FOCUS ON

Critical Psychiatry

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Abstract

Critical psychiatry appraises and comments upon psychiatric services as they are usually provided. This article, prompted by the publication of a recent book, considers the place of critical psychiatry historically and in the context of contemporary mental health care and treatment.

Key words

Critical psychiatry, anti-psychiatry, critical realism, conceptual frameworks, recovery

Last year saw publication of *Critical Psychiatry: The Limits of Madness* (Double, 2006). Given recent policy statements such as the White Paper, *Our Health, Our Care, Our Say* (Department of Health (DH), 2006a), the Office of the Deputy Prime Minister's report, *Mental Health and Social Exclusion* (Social Exclusion Unit, 2004), and England's chief nursing officer's review of mental health nursing, *From Values to Action* (DH, 2006b), this was timely. Recent years have also seen support for policy implementation in the form of National Institute for Mental Health in England/Care Services Improvement Partnership (NIMHE/CSIP) programmes influencing, *inter alia,* mental health service provision for those from black and minority ethnic groups, acute inpatient care, professional roles and responsibilities, and access to psychological therapies. All of these are set to facilitate change in mental health service practices and philosophy in ways that resonate strongly with the positions adopted by critical psychiatry's proponents. Unfortunately it is difficult to find a connection between these service developments, and critical psychiatry or other theoretical accounts. This robs those attempting to achieve change in mainstream settings of the support that a coherent conceptual framework can provide, and it threatens to rob those championing a shift towards a more humanitarian approach of support from mainstream practitioners.

Despite being frequently critical of certain traditional mental health practices, policy documents and NIMHE/CSIP publications avoid explicit reference to, or criticism of, the intellectual and conceptual underpinnings of them. Where there is resistance to change, this can legitimise it. However several of the authors contributing to *Critical Psychiatry: The Limits of Madness* and other related publications (for example, Thomas and Bracken 2004) attempt to distinguish between critical psychiatry and anti-psychiatry, the Critical Psychiatry Network's website gives links to some 17 sites and organisations that are openly critical of conventional psychiatric practice. The book and other publications by critical psychiatrists pull no punches with their views of a biomedical approach to mental health problems (for example, Moncrieff & Kirsch, 2005). This cannot enhance understanding and support from among those whose daily tasks are to service and maintain mainstream services. Writing in the *Times Higher Education Supplement* (April 21 2006) Adam James describes Double's suspension from his NHS post for six months during 2000 as 'a response to the perceived threat that psychiatrists like him are seen to be by the biomedical hegemony gripping contemporary psychiatric practice'.

The term 'critical psychiatry' was probably first seen in print as the title of David Ingleby's book, initially published in 1981. This is a collection of essays effectively drawing attention to the shortcomings of a simple, positivist approach to the issue of 'mental health difficulties'. Ingleby and his co-contributors further develop the view that mental illness is most usefully seen from a political perspective. To a large extent this was a re-statement of the more celebrated anti-psychiatry sentiments of the 1960s – Laing, Cooper, Berke and Szasz. In their respective turns, Laing, Ingleby and Double have all been subject to what could be regarded as 'suppression'. The anti-psychiatry movement with which Laing was (perhaps inaccurately) associated was

largely discredited during the 1970s and 1980s, and although a popular cult figure during the zenith of his working life, Laing and the ideas he promulgated have never found widespread application in mainstream mental health services. According to Double, Ingleby was overtly passed over for preferment in Cambridge by the inaugural university professor of psychiatry and first president of the Royal College of Psychiatrists, Sir Martin Roth. I have already made reference to Double's own suspension for 'retraining', which he refers to himself in the book. Perhaps there are good reasons why psychiatry's political dimension should not be ignored.

