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Education and debate

Postpsychiatry: a new direction for mental health

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Government policies are beginning to change the ethos of mental health care in Britain. The new commitment to tackling the links between poverty, unemployment, and mental illness has led to policies that focus on disadvantage and social exclusion.[1] These emphasise the importance of contexts, values, and partnerships and are made explicit in the national service framework for mental health.[2] The service framework raises an agenda that is potentially in conflict with biomedical psychiatry. In a nutshell, this government (and the society it represents) is asking for a very different kind of psychiatry and a new deal between health professionals and service users. These demands, as Muir Gray has recently observed, apply not only to psychiatry but also to medicine as a whole, as society's faith in science and technology, an important feature of the 20th century, has diminished.[3]

According to Muir Gray, "Postmodern health will not only have to retain, and improve, the achievements of the modern era, but also respond to the priorities of postmodern society, namely: concern about values as well as evidence; preoccupation with risk rather than benefits; the rise of the well informed patient."[3] Medicine is being cajoled into accepting this reality, but psychiatry faces the additional problem that its own modernist achievements are themselves contested. Consider this: although patients complain about waiting lists, professional attitudes, and poor communication, few would question the enterprise of medicine itself. By contrast, psychiatry has always been thus challenged. Indeed, the concept of mental illness has been described as a myth.[4] It is hard to imagine the emergence of "antipaediatrics" or "critical anaesthetics" movements, yet antipsychiatry and critical psychiatry are well established and influential.[5] One of the largest groups of British mental health service users is called Survivors Speak Out.

Psychiatry has reacted defensively to these challenges and throughout the 20th century has asserted its medical identity.[6] Although the discipline survived the antipsychiatry movement of the 1960s, fundamental questions about its legitimacy remain.[7] We argue that the well publicised failure of community care and the UK government's response (in the form of the national service framework) make it essential that we re-examine critically psychiatric frameworks. In this article we develop a critique of the modernist agenda in psychiatry and outline the basic tenets of postpsychiatry—a new positive direction for theory and practice in mental health.[8]

Summary points

Faith in the ability of science and technology to resolve human and social problems is diminishing

This creates challenges for medicine, particularly traditional psychiatry

Psychiatry must move beyond its "modernist" framework to engage with recent government proposals and the growing power of service users

Postpsychiatry emphasises social and cultural contexts, places ethics before technology, and works to minimise medical control of coercive interventions

Postmodernity provides doctors with an opportunity to redefine their roles and responsibilities

Roots of modern psychiatry

Both supporters and critics of psychiatry agree that the discipline is a product of the European Enlightenment and that movement's preoccupations with reason and the individual subject. Although a critical, postmodern position does not mean rejecting the Enlightenment project, it demands acknowledgment of its negative as well as its positive aspects. It means questioning simple notions of progress and advancement and being aware that science can silence as well as liberate.

On one level, the Enlightenment's concern with reason and order spawned an era in which society sought to rid itself of "unreasonable" elements. As Roy Porter wrote:

the enterprise of the age of reason, gaining authority from the mid-seventeenth century onwards, was to criticise, condemn, and crush whatever its protagonists considered to be foolish or unreasonable … And all that was so labelled could be deemed inimical to society or the state—indeed could be regarded as a menace to the proper workings of an orderly, efficient, progressive, rational society.[9]

According to Foucault, the emergence of large institutions in which "unreasonable" people were housed was not a progressive medical venture but an act of social exclusion. Psychiatry was the direct product of this act.[10] Porter agrees: "The rise of psychological medicine was more the consequence than the

cause of the rise of the insane asylum. Psychiatry could flourish once, but not before, large numbers of inmates were crowded into asylums."[9]

On another level, the concern with reason also led to a belief that a framework derived from medical science was the best way to engage with madness. Psychiatrists like Griesinger seized on the early successes of pathology in explaining some forms of psychosis and asserted that this framework could be extended universally.[11]

From Descartes onward, the Enlightenment was also concerned with an exploration of the individual subject. Eventually, this gave rise to the disciplines of phenomenology and psychoanalysis. Our thesis is that 20th century psychiatry was based on an uncritical acceptance of this modernist focus on reason and the individual subject. We can identify three main consequences of this.

