

From the founders of *Asylum* magazine

PHIL VIRDEN with
ALEC JENNER and **LIN BIGWOOD**

MENTAL HEALTH
The alternative textbook

Revision of *Psychiatry - the alternative textbook* (2009)

Volume 1
The failure of the medical model

Tiger Papers/Asylum Books

**MENTAL HEALTH -
THE ALTERNATIVE TEXTBOOK**
Volume 1
**THE FAILURE OF
THE MEDICAL MODEL**

by

PHIL VIRDEN *with*
ALEC JENNER *and* **LIN BIGWOOD**
and with contributions from
ANNABEL MARSH *and* **PETER SPEEDWELL**

A revision of the first volume of
Psychiatry - the alternative textbook (2009)

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This book is dedicated to the victims of psychiatric oppression, and everyone contesting it; and especially to the memory of RD Laing (1927-1989), shunned, slandered and hounded from the psychiatric profession for publicly opposing its unfounded ‘medical model’; Professor Alec Jenner (1927-2014), a champion of democratic psychiatry and co-founder of *Asylum*, without whose vision and commitment the magazine would not have got established and survived; and the editor of *Asylum* for seven years, Terry McLaughlin (1947-2007), a gentle but determined militant for truth and social justice.

Although I am fully convinced of the truth of the views given in this volume... I by no means expect to convince experienced naturalists whose minds are stocked with a multitude of facts all viewed, during a long course of years, from a point of view directly opposite to mine.... but I look with confidence to the future, to young and rising naturalists, who will be able to view both sides of the question with impartiality.

Charles Darwin*

* Darwin, C (1866) *On the Origin of Species (4th edn)*. darwin-online.org.uk/Variorum, 568-569.

SUMMARY OF THE BOOK

Specious medicine has proved a tremendous propaganda and public relations success for the psychiatric profession, and is nowadays applied without question across the whole of the GP and mental health services. Yet for most patients there is no evidence of benefit, and much that many are harmed: far from remedying mental disorders, psychiatry's peculiar 'medical model' is a failure.

Volume 1 is a comprehensive critique of the conventional approach, which takes for granted the so-called medical model of mental illness and treatment. We find that in the application of this 'model', individual confusion and distress is systematically compounded by oppressive care and treatment, no matter how laudable the intentions of the officials.

In the Introduction we outline our argument, make some preliminary comments on the nature and incidence of mental disorder - so said 'mental illness' - and briefly chronicle striking alternations in the socially organised response during the last two centuries. Next, and so as to acquaint readers with the topic in hand, we offer several vivid first-hand accounts of what it is like to suffer from a serious mental disorder. Since mental health theory and practice is normally based in 'the medical model', we then scrutinise this 'model' and find it confused, unscientific and largely unhelpful to anyone incapacitated by overwhelming emotional or psychological distress. This leads us to review the standard procedures of mental health diagnosis, care and treatment. Consecutive chapters examine the rituals of the psychiatric encounter, describe and discuss the main diagnostic categories, offer evidence and argument regarding the dubious value of drugging and electroshock, and explore the pivotal role played by faith or placebo in any mental health remedy. So as to illustrate the daily organisation of care and treatment, those chapters are followed by three accounts from seasoned professionals who describe their experiences when working in psychiatry. These front-line reports agree with the feelings of many patients and ex-patients, and even with much psychiatric research: that is, for the great majority of cases - those individuals presenting with a functional mental disorder - the medical model is inappropriate, often hinders the recovery of emotional and mental well-being, and too often results in significant psychological or physical harm, or even untimely death.

Psychiatry's 'medical model' has set the agenda for the management of individual irrationality for the last hundred years. Volume 1 closes with four chapters which expose and criticise the assumptions and methodological pretensions of that supposedly medical-scientific hypothesis. From a perspective which employs the concepts of humanistic psychology, sociology and history, we are able to account for the perennial seductiveness of this mental health ideology despite the absence of any convincing evidence for its truth or efficacy.

Volume 2 is a theoretical and programmatic reconstruction of the care of patients and the remedy of functional mental disorder. We argue for a social-psychodynamic perspective, and recommend various entirely practical but non-medical ways of ameliorating individual misery and irrationality.

The vague and unfounded 'medical model' currently governs the whole of the official mental health response. As demonstrated in Volume 1, this hypothesis is inflated by unevidenced pretensions of medical science; it is confused, confusing, often harmful and at best only minimally helpful to anyone burdened with psychological difficulties. By contrast, our proposal is informed by a coherent theory of personal development and crisis. The greater utility of this alternative is indicated by analysis of the representative cases of serious mental disorders presented in Chapter 2 (Volume 1). However, before proposing a rounded social-psychological perspective on individual irrationality, we feel it is necessary to examine the groundbreaking psychoanalytic ideas of Sigmund Freud; elements of that approach are already endorsed by some mainstream psychiatric research, as well as by independent observers. Unlike the ill-conceived and unfounded 'medical model', our perspective generates a reasoned theory of functional mental disorder based in the accumulating evidence that it is a confused, panicked response to psychological trauma, and usually engendered during childhood.

Finally, we propose forms of care and therapy more appropriate to the real and expressed needs of those suffering from devastating emotional distress and mental turmoil. These measures are informed by social and psychodynamic analysis, and aim to provide people with emotional, cognitive and material assistance.

Revised and renamed edition, 2018

The first version of this book appeared in 2009, entitled *Psychiatry - the alternative textbook*. At that time we chose to speak first of all about psychiatry because every kind of official mental health response was strictly governed by the pronouncements of that profession. This is still the case, but just recently the havoc wreaked by mental disorder on so many lives (and the economy) has become a hot topic in the national conversation, to the extent that political parties now feel obliged to declare that this appalling problem is one of their major concerns. However, the word 'psychiatric' barely figures in this discussion, which prefers the less scary formulation: 'mental health problems'. And since what we then had to say about psychiatry was intended to apply to mental health provision in general - and still does - renaming the book seemed an obvious adjustment. Hence: *Mental Health - the alternative textbook*.

The text is now extensively reworked, so as to make it more precise and hopefully less clunky. Of course, there have been interesting research reports and other developments in the meantime, and there has also been time to reflect on shortcomings in the first edition, some pointed out by readers. Consequently, while the main argument remains broadly the same, there are a number of significant clarifications and additions.

I have to thank Paul Dawson for pointing out that without a careful commentary on the position taken by the standard textbooks - and near the beginning of our book - a neutral or someone who wasn't much aware of the issues would not necessarily be convinced by the various points we try to make about the failings of the psychiatric medical model. That commentary is now included in Chapter 3. It seems to me that those textbooks do make interesting reading, but only to strengthen our case.

