

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 obfuscation 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, lent 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 21 in 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.