Consequences of the modernist focus

Madness is internal

Perhaps the most influential 20th century psychiatric text was Karl Jaspers's *General Psychopathology*.[12] Jaspers worked within the framework of phenomenological psychology developed by the philosopher Edmund Husserl, who promoted phenomenology as a "rigorous science" of human experience. His method involved "bracketing out" contextual issues and an intense self examination, with strong echoes of Descartes' *Meditations*.[13] In this theoretical tradition the mind is understood as internal and separate from the world around it. Jaspers also distinguished the form of a mental symptom from its content: "It is true in describing concrete psychic events we take into account the particular contents of the individual psyche, but from the phenomenological point of view it is only the form that interests us."[12]

This view had an extraordinary influence on European psychiatry. According to Beaumont, Aubrey Lewis described *General Psychopathology* as "one of the most important and influential books there are in psychiatry."[14] Psychiatry continues to separate mental phenomena from background contexts. Psychosis and emotional distress are defined in terms of disordered individual experience. Social and cultural factors are, at best, secondary and may or may not be taken into account.[15] This is partly because most psychiatric encounters occur in hospitals and clinics, and there is a therapeutic focus on the individual, with drugs or psychotherapy. It is also because biological, behavioural, cognitive, and psychodynamic approaches share a conceptual and therapeutic focus on the individual self. Even social psychiatry has had an epidemiological priority for the identification of disordered individuals in populations.[16]

Technical explanation for madness

The Enlightenment promised that human suffering would yield to the advance of rationality and science. For its part, psychiatry sought to replace spiritual, moral, political, and folk understandings of madness with the technological framework of psychopathology and neuroscience. This culminated in the recent "decade of the brain" and the assertion that madness is caused by neurological dysfunction, which can be cured by drugs targeted at specific neuroreceptors. It is now almost heretical to question this paradigm.

The quest to order distress in a technical idiom can also be seen in the *Diagnostic and Statistical Manual of Mental Disorder* (DSM). This defines over 300 mental illnesses, most of which have been "identified" in the past 20 years. In their account of this project, Kutchins and Kirk remark: "DSM is a guidebook that tells us how we should think about manifestations of sadness and anxiety, sexual activities, alcohol and substance abuse, and many other behaviours. Consequently, the categories created for DSM reorient our thinking about important social matters and affect our social institutions."[17]

Coercion and psychiatry

The links between social exclusion, incarceration, and psychiatry were forged in the Enlightenment era. In the 20th century, psychiatry's promise to control madness through medical science resonated with the social acceptance of the role of technical expertise. Substantial power was invested in the profession through mental health legislation that granted psychiatrists the right and responsibility to detain patients and to force them to take powerful drugs or undergo electroconvulsive therapy. Psychopathology and psychiatric nosology became the legitimate framework for these interventions. Despite the enormity of this power, the coercive facet of psychiatry was rarely discussed inside the profession until recently. Psychiatrists are generally keen to play down the differences between their work and that of their medical colleagues. This emerges in contemporary writing about both stigma and mental health legislation in which psychiatrists seek to assert the equivalence of psychiatric and medical illness.[18] Ignoring the fact that psychiatry has a particular coercive dimension will not help the credibility of the discipline or ease the stigma of mental illness. Patients and the public know that a diagnosis of diabetes, unlike one of schizophrenia, cannot result in their being forcibly admitted to hospital.