Also, since the first edition we learnt from Catherine Clarke (a contributor to *Asylum magazine*) about the important issue of pharmacogenetics, by means of which it is now possible to understand the puzzle of patients' differential experiences of the effects and terrible ill-effects ('side-effects') of various kinds of psychiatric medication. Chapter 6, on the main psychiatric drugs, now includes a section on scientific, technical and political developments around psychopharmacogenetics.

Other revisions are less crucial. For clarification, both the Introduction (Chapter 1) and the summary sections on Diagnosis (Chapter 5) are reformulated. In Chapter 14: Alienated Theory & Practice, in order to summarise arguments made more disparately elsewhere, a section is inserted on 'Medicalising the problems of everyday life'. And in Chapter 15 (which concludes Volume 1), in the section: 'The classic critiques of psychiatry', in the first edition we somehow contrived not to mention the UK's two most influential 'anti-psychiatrists', RD Laing and David Cooper; comments on both are now included.

On reflection, when discussing the question of the fundamental difference between organic (neurological) disorders and functional mental disorders (which we do most thoroughly in the introductory section to Chapter 16: The Social-Psychodynamic Perspective), it seemed necessary to discuss autism, and also those mental health diagnostic categories which are sometimes employed even though the symptoms (the emotional, cognitive or behavioural effects) may well be due to an identifiable organic cause.

Otherwise, changes in Volume 2 are mainly to register a welcome increase, during the last decade or so, in the number of studies which provide evidence to confirm the hypothesis that at the root of every functional mental disorder is generally a profound but publicly unacknowledged emotional trauma. This has meant that finally, in the last few years, a high correlation between the experience of serious adversity (cruelty or abuse) during childhood and later occurrence of a mental disorder was recognised in the UK by an important official report and by mention in recent mental health policies. However, no official cognisance is given to how this evidence must surely bear on the validity of the so-called medical model, which all the same is still taken for granted as supposedly the best way to explain and respond to incapacitating emotional distress and mental disorder.

Volume 1

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THE MEDICAL MODEL**

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INDICES & ACKNOWLEDGEMENTS

DEFINITIONS

STORY: HARVEY PEKAR
ART: MICHAEL T. GILBERT



LATER...



From *American Splendor* #6 (1981)
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In 1986 the three main collaborators on this book founded *Asylum – a magazine for democratic psychiatry*. Always run by a loose collective, this continues as an independent, non-partisan forum for the expression of the views of anyone with an interest in mental health issues, whether a current or former patient or service-user, any kind of mental health worker, a carer, or simply an interested member of the wider public.

For more information go to: www.pccs-books.co.uk/asylum-magazine

PHIL VIRDEN, MA (Oxon), MA (Leics), won a scholarship to read Philosophy, Politics and Economics. He then took an MA in Sociology at Leicester. For ten years he was a lecturer in Sociology at the University of York. In response to his outspoken democratic and critical activities, when the Conservatives were elected in 1979 his academic and teaching career was swiftly terminated by his being illegally sacked and blacklisted. He has since made his way in a variety of occupations, but for more than thirty years he has also channelled a commitment to the struggle for human rights into the movement for democracy in psychiatry. He was Executive Editor of *Asylum magazine* for its first six years, and also did most of the typing, design, lay-out and secretarial work. He occasionally writes articles for the magazine, and in 2008 he once again became Executive Editor.

ALEC JENNER, MB, ChB, PhD, FRCP, FRCPsych, Emeritus Professor of Psychiatry (Sheffield), Profesor Visitante (Conception, Chile), was in practice for fifty years. After qualifying in medicine he was recruited to psychiatry for his expertise in biochemical research. In 1967 he was appointed Professor at Sheffield University and manager of the psychiatric services for the whole of the Trent Region - a population of six million. Meanwhile, he had carried out the first double-blind UK trials on Librium and Valium, and was made Honorary Director of the UK's Medical Research Council Units for Chemical Pathology of Mental Disorders and for Metabolic Studies in Psychiatry. Professor Jenner was also instrumental in a number of reforms. In particular, he initiated the Phoenix House Drug Addiction Rehabilitation Unit at Sheffield (the second biggest in the country) and established the city's specialist psychogeriatric service. He was the first Western psychiatrist to draw the public's attention to the political use of psychiatry in the Soviet Union. In light of the accumulating evidence, and in opposition to the prevailing but unproven and often harmful 'medical model', Professor Jenner came to advocate a kind of humanistic social psychiatry. A regular contributor to *Asylum*, his vision, organisational skills and financial help proved vital to setting-up the magazine and keeping it going.

LIN BIGWOOD, RMN, BA (Hons), MA (York), Dip Couns began psychiatric nursing as a cadet, more than forty years ago. After nursing for some years, she took a degree in Sociology and later a master's degree in Social Policy. She has experience of working and managing in many areas of psychiatry, counting nine acute admission wards (including forensic) and A&E. In 1984 Lin was a Nurse Tutor when she organised an international conference on the government's proposals to close down the big old psychiatric hospitals and introduce 'Care in the Community'. At the plenum of the conference it was decided to establish a magazine (*Asylum*) so as to continue openly debating mental health issues. At about the same time, she heard from some patients (and then some staff) that two senior psychiatrists had been sexually assaulting female patients for many years. In order to discredit and silence her when she 'blew the whistle' on this abuse and its cover-up, in 1986 managers and executives in local, regional and national organisations of the NHS, in a university, and in her trade union conspired to have her sacked, thereby terminating her high-flying nursing career. She was only able to return to nursing in 1997, when the political climate had thawed and the police finally began to investigate and confirmed the existence of the long-running abuse.

ANNABEL MARSH, RMN, BA (Hons), and PETER SPEEDWELL, BA (Hons), PhD (Cantab) also contribute to this volume.

Chapter 1: INTRODUCTION & OVERVIEW

Of all the afflictions to which human beings are liable, the loss of reason is certainly the most severe. Deprived of this noble faculty, man is at once shut out of every social endearment and becomes a painful spectacle to all around him. The restoration then of the mind to its natural vigour must be to every feeling heart an object of the most anxious solicitude.