Critical psychiatry and critical realism

In his book, which introduces the term 'critical psychiatry', Ingleby acknowledges this use of the term 'critical' as a link to (though not synonymous with) its use in relation to critical theory (Horkheimer & Adorno, commented upon in Tar, 1977). This in turn shares philosophic underpinnings with Bhaskar's critical realism (Bhaskar 1975), which is attracting increasing interest as an epistemology suited to the study of mental health and its related practices (Ellis, 1992; Pilgrim & Bentall, 1999; Houston, 2001; Littlejohn, 2003; Pilgrim and Rogers, 2005; Stickley, 2006; Middleton & Shaw, 2007). Critical realism provides a position from which the contributions of differing perspectives can all be acknowledged but at the same time recognised as providing only a partial explanation of the object of study constrained by their individual context and methods. Thus, there may be some validity in a biomedical/illness model of some features of some types of emotional or psychological distress but these will always also have psychological, social, political, economic and spiritual dimensions, which cannot be explained or manipulated without attention to the relevant dimension.

Critical psychiatry echoes this approach. It promotes the view that no one of the very many theoretical, research and/or therapeutic approaches that might fall under a wide umbrella of mental health research, psychiatry, mental health practice and mental health services can be expected, on its own, to provide the basis of an all-embracing theory or a universally effective family of therapeutic interventions. Instead, critical psychiatry draws attention to the shortcomings of such claims by theorists and practitioners alike. It argues that mental health practice and services should acknowledge the critically appraised value of neurobiological, psychological, social, economic, political and spiritual determinants of wellbeing, their vagaries and the

techniques and institutions employed to mitigate them. Criticism *per se* is reserved for the influences of a dominant biomedical hegemony and abuses of power; attention perhaps to the political and economic dimensions of the subject.

Recovery

Another development in mental health circles that reflects this 'the whole is greater than the sum of its parts' perspective is that of attempts to conceptualise and facilitate 'recovery'. Currently the term is being used in a variety of ways, and there are some intimations that these might include an obfuscation with the remission of symptoms (Andreasen *et al* 2005), perhaps with a view to the psycho-pharmaceutical market. For others, and perhaps more legitimately, this use of the term refers to the recovery of a state of self-actualisation, autonomy and relative existential stability, grounded in and reflecting lived experience, rather than a symptoms rating scale (Deegan 1988). At its simplest an analogy can be made with the 'recovery' of someone who has suffered a spinal injury, perhaps as a result of an accident, who does not and will not recover the ability to walk once again, but who can recover their humanity and senses of self and self-worth as an effective wheelchair user and, possibly, a para-athlete.

In the context of mental health difficulties this might mean acquiring the ability to live with the experience of sometimes-intrusive voices, knowledge of one's own emotional liability or undue sensitivity to criticism. Recovery in this sense means more than just successful biomedical treatment; it refers to concomitant psychological, social, economic, political and spiritual developments which, as a critical realist perspective insists, need not depend upon the first or even one another in any identifiably causal manner.

Acknowledging that the holistic concept of 'recovery' is the appropriate therapeutic goal rather than the relief of symptoms challenges many orthodoxies in the way that critical psychiatry does. It directs attention from the view that an individual's mental health difficulties can be somehow wholly understood in terms of a diagnosis or some other form of classification, and towards a need to understand the problems posed by an individual suffering from emotional or psychological difficulties, not as 'a case of...', but as a singular human being with a potentially identifiable and probably complex set of needs and difficulties.

In their book Repper and Perkins (2003) outline what this might entail. They emphasise the need for an approach that builds on strengths rather than one that focuses upon the eradication of symptoms and

the identification of deficits. The wide gulf between professionals' practices and perspectives and the lived experience of mental health difficulties is identified as a barrier to setting therapeutic endeavour in the context of a hope-inspiring, supportive relationship. Political, social and economic determinants of social exclusion are seen not as 'unfortunate but inevitable consequences of mental illness', but as powerful and potentially remediable contributors to continuing disability and dependency in their own right.

Critical practice

If the aspirations of a recovery-oriented approach to providing mental health services are to be realised, practitioners of all backgrounds are called upon to address some fairly challenging issues. Allott (2005) identifies 12 principles of a recovery-oriented approach to mental health service provision derived from experiences in Ohio (Townsend *et al*, 1999). Among these are:

- the service user directs the recovery process

- the mental health system must be aware of its tendency to enable and encourage service user dependency

- there is a need to merge all intervention models, including medical, psychological, social and recovery

- clinicians' initial emphasis on 'hope' and the ability to develop trusting relationships influences service users' recovery

- family involvement may enhance the recovery process. The service user defines his/her family.