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Housing "unreasonable" people in large institutions was, according to Foucault, an act of social exclusion

Hearing Voices Network

The Hearing Voices Network was started by Marius Romme (psychiatrist) and Sandra Escher (journalist) in Holland. Romme had been struggling to treat a woman whose voices had not responded to neuroleptic drugs. She arrived at her own, non-medical way of understanding the experience and challenged Romme to appear on television to discuss her experiences. After the broadcast, over 500 "voice hearers" phoned in, most of whom had not been in contact with psychiatric services. This led to the formation of Resonance, a self help group for people who heard voices and who were dissatisfied with medical diagnosis and treatment for the experience.[25] The Hearing Voices Network was established in Britain in 1990 after a visit by Romme and Escher. The network now has over 40 groups across England, Wales, and Scotland and offers voice hearers the opportunity to share their experiences using non-medical frameworks. The groups are open only to voice hearers who share ways of coping with the experience and discuss their explanatory frameworks (which do not necessarily exclude medical ones). The network operates nationally and internationally, in alliance with sympathetic professionals. It validates voice hearers' own accounts of their experiences and makes it possible for these experiences to become meaningful.

A new direction for mental health

Muir Gray's challenge to medicine to "adapt to the 'postmodern environment' "[3] applies particularly to psychiatry, and while some question the Foucauldian critique of psychiatry, there is a general acceptance that his rejection of a simple "progressivist" version of psychiatry's development is justified.[19] Psychiatry can no longer ignore the implications of this analysis. Our critique can be stated as a series of questions:

(1) If psychiatry is the product of the institution, should we not question its ability to determine the nature of postinstitutional care?

(2) Can we imagine a different relation between medicine and madness—different, that is, from the relation forged in the asylums of a previous age?

(3) If psychiatry is the product of a culture preoccupied with rationality and the individual self, what sort of mental health care is appropriate in the postmodern world in which such preoccupations are waning?

(4) How appropriate is Western psychiatry for cultural groups who value a spiritual ordering of the world and an ethical emphasis on the importance of family and community?

(5) How can we uncouple mental health care from the agenda of social exclusion, coercion, and control to which it became bound in the past two centuries?

If we are unable to address these questions, the failures of institutional care will be repeated in the community. For these reasons, postpsychiatry is driven by a set of contrasting goals.

Goals of postpsychiatry

Importance of contexts

Contexts, that is to say social, political, and cultural realities, should be central to our understanding of madness. A context centred approach acknowledges the importance of empirical knowledge in understanding the effects of social factors on individual experience, but it also engages with knowledge from non-Cartesian models of mind, such as those inspired by Wittgenstein and Heidegger.[20] We use the term "hermeneutic" for such knowledge, because priority is given to meaning and interpretation.[21] Events, reactions, and social networks are not conceptualised as separate items which can be analysed and measured in isolation. They are bound together in a web of meaningful connections which can be explored and illuminated, even though these connections defy simple causal explanation. This approach also resonates with the work of Vygotsky.[22] We have attempted to use this approach in our clinical and theoretical work on trauma and on hearing voices.[23] [24]

We also believe that in practical, clinical work mental health interventions do not have to be based on an individualistic framework centred on medical diagnosis and treatment. The Hearing Voices Network (box) offers a good example of how very different ways of providing support can be developed.[25] This does not negate the importance of a biological perspective, but it refuses to privilege this approach and also views it as being based on a particular set of assumptions that are themselves derived from a particular context.

Ethical rather than technological orientation

Clinical effectiveness and evidence based practice—the idea that science should guide clinical practice—currently dominate medicine. Psychiatry has embraced this agenda in the quest for solutions to its current difficulties. The problem is that clinical effectiveness plays down the importance of values in research and practice. All medical practice involves some negotiation about assumptions and values. However, because psychiatry is primarily concerned with beliefs, moods, relationships, and behaviours this negotiation actually constitutes the bulk of its clinical endeavours. Recent work by medical anthropologists and by philosophers has pointed to the values and assumptions that underpin psychiatric classification.[26] [27]

This is an issue for all mental health work, but the dangers of ignoring these questions are most apparent in the problematic encounter between psychiatry and non-European populations, both within Europe and elsewhere.[28] In Bradford we work with many immigrant communities. The Bradford Home Treatment Service attempts to keep values to the fore and strives to avoid Eurocentric notions of dysfunction and healing.[29] While recognising the pain and suffering involved in madness, the team avoids the assumption that madness is meaningless (see box). It has also developed a number of ways in which service users can be involved in shaping the culture and values of the team.[30]