Sir William C Ellis, MD, first Director of Wakefield County Asylum, 1818.¹

The standard psychiatric textbooks are invariably pitched as authoritative accounts of a monolithic medical theory and practice; they claim to disclose an accumulating body of ever more scientifically exact solutions to the increasingly better understood problem of mental illness. As we will demonstrate, however, the authors of those texts misread the nature and causes of incapacitating emotional distress and mental disorder, and there is no evidence to support their principal assertions and recommendations. In fact, the official mental health response is experienced as unhelpful by many patients, and too often it is also actually harmful. Since we do not agree with the dominant consensus, our textbook is a quite different kind of comprehensive survey of the field.

Except amongst the elderly - who, of course, often suffer from dementia - few mental health patients are diagnosed with an organic disorder, a real disease. Instead, the person presents with a functional mental disorder: there is nothing wrong with his brain or nervous system but to a worrying extent he seems unable to feel, think or behave as he or others might wish. This kind of condition is generally known as a mental illness, but strictly speaking there should be no talk of illness when someone's behaviour and beliefs cause concern yet there are no signs of organic dysfunction: an individual's persistent irrationality is identified as a functional mental disorder precisely because he does not appear to suffer from a medical condition. It is therefore confusing that nevertheless the doctors regularly say that he is ill, that he 'has a mental illness'.

We begin this Introduction by outlining our dispute with the conventional psychiatric wisdom, which hinges on this confusion. (This fundamental question is discussed in greater detail in Chapter 3.) This is followed by an overview of the incidence and the costs of mental disorder, and then a section on the forms taken by the routine response. Finally, we review several disparate beliefs about worrying individual irrationality - its nature, its cause, and the appropriate response; during the last two-hundred years, these opposing ideas succeeded each other as the ruling precepts for the approved management of the insane. Our historical sketch suggests that today's organised response to mental disorder emerged out of professional and commercial interests and certain widely shared emotional imperatives and changing ideological fashions, much more than from the strict logic of genuine advances in proven medical science.

Emotional distress and mental turmoil: endemic and misunderstood

For more than a century, spurious medicine has proved a tremendous propaganda and public relations success for both the psychiatric profession and the pharmaceutical industry, and it is nowadays applied without question across the whole of the GP and mental health services. And yet for most patients there is no evidence of benefit but much that they are often harmed: far from

¹ Quoted by Ashworth, AL (1975) *Stanley Royd Hospital - One Hundred and Fifty Years: A history*. Wakefield: Wakefield Area Health Authority, 1.

consistently remedying emotional and mental disorder, psychiatry's fanciful 'medical model' is experienced by many patients as a failure.

The disjuncture between the public reputation and the actual performance of the mental health services, so far as many patients are concerned, is addressed in the first part of our book. It is no small matter. One-sixth of the UK population currently receives some kind of mental health treatment, and in any twelve months the proportion is close to one-quarter. At some time or another, three out of every ten of us will experience an emotional or mental crisis so troubling as to seem to require expert assistance.² Rich or poor, few families will be lucky enough to escape direct acquaintance with that kind of harrowing, incapacitating and often hazardous emotional and mental turmoil. If a general practitioner feels unable to help someone in the throes of such a crisis, for example, and he feels the individual could pose a danger to himself or to others, he will refer him to the specialist mental health service - psychiatry.

Naturally, anyone going through such a crisis is likely to feel devastated by what is happening, and so might those around him. Happily, a high degree of overt, frightening and disabling anguish and irrationality is sometimes fairly transient. Nonetheless, despite the attentions of the professionals - and often, we will argue, at least partly as a result of it - many people continue to suffer for months, years or decades. Or they find that their overwhelming emotional and psychological troubles revisit them throughout their lives, again and again. The personal, social and economic costs of mental health problems are high, but the organised response is fairly low on the collective agenda. 'Mental health problems accounted for 23% of the total impact of ill health in the UK in 2014 but were given only 13% of the NHS budget.'³ More than this, what is on offer - mainly medication but sometimes shock treatment - does not and cannot provide the kind of help that most people going through an emotional or psychological crisis regularly report that they need.

Mental health care and treatment is routinely dispensed according to the medical model of mental illness. This 'model' (or theory) is supposed to be part of medical science, and to warrant a kind of response that most people imagine is undoubtedly beneficial. Nevertheless, neither the balance of the research evidence nor patients' reports support this idea. Rather, as we indicate when we pursue our argument (and especially in Chapters 4 to 7), there is no clear benefit to the majority of patients, and standard care and treatment is largely experienced as wanting. The first Volume of our book is mainly given over to demonstrating these propositions, in all their various scandalous aspects. At the same time, however, by way of unequivocal propaganda and public relations deceptions, the psychiatric medical model has proved a resounding success as a popular ideology - a motivated misconception - which ratifies the coercive administration of those disturbed and disturbing individuals who find themselves oppressed and rendered vulnerable by overwhelming emotional distress and mental turmoil.

After Chapter 2, in which we illustrate the kinds of emotional or psychological crisis that officials are called on to manage, we begin to present detailed arguments and evidence for our case that the medical model supposed to underwrite 'biological psychiatry' neither makes sense nor provides a great deal of help to most patients; more than this, there is now much evidence for the harm caused

2 '...[B]ased on 175 surveys across 63 countries, we can say that just under 30% of us will have a mental disorder at some time or other in our lives.' Marmot, M (2014) Commentary: Mental health and public health. *International Journal of Epidemiology* 43 2 293-96; 'During 2007 nearly one person in four (23%) in England had at least one psychiatric disorder, and 7.2% had two or more disorders.' McManus, S et al (2009) Adult Psychiatric Morbidity in England - 2007, Results of a household survey. *Health & Social Care Information Centre* 27 Jan. This is their most recent survey, and the chances remained more or less the same as those found in 2000; Singleton, N et al (2001) *Psychiatric Morbidity among Adults Living in Private Households, 2000*. London: Office for National Statistics. 'One-in-six on any one day' is apparently the most up-to-date reckoning.

3 Hobbs, R (2014) The NHS will pay a high price for short-term mental health cuts. *Rethink Mental Illness*. www.rethink.org/news-views/2014/04/ See also Singh, S (2014) *Mental Health and Work: The United Kingdom*. Paris: OECD; this study estimated the yearly cost of healthcare, benefits and lost productivity at 'around £70bn, or roughly 4.5% of GDP'; also UK needs to tackle high cost of mental-ill health, says OECD (2014) *OECD/UK* 10 Feb.

by the usual mental health treatments. Towards the end of this Volume we explore the reasons for this state of affairs, along with the possible motives for most people believing in the psychiatric medical model even though it authorises practices that have no basis in scientific medicine and are often harmful, and despite the absence of clear evidence that they ever act as remedies, or that many patients even feel they might be helpful.

