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Critical Psychiatry

- 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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