Rethinking the politics of coercion

The debate about the new Mental Health Act in Britain offers an opportunity to rethink the relation between medicine and madness. Many service user groups question the medical model and are therefore outraged that this provides the framework for coercive care. This is not to say that society should never remove a person's liberty because of their mental disorder. However, by challenging the notion that psychiatric theory is neutral, objective, and disinterested, postpsychiatry weakens the case for medical control of the process. Perhaps doctors should be able to apply for detention (alongside other individuals and groups), but not make the decision to detain someone. In addition, the principle of reciprocity means that legislation must include safeguards such as advocacy and advance directives.[31]

Postpsychiatry and psychopathology

Postpsychiatry opens up the possibility of working with people in ways that render the experiences of psychosis meaningful rather than simply psychopathological. A 53 year old married Sikh woman had had two admissions to hospital in the previous six years with a diagnosis of affective disorder (ICD F31.2). She was referred urgently by her general practitioner in July 1999, and when seen at home she had pressure of speech and labile, irritable mood and was noted to be preoccupied with religion and past events in her life. Her family complained that she was overactive and spending excessive amounts of money. She was referred to Bradford Home Treatment Service where her key nurse, a Punjabi speaker, explored a number of issues with her and her family.

It emerged that the patient felt in conflict with her elderly mother in law, with whom the family shared the house. She believed that the elderly lady, who seemed to govern decisions about her grandchildren's forthcoming marriages, was usurping her position in the family. At the same time she had a duty of care to her mother in law, who suffered from diabetes and required her daughter in law's help to administer insulin. She also had a bond of loyalty towards her mother in law, which made it difficult for her to acknowledge the conflict, particularly outside the family.

With her nurse's support, the patient was able to produce her own interpretation of her psychotic behaviour:

• *Overactive behaviour and spending excessively*: to reclaim her role as mother and wife, to increase her contribution to family life, empowerment

• *Overtalkative*: seeking and demanding her husband's time when alone, need to discuss and influence family decisions, openly airing grievances

• *Hostile, irritable*: openly critical of family, challenging and retaliating, disagreeing

• *Preoccupation with past*: to contextualise grievances, add weight to her argument, and elicit understanding

• *Religious preoccupations*: to renew her strength, a way of coping with stress, a focus in her life.

Framing her problems in this way rather than in terms of a medical diagnosis allowed a space in which these issues could be explored gently with the patient and her family. Her husband became more accepting of his wife's grievances and her behaviour. She has kept well over the past 12 months, needing no drugs.

Conclusion: postpsychiatry and antipsychiatry

Postpsychiatry tries to move beyond the conflict between psychiatry and antipsychiatry. Antipsychiatry argued that psychiatry was repressive and based on a mistaken medical ideology, and its proponents wanted to liberate mental patients from its clutches.[32] In turn, psychiatry condemned its opponents as being driven by ideology. Both groups were united by the assumption that there could be a correct way to understand madness; that the truth could, and should, be spoken about madness and distress. Postpsychiatry frames these issues in a different way. It does not propose new theories about madness, but it opens up spaces in which other perspectives can assume a validity previously denied them. Crucially, it argues that the voices of service users and survivors should now be centre stage.

Postpsychiatry distances itself from the therapeutic implications of antipsychiatry. It does not seek to replace the medical techniques of psychiatry with new therapies or new paths towards "liberation." It is not a set of fixed ideas and beliefs, more a set of signposts that can help us move on from where we are now.

Psychiatry, like medicine, will have to adapt to Muir Gray's "postmodern environment." Mental health work has never been comfortable with a modernist agenda, and an increasing number of psychiatrists are becoming interested in philosophical and historical aspects of mental health care. Indeed, psychiatry, with its strong tradition of conceptual debate, has an advantage over other medical disciplines when it comes to the postmodern challenge. Postpsychiatry seeks to democratise mental health by linking progressive service development to a debate about contexts, values, and partnerships. We believe that the advent of postmodernity offers an exciting challenge for doctors involved in this area and represents an opportunity to rethink our roles and responsibilities.

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