By reference to the notion of mental illness, in any modern society it is generally agreed that mental health services must be organised around a sound technical (i.e., medical) response to problems that arise within people's brains, and that this certainly helps the affected individuals. We will see that there is little to support this idea, and when we look beneath the surface bustle, the normal procedures appear highly questionable. First of all, there is no evidence that the great majority of people who suffer from a mental disorder need medicine because they have a chemical imbalance or a genetic disorder - that they really are ill. Instead, they suffer from what is known as a functional mental disorder: while there seems to be nothing wrong with their brains, there *is* something worryingly irrational about what they do and say, and that is why they are referred to the mental health service rather than to a neurologist. Second, neither is there any clear evidence that medical treatment is particularly helpful to anyone in the throes of an emotional or psychological crisis. On the contrary, there is evidence that recovery of a person's rationality may be *obstructed* by treating the crisis as due to nothing but a kind of illness (a 'mental illness'), and that official treatment is often a *cause* of both physiological and further psychological harm.

Certainly, someone who suffers from a functional mental disorder may well feel that something is terribly wrong, and his behaviour may make it seem as if he has fallen ill; he may indeed experience powerful physical symptoms, such as numbness with anxiety and lethargy with depression. Just the same - as we show when we develop our argument towards the end of this Volume, and through into Volume 2 - the immediate cause is an event (or events) with *emotional* and *psychological* significance, and the belief that the person is ill - that he 'has a mental illness' - is unproven dogma. No matter: despite the recognition that there is no evidence that they have anything organically wrong with them, people who suffer from a functional mental disorder are still said to be ill, to 'have a mental illness'. This is confusing since it is not that the body (the brain) is ill but that *the person* is troubled, confused and caught up in an emotional and psychological (and most likely interpersonal) crisis. As we shall see, it is now well established that there is no evidence that it was ever helpful to think of such an apparently intractable personal impasse as illness. Surely this implies that neither is it helpful to hand responsibility for care and remedy to medical officials who do little more than simply turn to a chemical or electrical 'quick fix'?

As opposed to the so-called medical model, in Volume 2 we argue that emotional or mental crisis - manifesting as incapacitating individual irrationality, in all its varieties - is best understood as fraught response to unacknowledged emotional and psychological trauma. Issues of emotional and psychological well-being, and the traumas and stresses which induce them, are essentially social or interpersonal problems that infect every corner of a person's sense of who he is and how he relates to the world.

Trauma and resistance to trauma can in the human case be understood not in the analogy of a physical force striking a more or less brittle object nor on the lines of the invasion of an organism by a hostile bacteria, but *only through the transformation of elements in a person's identity and capacity to relate to other persons and social collectives.*⁴

Nowadays, of course, it is recognised that someone may be psychologically traumatised by war or other kinds of extreme jeopardy. But what is not officially recognised - what is generally resisted - is the idea that probably *most* emotional trauma and psychopathology is a product of apparently civil or 'normal' social relations that are experienced by the individual in question as unbearably oppressive. Where there is cruelty, neglect, abuse or exploitation of a vulnerable person there will be emotional trauma; and if that trauma is not recognised and somehow resolved in the heart and mind of the victim, it leads to dire psychological repercussions; and if the consequent psychological malaise then

4 Sedgwick, P (1982) *Psychopolitics*. London: Pluto Press, 26. Our emphasis.

issues in visible and worrying emotional, motivational or mental deviance - perhaps years after the original trauma - the individual will most likely be referred to a doctor; and then, rather than find any recognition of the underlying emotional and psychological trauma, he will simply be diagnosed as 'having' one or another type of 'mental illness', and administered dubious medical treatment.

In other words, it seems to us that functional mental disorder is one of the inevitable results of the perennial contradictions of the social relations, especially when they are organised in a manner which fails to adequately defend the vulnerable from the ill-effects of competition and exploitation: the seriously irrational individual is a casualty of the general alienation, and embodies and expresses it in a particularly overt manner. In which case - as we argue through this book - medical attentions may sometimes provide stop-gap relief, but no solution to the persisting problem of so-said mental illness will be found in any medical discovery. Instead, we hope that both the fundamental misconceptions which underwrite psychiatry's medical model and the unsuitability of much of the standard treatment will at last be recognised, and that a social-psychodynamic understanding of mental malaise will come to prevail; in turn, this will point towards more fitting kinds of therapy and welfare interventions, and more helpful social, cultural and political perceptions and actions.

As things stand, however, the worse the psychological condition, the more likely the individual is officially viewed as if he were essentially uninfluenced by the impingements of his world and is simply so unlucky as to have randomly developed or contracted a medically strange kind of ailment - a so-called mental illness - the cause of which is presently unknown but 'probably genetic'. Until the middle of the 19th century, though - before the moral and psychological intentions of the specialist 'mad doctors' were replaced by the aspirations of Scientific Medicine - it was widely believed that the insane were in a condition of radical alienation (separation) from reality; before they organised themselves into a new profession as 'psychiatrists', these doctors often liked to be known as 'alienists'. At that time, few people assumed that there was definitely an organic cause to every form of madness since there was no evidence to support that idea, and most authorities agreed that the best way to reinstate someone's sanity was to try to address his alienation from society. During the last century or so, that sense of an essential connection between individual irrationality and harmful social dynamics was increasingly shunted off into the sidelines of official theory and practice. Today, a person's problematic biography or social situation is considered a fairly irrelevant side issue: the millions of individuals who experience incapacitating emotional distress and mental turmoil are simply said to suffer, first and foremost, from the medical condition of one or other 'mental illness'. We disagree. It seems to us that, if those who suffer from overwhelming emotional and mental torment are ever to be served appropriately, the idea of alienation must be re-instated at the heart of mental health theory and the social response.

That every kind of emotional or mental crisis *must be* the result of a medical condition, i.e., that they are due to the development of a mysterious illness (a mental illness) with a peculiarly elusive organic cause, is an unfounded psychiatric dogma which has not always gone uncontested. Nearly fifty years ago, for example, 'The personal is political' was a slogan popular in the counter-culture.⁵ This reminded us that, whether by chance or choice, we are always entangled in specific relationships of power and dependency, and that the hazards we meet, and the psychological habits or 'conditions' which we develop in response to such events, are most often the outcome of those relationships. At that time, amongst a few psychiatric workers and some of the general public, it was recognised that this formula - concerning access and vulnerability, ability to exploit and inability to defend - certainly applies to all those social processes by which emotional distress and mental disorder is first of all generated and then officially managed and treated.

