CRITICAL PSYCHIATRY WEBSITE

TRAINING IN "ANTIPSYCHIATRY"

A few years ago I was struck by a psychiatric registrar's comment about psychiatric training in Sheffield. The University Department at that time had developed a critical approach to psychiatry. The registrar had been interested in "antipsychiatry" ideas. He had been warned, however, that it would not be in the best interests of his career development if he was seen as being too closely associated with such ideas. It was suggested to him that he should develop a more "biological" approach to his work.

The registrar's ambitions would have made it sensible for him to develop an orthodox "biological" approach to psychiatry. What sort of stranglehold, though, does an apparently orthodox psychiatry have over training, that it can reserve places for career advancement only to those who uphold it? A conflict of interests between biological psychiatry and psychotherapy is well recognised, and psychotherapy has managed to create some independent professional status for itself. This split is experienced by most psychiatric trainees and they will recognise, for example, the feeling of uncertainty about whether to express an interest in psychotherapy before a psychiatric appointments committee. Yet psychotherapy does not monopolise the critique of biological psychiatry. The challenge to traditional psychiatry is stronger than that from psychotherapy and includes what has been called "antipsychiatry".

I have been told that the University Department in Sheffield did not have a good reputation because of its antipsychiatric stance. Dismissing criticism is a way of marginalising its influence, perhaps in a similar way to which it has been suggested that psychiatric patients are marginalised by the society which finds it hard to tolerate them. Is the term "antipsychiatrist" merely a term of denigration? I am concerned about the institutional and professional pressures that find it difficult to accept a challenge to biological psychiatry and I want to make a case for a more widespread acceptance of the critique, both in practice and training. If antipsychiatry is merely a label for any criticism, apart from psychotherapy, of the "biological" disease model of mental illness, then its position may actually need strengthening in the current psychiatric scene, not undermining.

The vigorous defence of biological psychiatry is perhaps unsurprising. It can be defined as the attempt to discover biological correlates of psychiatric disorder with the aim of establishing aetiology, therapy and prognosis (Guze, 1989). Its claims to understand the phenomena of human existence are attractive, and suggest some certainties are attainable. But its ideological impact has to be acknowledged. It proposes specific ways of treating people identified as "mentally ill". Its oversensitivity to criticism could reflect an unconscious awareness that it has reified the personal dimension in its dealing with patients. Abuse has often been recognised, and possibly is endemic in psychiatric practice and living with such a heritage can be difficult. If biological psychiatry can create a clear method of working, which need not be a justification of such practices, it will have adherents.

Antipsychiatry defined

Antipsychiatry is a term loosely applied to several critical views of psychiatry, such as those of Thomas Szasz,

R. D. Laing and Franco Basaglia (Tantam, 1991). The term was introduced by David Cooper, although disowned by colleagues like Laing. Antipsychiatry can be seen as having arisen as part of a general cultural critique of the 1960s. This is particularly the case with Laing, who was involved in left-wing politics, such as the Dialectics of Liberation Conference in 1967, whereas Thomas Szasz's position comes from a radical libertarianism. The phenomenon of antipsychiatry's popular appeal and its later demise can probably be related to wider political and cultural developments. Antipsychiatrists have been particularly identified with the idea that the term "mental illness" should be restricted to an organic, physical lesion; and, because this link has not been demonstrated, that mental illness does not exist or is a "myth". Such a view does seem overly rigid. It may be internally consistent but it seems to limit unnecessarily the application of the term "mental illness". It fails to take into account the extent to which the pathology of physical illness in general may not be understood. Moreover, it does not allow mental illness to be tied to the looser criterion of psychological abnormality. A philosophical dualism of mind and body should obviously be avoided. Mental functioning is due to the brain, yet labelling someone as mentally ill is primarily a statement about psychological, not physical functioning. The extent to which illness in general, including physical illness, is an evaluative concept, may be underestimated.

Biological Reductionism

Biological psychiatrists may be tempted to believe that there must be a link between mental illness and organic pathology, partly because of their training and their realisation of the success of the anatomoclinical method in general medicine. The resurgence of interest in biological psychiatry over the last 20 to 30 years reflects an expectation that psychiatry can improve its status by identification with medicine and the use of physical treatments.

Yet, is the connection between the mind and brain any different in the mentally ill than others? It may make it easier and safer for psychiatrists to assume that there is some biochemical disorder producing mental illness, but the peace of mind of psychiatrists does not justify inaccuracy and falsehood. Psychopathologists such as Kraepelin, Jaspers and Kurt Schneider have, of course, recognised that the organic hypothesis was only a hypothesis, yet they have believed and acted on it in practice. Sceptics will have more difficulty in taking this leap in faith. I see no reason why the kinds of processes that underlie mental illness at the biochemical level should be any different from those that produce thoughts, feelings and behaviour amongst the "normal".

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? I am aware that such an assessment of the research evidence will be seen as prejudiced by biological psychiatrists. Scientific logic, however, demands the testing of a hypothesis, not rampant speculation in pursuit of "the answer" to mental illness. It is curious how difficult it may be to shift a biological paradigm. I, too, was schooled in a blinkered "scientific" understanding of human nature, and can remember jettisoning it, when it was pointed out to me that it was questionable whether an understanding of human behaviour should take a form similar to the laws of natural sciences. What in fact is the point of psychiatry defending a biological sectarianism? It surely needs to be open to the uncertainty of human action, rather than seeking to fix it in its biological substrate.

Perhaps one of the best examples of the closed attitudes of psychiatrists is the use of Electro-Convulsive Therapy in treatment. Any challenge to the value of ECT is aggressively suppressed. I was astonished to experience the vehement hostility of a meeting of the Royal College of Psychiatrists listening to Eve Johnstone presenting the results of the Northwick Park trial, seen by the meeting as undermining the effectiveness of ECT. Ethical objections by trainees to using ECT cannot be entertained because giving ECT is seen as a necessary part of training. Yet blunting the sensitivities of people is unlikely to be good for psychiatry. Biological reductionism, or "neurologising tautology" as Adolf Meyer used to call it, should not prevent the treatment of the patient as a person (Double, 1990). Far too much of psychiatric practice has been inhumane

and clients generally deserve better than to be treated as automatons that need their biology cured.

Alternative psychiatry promoted

Maybe psychiatry is doomed. Its basis in medicine may be useful for understanding the common physical complaints of psychiatric clients. Yet if this foundation prevents the development of other than a biological understanding of mental illness, its value can be questioned. Clinical psychology may be more free to appreciate the uncertainties of psychiatric practice. Recently this seems to have been possible, at least as regards the theory of schizophrenia (Boyle, 1990; Bentall, 1990).

My argument has been against a creed of biological psychiatry. I know there were those who hoped for the opportunity to bring the Sheffield University Department of Psychiatry back into the presumptive orthodox fold of psychiatry. On the contrary, there needs to be a release of training in psychiatry, so that free of the current power strongholds vested in biological psychiatry, there can be opportunities for improvements in the treatment of psychiatric clients.

References

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