How well are current practices fit for these purposes – to allow service users to direct their management, avoid paternalism and dependency by accommodating risk-taking, prioritise trusting relationships between clinicians and their clientele, and explicitly involve family and friends? Contemporary mental health practices and the services that support them are as much a product of their historical origins as any other form of human activity. Fulford (2003) points to the history of twentieth century psychiatry as 'a history of fashions – psychoanalysis, community care, narrowly conceived "biological" psychiatry, [which] all started as good ideas that, lacking the perspective of history, deteriorated into ideologies'.

The need to provide for those who have become confused, distressed, threatening, dangerous or suicidal is a task all societies face and each has and does do so in ways that reflect their wider context. The last two centuries of British history have seen

passage through the provisions of the Poor Laws, entry into the workhouse, certification as insane and admission to a mental hospital, asylum or state institution, various forms of psychotherapy and, over the last half century or so, 'treatment of a mental illness'. At any particular point in time and place the prevailing social construct of uncontainable emotional and/or psychological excess, and how to respond to it, are emergent properties of the prevalent social, political and professional climate. The experiences and expectations of the distressed and those empathic with them are not so arbitrarily determined. Intense anxiety, despair, anger, fear and confusion are universal qualities of human experience. Historically mental health services have been 'what society provides', determined as much by prevalent ideologies, politics and economic constraints as they have been by the immanent needs of those they serve.

Recognising the contextual determinants of professional and institutional practices is, of course, an expression of critical theory. Critical theorising leads to critical thinking. Critical thinking leads to critical actions, and these in turn to critical practice (Adams *et al*, 2002). Respect for the influence of context upon practitioners' actions also lies at the heart of Donald Schön's (1983) work, *The Reflective Practitioner*. Schön does not explicitly base his theorising upon critical theory but he does refer to the related philosophical analysis of the sociology of knowledge (Mannheim, 1936), itself the basis of Foucault's criticism of prevailing views of madness (Foucault & Khalfa, 2006).

Schön focuses upon the distinctions and tensions between what he dubs 'technical rationality' and 'reflection-in-action'. In essence the former refers to formalised professional knowledge, analyses and related practices and institutions, and the latter to the realities of conducting a piece of work in an identified context. His book reviews some of the issues raised by this contrast as it operated in the activities of a consulting architect, psychotherapy supervision, engineering design, scientific investigation, town planning and management. For each of these situations he illustrates how the practitioner's formally acquired knowledge of their subject operates not as an immutable framework of problems definition and repertoire of solutions, but as a reservoir of informed experience. He shows how practice in action is a creative process drawing upon, but not defined by, that reservoir. In this way his work endorses a refreshing shift in institutional and explanatory power from the profession to the individual practitioner.

In the context of a mental health service this perspective gives precedence to creative problem solving over presumptive professionally or institutionally defined procedures and protocols. Along with the views of the Critical Psychiatry Network it respects the view that it is not sufficient to regard anyone as 'a case of...' to be managed exclusively by algorithm. It embraces fundamental tenets of a 'recovery' approach in that it focuses upon the need to engage with all the particulars of an individual rather than a selected, professionally defined subset. From an epistemological point of view it is consistent with critical theory in that it formally acknowledges the contextual nature of knowledge and solutions. If a person might benefit from cognitive behaviour therapy it is no solution simply to put them on a long waiting list, just because that is what the book says they should have and the practitioner has no power to make cognitive behaviour therapy more readily available. The contextually defined solution will have to be one that makes optimal use of what is available, even though it might not be precisely what the research evidence recommends. What good is there in withholding all support from someone who does not 'fulfil referral criteria' when there may be some things could be usefully offered?

To conclude

Quite rightly critical psychiatry is critical of psychiatry as it is generally practised and provided; it would be remarkable indeed if psychiatry were entirely beyond reproach. The form this criticism takes is intellectually and professionally challenging, particularly as it questions frequently unquestioned assumptions, such as psychiatry's political and economic contexts. Nevertheless it also complements other developments in mental health theory and practice which ask and attempt to answer similar questions, and points a way towards a more congenial, rewarding and honest description of what mental health practitioners actually do and might achieve.

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