Despite gaining some publicity at the time, due to the forceful arguments of a few clear-headed psychiatrists and sociologists, and some bitter patients, ex-patients and sympathisers, the perception that personal life always has a highly significant political dimension was dismissed out of hand by the psychiatric establishment. Over the years, the idea seems largely lost from view. It is true that

5 Hanisch, C. The personal is political. In Firestone, S & Koedt, A (Eds) (1970) *Notes from the Second Year: Women's Liberation*. New York: Radical Feminism.

recently, in the UK at least, it was at last officially recognised that there is *a correlation* between serious mental disorder and abuse or neglect during childhood. The possibility of a definite causal link is not acknowledged, however, and mental disorder is still conceived and treated first of all in terms of the medical model of mental illness: due to some unknown cause, and apparently ‘out of the blue’, the person is supposed to become mentally ill - *and might also* happen to have suffered terribly during childhood. In practice, when psychiatry makes contact with someone in crisis, whether he or she may have been emotionally and psychologically traumatised, especially during childhood, it is rarely more than a matter of ticking boxes on a standardised questionnaire.

Accordingly, the professional discourse of mental healthcare is suffused with a rhetoric which superficially might *appear* objective, scientific and technical (i.e., ostensibly apolitical), but is rarely supported by any evidence. This is why we say that, far from being genuinely medical and scientific, the ideas and techniques of psychiatry are absolutely political: precisely because it ignores or denies the personal-political nature of the causes of much mental disorder, and of the standard forms of care and treatment, mental health provision constitutes a powerful machinery and ideology in the service of the established social relations and too often *against* the interests of the suffering individual. We will see that the false consciousness of psychiatry - its muddled and distracting rationale - issues in procedures which are not based in sound medical science but rather in false assumptions and wishful thinking. Moreover, in terms of helping the person to overcome his or her personal crisis, neither are the normal methods generally effective, no matter how laudable the intentions of the carers and therapists. There is simply no evidence that the conventional psychiatric routines are at all adequate to the recovery of the emotional and mental well-being of many patients. Often, they are simply a kind of magic which has *the appearance* of scientific medicine, and which everyone *assumes* must be helpful: that is, there is sometimes a placebo effect. Even so, to the extent that people believe in this ‘medical’ ideology and ritual - which most do - it serves to hide from view those endemic and cruel processes of competition and exploitation (abuse) which, if unacknowledged or denied and not combated, tend to perpetuate the disabling emotional and mental turmoil of so many terrified, oppressed, isolated, confused and miserably preoccupied individuals.⁶

In this Volume we muster evidence and argument for the proposition that functional mental disorder is not a kind of illness but an overwrought and dysfunctional psychological response to personal crisis. We will also see that, during the century-and-a-half during which the medical profession came to dominate the field of emotional and mental welfare, the failure to appreciate this possibility resulted in the revictimisation of tens or hundreds of millions of individuals already overburdened by psychological trauma. To this day, by means of stigmatisation, discrimination, coercion, detention and invasive so-called scientific treatments, this failure of the official imagination continues to issue in an untenable assault on the rights, bodies and minds of tens of millions of mental health patients. We will see that the official response to functional mental disorder is ersatz medical-science, and that it amounts to an outrageous, colossal and ongoing world-wide abuse of vulnerable and distressed people.

A different kind of textbook

Standard textbooks are packed with all the latest diagnostic distinctions and procedures for the medical management of anyone said to have a mental illness. However, we challenge the validity of the mental health diagnostic system, dispute the efficacy of most treatments, and offer an alternative view of a welfare enterprise which we feel is long overdue radical change. In this Volume we will see that the normal forms of mental health care and treatment, no matter how well-intentioned, are not particularly helpful and are too often detrimental to patients’ mental and physical wellbeing.

Since the content of our book is very different from the standard texts, so is its style. Volume 1 is devoted to a comprehensive critique of today’s mental health provision, based as it is on the so-called

⁶ Later in this Volume, especially in Chapter 13, we discuss the powerful, unacknowledged motives which urge people to believe in the so-called medical model rather than in psychodynamic explanations of mental disorder.

medical model of mental illness.⁷ Volume 2 outlines an alternative theory of functional mental disorder and, following from that, proposals for reforming therapy and care. Both parts of the book should interest students and officials already working in the field of mental health - doctors, nurses, social workers, clinical psychologists and therapists. It is also written for anyone who is (or has been) receiving mental health treatment, and for their relatives, friends and advocates. Additionally, since we are critical of many of the received ideas about psychopathology, social organisation and culture, it could appeal to those with an interest in the history of ideas and institutions. Anyone else also has good reason to be aware of the issues we raise: as we indicated near the top of this Introduction, each of us faces a significant risk of being pitched into a personal crisis so overwhelming as to result in a serious mental disorder and consequent official care and treatment.

First of all, we subject to criticism the whole of the conventional response to functional mental disorder. Mental health professionals imagine that medical diagnosis and treatment is always appropriate. It seems clear to us, however, that the routine forms of diagnosis, care and treatment are generally and *systematically* irrational and counter-productive to the emotional, mental and physical well-being of the patients. There are no objective criteria by which to make a mental health diagnosis; rates and levels of recovery from serious mental disorders are not good; and there is no evidence that medical treatment is more effective than placebo or no intervention at all. Besides, many patients find that mental health care and treatment compounds their misery: they experience the official response as unhelpful and oppressive. Indeed, by means of an array of research findings, we show that there is clear evidence that there is no such thing as mental illness - as *actual disease* - and no evidence that psychiatric medicine is the best remedy for any kind of functional mental disorder.

For, as we mentioned, it is precisely the case that, by definition, anyone diagnosed as 'having a mental illness' *does not* suffer from an organic condition for which there might be a tried and tested medical remedy; that is to say, they do not suffer from an identifiable disease - a neurological, cellular, biochemical, hormonal or genetic pathology. Rather, functional mental disorder - what is known as 'mental illness' - is no more and no less than an overwhelmingly distressing, preoccupying, disabling and often apparently intractable condition of aberrant emotion, rumination and motivation. And the most helpful response - along with material assistance - is not medicine but appropriate forms of *social* and *psychotherapeutic* intervention.

Moreover, there is a perfectly reasonable alternative theory and therapy that can substantially answer this need - one that has undergone refinement and confirmation during the last one hundred years or so, but which has consistently been relegated to the psychiatric sidelines. This other kind of theory and therapy may be identified as 'the psychodynamic model'. We explore this approach in Volume 2, where we demonstrate that functional mental disorder is not *inherently* incomprehensible: it may at first appear unaccountably deviant, but it is the result of confusion and psychological distress which, on closer investigation, generally turns out to have a perfectly intelligible cause. This idea contests the medical model of mental illness which, *in principle*, is disinterested in most of what goes on in the patient's life and mind.

