealed (Schultz 1996).

Studies where an attempt to measure unblinding has been made confirm that it does occur and significant correlations with efficacy ratings have been found (Shapiro & Shapiro 1997). These problems of unblinding may be minimised by trialists because there seems to be nothing that can be done to prevent it completely. Nonetheless, there should then be no pretence that unbiased evaluation of treatment is being carried out. Although the apparent specific effect of treatment may not be as great as the placebo effect itself, it may merely be the wishfulfilling amplification of nonspecific effects. Using active drugs without apparent specific treatment effects as controls generally reduces the effect size of the active treatment, maybe because patients are less likely to be unblinded in the trial because of the detection of active effects in the control drug (Thomson 1982).

The placebo effect may be relevant to problems in discontinuation. People may form attachments to their medication more because of what it means to them than what it does. Any change threatens an equilibrium related to a complex set of meanings that their medication has acquired. These issues of reliance on medication should not be minimised, yet commonly compliance with treatment is reinforced by emphasising that antidepressants, for example, are not addictive (Double 1997). Psychotropic medication is often prescribed in life crises reinforcing defensive mechanisms against overwhelming anxiety, and the power of the placebo effect should be recognised. Counteracting such placebo effects may not be easy when discontinuing medication.

Conclusion and future developments

Psychiatric practice can be criticised for its failure to regard the patient as a person. Mainstream psychiatry acts on the somatic hypothesis of mental illness to the detriment of understanding people's problems. Laing's (1982) primary motivation was his appreciation that schizophrenia, in particular, was more understandable than mainstream psychiatry recognized. This stance is consistent with Adolf Meyer's (1951/2) philosophy. The neo-Kraepelinian has eclipsed the Meyerian approach over recent years and encouraged excessive enthusiasm about diagnosis and treatment which requires critical analysis (Double 1991).

Antipsychiatry has been marginalised because it accuses psychiatry of social control (Farrell 1979). Renewed criticism of modern psychiatry is required and the Critical Psychiatry Network gives expression to a "post-psychiatry" (Critical Psychiatry Network website). Psychiatry need not feel negative about this process. Patients and society will continue to demand its services and appreciate realistic expectations.

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Editorials

Time to move beyond the mind-body split
The "mind" is not inside but "out there" in the social world

Descartes distinguished between the res cogitans and the res extensa. The former referred to the soul or mind and was said to be essentially "a thing which thinks."1 The latter was the material stuff of the body. It was characterised primarily by the fact of extension: it occupied space and was therefore amenable to measurement. In recent years neuroscientists and cognitive psychologists have argued that this ontological separation of mind and body is no longer tenable.2 The former maintain that mental functions can be fully explained by brain science. The latter make the case for a distinct psychological realm but one whose operations, like those of computer software, are measurable and

open to scientific investigation. The res cogitans is illusive no longer. We can map it, scan it, and explain its functions in biological or computational terms.

These ideas have become dominant in medical circles and, in some form or other, have become articles of faith for most doctors, psychiatrists, and psychologists. Contemporary philosophers such as Paul and Patricia Churchland and Jerry Fodor offer support for this position. 3 4 Many philosophers disagree, however, and point out that, although it claims to get us beyond ontological dualism, this doctrine really keeps alive the essential features of Descartes's philosophy. In particular, it continues his epistemological separation of inner mind from outside world. It also fails to recognise the problems involved in regarding the mind as a "thing"Descartes's res.

For these reasons, we argue that this doctrine represents a limited understanding of human reality and undermines our ability to comprehend fundamental aspects of human suffering. Medicine requires a different approach if it is to move beyond the problems of Cartesianism. At the heart of this debate is the question of meaning.

Human beings exist in a meaningful world. When we use terms such as "mind" and "mental" we are referring to some aspect of this world. But this is not something internal, locked away inside a physical body. Think of a painting by Picasso: the famous "Guernica," perhaps. How do we understand and appreciate this? The type of pigment is important, as are the brushstrokes used. So too are the colours and the shapes of the figures. But to understand what the painting means and the genius of its creator we reach beyond the canvas itself to the context in which it was created. This entails historical, political, cultural, and personal dimensions. Without engaging with its context, we could never appreciate "Guernica" as a work of genius. Its meaning does not reside in the pigment or the canvas but in the relation between these and the world in which it was created and now exists. Similarly, we will never be able to understand the various elements of our mental life such as thoughts, beliefs, feelings, and values if we think of them as located inside the brain. Trying to grasp the meaningful reality of sadness, alienation, obsession, fear, and madness by looking at scans or analysing biochemistry is like trying to understand a painting by looking at the canvas without reference to its wider world. The philosopher Wittgenstein and his modern followers argue that "mind" is not inside but "out there" in the middle of a social world.5 We agree.

We also agree with philosophers from the European continent who have warned against treating human experience as just another thing in the world. People who are influenced by Heidegger understand human reality as being in the world in a way that is fundamentally different from the way other things are in the world.6 We bring meaning to the world that we inhabit: we construct our world as we live in it. Humans have a certain way of hearing, seeing, and smelling the world, a certain way of experiencing space and time. We bring colour and sound to it. It is difficult for us to imagine what sort of world "opens up" to a fruit fly, a fish, or a bat. We are simply not "in" a world that is separate from ourselves. Rather, we allow a world to be by our very presence and through our physical bodies. But these also depend on the sociocultural context in which this opening occurs. Heidegger used the composite term "being-in-the-world" and argued that

human reality is not a "thing" at all but is better understood as a "clearing," a site in which a meaningful world is revealed. One of us has recently used this framework to explore the question of trauma and its sequelae.7

Conceptualising our mental life as some sort of enclosed world residing inside the skull does not do justice to the lived reality of human experience. It systematically neglects the importance of social context.8 Signs are encouraging that psychiatrists are becoming interested in philosophy.9 But the rest of medicine also needs to get beyond the legacy of Descartes. For this, medicine will require a deeper relation with philosophy.

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Footnotes

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