For now we may briefly characterise the psychodynamic model as starting with the hypothesis that however bizarre it may immediately appear, and unless he certainly suffers from a neurological disease, a person's worryingly irrational behaviour is not to be explained as something his purported illness (his 'mental illness', his allegedly sick or deficient brain) causes him to do. Rather, it is possible to interrogate that kind of abnormal behaviour as potentially intelligible, as *a fraught response which signifies an extremely troubling context*. Individual irrationality is the result of the desperate and ultimately dysfunctional tactics that a person employs in his struggle to cope with emotionally and psychologically traumatic events that are not publicly recognised as such. In this perspective, a mental disorder is the visible sign of a personal crisis; it is a reaction to events which the individual finds overwhelming - a panicked response to predicaments such as the loss of a loved

⁷ In Chapter 3 we spell out our reasons for believing that psychiatry's 'medical model' has no epistemic merit. See the sections: The confusion of the medical model, and The psychiatric medical model is unproven, unhelpful and harmful.

one, cruelty, oppression or abuse, or any other emotional and psychological trauma which is private or not fully acknowledged, and is in urgent need of expression, recognition, comprehension and resolution. It follows that it is only possible to discover and helpfully address the underlying cause or causes of any functional mental disorder by carefully and sympathetically listening to the person and investigating the circumstances of his or her life.⁸

This is not to deny that there may be measurable hormone, genetic, brain-electrical or brain-scan evidence, already known or possibly discernible in the future, to correlate with undesirable mental or behavioural states. Be that as it may, if any such evidence signals real (organic) disease, then that is not a mental health or psychiatric diagnosis but one made by means of physiological, neurological or genetic science, and which therefore calls for the expertise of a specialist in one of those areas of medicine. On the other hand, if there is nothing to indicate a genuine disease we are only permitted to assume that what registers is simply normal genetic variation (for example), or a particular state of a part of the body (the brain or the endocrine system, for example) during a certain phase in the dynamic life of the organism. Of course, everyone inhabits an environment to a greater or lesser extent different from everyone else, each of us is to some degree genetically unique, and we all generate and are subjected to a constant ebb and flow of hormones and brain activity. And yet, in themselves, no evidence concerning causes is provided by correlations of personal feelings, perceptions or behaviour with variations in genetics, hormone levels or the activity or development of specific areas of the brain. For example, research indicates that clinically depressed subjects tend to have lower than normal levels of the chemical neurotransmitters serotonin and noradrenaline, and that these deficits correlate with lethargy or sleepiness and reported 'low spirits'. But this is not proof that those deficits *cause* depression: it is possible that the psychosomatic response of 'being depressed' is the result of a person, for his own reasons, being convinced that his life is devoid of hope and joy.⁹

On the other hand, it is unarguable that each of us habitually mediates our relations with the world in which we find ourselves. This is accomplished by a constant play of the imagination: so as to guide our actions, in conversation and in our minds, we all respond to events by forever constructing and reconstructing scenarios of the present, past and future. (Of course, a person's 'world' also includes ideas about his own more or less recalcitrant body and mind.) After the event, or perhaps to others around us at the time, these 'constructs' or beliefs might appear more or less true or false, helpful or unhelpful, rational or irrational. Although it might seem obvious that the complex functioning of genes, endocrine-system and brain must somehow impact on the way a person construes reality (and thereby influence his behaviour), even if one day such an influence might be measured, it is not yet. And although it seems that every psychiatrist wishes it were so, neither would any such measurements solve the question of cause and effect which we just mentioned. Do abnormal hormone levels or brain states cause undesirable 'constructions of reality' (i.e., mental disorders) or, inversely, along some or other simple or tangled chain of stimuli, significations, beliefs, feelings and behaviour, do undesirable constructions of reality result in perceptible differences in brain-patterns or hormone levels? Hence the practical distinction between neuropathology and psychiatry: one is the response of authentic medical science to the discernible causes of actual illnesses, and the other responds not to real diseases but to those subjective constructions of reality deemed so inappropriate as to occasion an intolerable nuisance or danger.¹⁰ This is just one of the confusions bred by psychiatry's medical

8 This perspective was inaugurated largely by way of the theory and practice of Sigmund Freud. See almost any item in *The Complete Psychological Works of Sigmund Freud: Standard Edition* (1953-74) Strachey, J et al (Trans and ed) London: Hogarth Press. We discuss Freud's ideas in Chapters 21 and 22 (Volume 2).

9 This issue is discussed further in Chapter 3, below, in the two sections on the psychiatric medical model. It is then considered in detail in Chapter 12 and its Appendix (below), especially by examining decades of research into a variety of hypotheses based in the notion that functional mental disorder will finally be explained by some intrinsic (genetic or bio-chemical) abnormality. No evidence has been found to indicate any such cause.

10 The nature of psychiatry (and mental healthcare), as distinct from neurology (or endocrinology, etc.), is discussed in Chapter 3, below, and in Chapters 16 and 17 (Volume 2).

model. That today's mental health provision is generally based in conceptual muddle and poor or bogus medical science is the main topic of this first Volume.

Meanwhile, perhaps especially among those who consider themselves quite well informed, these days there seems to be a misconception that psychiatric practice was once horrific and coercive but now employs psychodynamic theory, with staff sitting around patiently listening to patients tell them their life-stories. It is true that psychotherapeutic techniques such as counselling and cognitive behavioural therapy (CBT) are recent additions to the menu of mental health treatments, but most patients still do not receive such treatments; they are mainly offered to those thought to have a less serious mental disorder, and then only for a limited time. Anyway, the type of talking therapy recommended by official policy - CBT - positively discourages patients from 'dwelling on' the possible emotional, psychological and social roots to their malaise. Rather, and despite the absence of supporting evidence, according to every mental health expert there is an undoubted formula: the more serious the mental illness, the more definitely must the cause be organic (genetic or bio-chemical), and the more it requires a medical intervention (medication or electroshock). True, there is official acknowledgement of the possible influence of psychological or social factors, but only in passing - in routine practice nearly every doctor and mental health worker still clings blindly to the unevidenced medical model when talking of causes and choosing treatments. Although we will see that it is a failed idea (and this has been known by its critics for decades), the so-called medical model remains the ruling ideology. After all, don't we all speak of 'mental *health*', and isn't psychiatry a branch of *medicine*?

In Chapter 3, so as to give a broad sense of the sands on which it is built - those elementary errors in logic and science committed by its supporters - we make some preliminary comments on the psychiatric medical model. Then, during the course of this Volume, we show exactly how and why mental health provision deviates from the rules, procedures and evidence of scientific medicine. We will see that since its inception the idea that psychiatry is a kind of medicine derived from scientific proofs has obscured the primary role of the profession (and ancillary professions) in the management of individual irrationality, which is: crypto-policing. This role could not be smoothly accomplished without a plausible rationale, and by endorsing and embodying them in its own specialist beliefs, routines and organisation, the apparent medical science of psychiatry validates the misconceptions and prejudices of the wider social consensus. This unquestioning complicity with the dominant social interests is facilitated by translating a few 'common sense' ideas about madness and its appropriate management into an ever more tortuous and arcane pseudo-technical professional discourse which, everybody is assured, is the necessary intellectual vehicle for offering the finest and most up-to-date assistance to the suffering individual. Masquerading as a bona fide branch of medical science, psychiatry's mystifying ideology conceals the fact that rather than serve the genuine and otherwise often fairly easily identified needs of those who are attributed (diagnosed with) 'a mental illness', the official process is largely skewed towards satisfying the anxiety-driven, self-serving wishes of the wider community of 'normal' citizens. For, as we shall see throughout this first Volume, it is clear from official theory, policy and practice that, in effect, the authorities are concerned with re-establishing the social peace as quickly as possible rather than with what might be best for the person in crisis.

For more than a century, conventional psychiatric theory, research and provision has been driven more by wishful ideological prejudice and political and economic interests than by genuine science. As a result, there are striking parallels between contemporary psychiatry and pre-Copernican astronomy. So as to illustrate the onerous weight of the cognitive inertia exerted by any dogma which serves a significant ideological purpose, these similarities might be worth a brief examination.

Five hundred years ago, people subscribed to a geocentric model of the universe. The Ancient Greeks had established that the Earth is round, but everyone still believed it was the unmoving centre of the universe, with the Sun, the Moon and all the stars circling above. In order to account for the way each heavenly body 'moves around the Earth', for more than a thousand years astronomers employed Ptolemy's mathematical workings of Aristotle's notion of concentric layers of celestial spheres or orbs, on or in which the stars and planets 'sat' and were somehow conveyed along their

various observed paths. But this model of the cosmos was only able to encompass all the observations by invoking complicated epicyclic, eccentric and equant tracks for the heavenly bodies, and different speeds on the spheres. By the middle of the 16th century Copernicus had cut through the obscure complexities of the Ptolemaic model by arguing for the simple idea of a heliocentric system, with the Earth spinning on an axis and orbiting as the Sun's third planet.¹¹ This idea found little favour until the invention of the telescope. Then, within a year or so, in 1610, Galileo's discovery of Jupiter's moons disproved Ptolemy and confirmed Copernicus: not every heavenly body circles the Earth. This event not only revolutionised astronomy but caused far wider controversy, leading to irrevocable changes in ideas about science as well as in humanity's view of its place in God's creation. The Copernican model now goes without saying, but the displacement of Earth from its hitherto stable and central position in the cosmos was so psychologically shocking that for two hundred years the idea was resisted by the full force of the Catholic Church.¹²

Both the pre-Copernican astronomer and our present-day psychiatrist (or mental health official) is misled by the false assumption at the heart of his theory. In each case the model remains stuck as a point of dogma, and in the light of fresh and more precise observations it requires constant patching-up with ever more convoluted and unlikely ad hoc hypotheses. This is simply because, making a false assumption from the outset, neither expert can get beyond the evidence as it seems to present itself immediately to his eyes. Both the pre-Copernican astronomer and today's psychiatric official conceive of an isolated and static object: the World on which we stand and which 'obviously' does not move, and the 'obvious' illness of anyone who becomes emotionally or mentally abnormal. Neither can bring himself to imagine that the behaviour of the object in question is the result of relations through time between interdependent objects: a spinning planet which circles a star since it is held by the gravitational pull, and a person tormented to distraction by psychological trauma resulting from the unacknowledged perils of his life amongst others.

Just as disbelief in the heliocentric theory was motivated by psychological as well as material interests, we will see that the fanaticism of those who believe in the medical model of mental illness is due to a combination of wishful thinking and political and economic factors. In both cases, the supposed expert who continues to believe in the discredited theory refuses to exercise his imagination to get beyond the prejudice in which he has invested so much cognitive, emotional and material capital.¹³ It also seems to us that not only does the ostrich-like, unscientific behaviour of the psychiatrists contrast starkly with the sounder procedures of every other discipline known today as a science, but it may be partly understood precisely as an envious response to the glamour of Science Triumphant. Psychiatrists are unable to boast of the indubitable successes of their own discipline, and they seem to be mesmerised by the great technical facility - the predictive power and utility - of the sciences of objects. Hence, despite constantly failing to abide by the rules of scientific procedure, wishful thinking persuades them (and everybody else) that, like their peers in general medicine, they are in the process of developing an accurate and increasingly useful science. In fact, the science and medicine of psychiatry is generally so biased that it is only because the notion of 'mental illness' and its medical treatment is convenient and comforting to most of the public that all those officials who endorse it are not viewed as the members of a bizarre, dogmatic and dangerous cult.¹⁴ We pursue this argument in the chapters towards the end of this Volume.

11 Over the next two centuries Galileo, Kepler and Newton progressively corrected the heliocentric model by filling in the details and using the laws of physics to account for the elliptic motions of the planets.

12 In 1633 the Inquisition forced Galileo to keep quiet about his findings, and the heliocentric theory was banned by the Church for more than a century after that.

13 With regard to psychiatric thinking, the full exposition of this assertion appears in Chapters 12 to 15, below.

14 For example (and perhaps contrary to what many people imagine), for decades those controlling the psychiatric profession were so fanatical in their defence of 'the medical model' that there used to be barely any official mention of psychological theories or psychotherapy, let alone official training. Consequently, by the end of the 20th century few doctors had taken it upon themselves to get such training, and only after the turn of the millennium did the Royal College of Psychiatrists soften its previously vitriolic opposition to psychodynamic

On the other hand, and from the social-psychodynamic perspective - the post-Ptolemaic view, as it were - no matter how strange a functional mental disorder may appear, it is *not* a medical condition and nor is it *intrinsically* incomprehensible. (This is demonstrated in detail in Volume 2.) People who suffer from a mental disorder which has no organic cause are the great majority of those who become mental health or psychiatric patients.

No doubt few psychiatric workers would disagree with the humane sentiments expressed nearly two hundred years ago by Sir William Ellis and quoted at the head of this chapter. However, in this Volume we see how belief in psychiatry's medical model causes carers and therapists systematically to frustrate the project of helping their patients. As the book proceeds, we will see how it is that, due to the universal sway of the misconceived medical model, more often than not the best of intentions only raise false hopes, lead care and therapy up a blind alley, and exacerbate patients' misery.

It is a hundred years since the psychiatric profession first talked-up the undoubtedly medical-scientific status of its theory and practice. We do not claim to offer a startlingly new critique of 'scientific psychiatry', which from the beginning was called into question by some dissenters within the profession. Nevertheless, Volume 1 is comprehensive and systematic when it brings together, illustrates and summarises a variety of disparate and sometimes limited criticisms raised by a small number of psychiatrists and other commentators. Still fewer critics seem to have understood that the medical model of mental illness is *irremediably* flawed and prejudicial to the emotional, mental and physical well-being of the patients.

And to our knowledge, when there is so much research evidence to the contrary, until now nobody has addressed the question of why nearly everyone still seems to believe that, in the main, current mental health provision represents the most caring and therapeutic approach that is humanly possible. Until this conundrum is resolved there will be no fundamental improvement in care and therapy: as well as continuing to suffer from their own private anguish and mental turmoil, mental health patients in their millions will also suffer from the muddled, inappropriate and often harmful attentions of doctors and other officials. What is new, then, is our attempt to account for the perennial seductiveness of that so-called medical model which has dominated the management of individual irrationality for more than a century. We argue that the propensity to be seduced by this modern myth is rooted in a common neurosis and a collective delusion.¹⁵

That form of the management of mental disorder which finds its justification in the so-called medical model is not the whole of psychiatry but it is certainly the mainstream which dominates the field. This model (or theory) proposes that every functional mental disorder is the result of some peculiarly elusive, as-yet-undiscovered organic cause, and that therefore a medical response is always the most appropriate: treatment must mimic the methods of general medicine. There is no evidence for either of these beliefs. And yet the psychiatric medical model is not employed throughout mental health practice as a hypothesis which may or may not correspond to reality, but rather as *undoubtedly true*. Excessively troubled individuals are forever being told that they definitely 'have' this or that 'mental illness' - depression, schizophrenia, attention deficit hyperactivity disorder, borderline personality disorder, or whatever - and that the only remedy is medical treatment.

Even heretics to psychiatric orthodoxy rarely go so far as to question *the totality* of its concepts and methods. However, our thoroughgoing critique of the psychiatric medical model is not simply a pedantic quibble. Profound consequences issue from the underlying assumptions of that 'model' - first for defining the nature of the individual's crisis, and then for shaping the processes supposed to remedy or manage it. When typically there seems so little benefit to the patients, our analysis gets to the heart of the question of the ongoing failure of the official mental health response.

At the risk of labouring the point, we repeat that (aside from the dementia that often comes with aging) there is no evidence of an organic cause for most cases of mental disorder. However, when mental health officials view personal crisis through the prism of their eccentric medical model,

theory and therapies. See Temple, N (1999) Should consultant psychiatrists be trained in psychotherapy? *Advances in Psychiatric Treatment* 5 288-295.

¹⁵ See especially Chapters 13 and 14, below.

anything that might be known about the individual's psychological, emotional or social problems is consigned to the category of relatively uninteresting 'background information'. The person is no longer seen as he really is: incapacitated due to panic and confusion in the face of overwhelmingly stressful personal circumstances. Whichever other real illnesses may afflict him, if any, he does not suffer from organic brain dysfunction. Never mind - according to the psychiatric medical model, first and foremost the person in crisis 'has' some kind of 'mental illness'; and inasmuch as appropriate treatment cannot be decided without a diagnosis, it follows that the main priority is to interpret the symptoms that the individual displays so as to decide exactly which 'mental illness' it may be.

Not so long ago there was professional optimism that medication or electroshock might cure patients, or at least cause their mental disorders to 'go into remission'. These days, doctors tend to hedge their bets by employing a less ambitious vocabulary: they talk of 'managing the illness'. Either way, convinced by those around him of the nature and cause of his misery and confusion - persuaded that he 'has a mental illness' - the individual undergoing the crisis may quite willingly adopt the role of someone who is sick. And if his emotional and psychological condition does not then quickly improve, he is likely to accept his mental illness diagnosis as an integral part of his identity. Instead of seeing himself as someone who faces vexing problems but who may still be able to act as the agent of his own destiny, he becomes a patient who 'has an illness' - someone who can do little or nothing about his fate, someone who may only be helped by becoming the passive recipient of medical care and treatment.

There are four main characteristics to being ill which affect what everybody expects, and which thereby define the sick role. First, the person is not blamed for being ill: it is supposed that there is not much he can do about it. Second, due to his incapacity he is exempted from his normal responsibilities (to that degree which accords with the purported nature or gravity of the illness). Third, sickness is socially undesirable and burdensome, and so anyone who becomes ill is expected to seek medical help: he *must* become a patient. Lastly, and consequently, the patient is expected to comply with whatever regimen is prescribed by an authorised physician: *for his own good*, he must accept care and treatment, and must do as he is told.¹⁶

The medical model of mental illness determines that anyone going through an emotional or psychological crisis is viewed as sick and must passively accept treatment, as a patient like any other. By contrast, any theory that suggests a psychodynamic basis to emotional or mental disorder views the agency of the subject as only provisionally in abeyance, due to some kind of overwhelming stress. With psychotherapy or counselling, the person is not seen as 'having an illness' and does not become simply the passive recipient of treatment. On the contrary, this alternative model must eventually encourage anyone who experiences a disabling personal impasse or crisis to face up to those events or circumstances in his life which trouble him to the extent of contributing so much to his present unwanted condition. While he should be offered sympathy and assistance if he is to recover his emotional and mental equilibrium - including perhaps a certain amount of respite and even short-term medication (such as a sedative) - medical treatment is ancillary to helping him to become better able to recognise and address the problems in his life. Albeit with the assistance of others, therapy and recovery has to be the self-activity of the person himself: unless he takes the main role, it *cannot* be the recovery of his own better mental equilibrium and autonomy.

Since it is true that, in some respects, the signs of mental disorder often seem like those of a physical illness, this might seem counter-intuitive: the person clearly suffers, he is incapacitated and in need of care, sometimes he may be delirious or worryingly lethargic, recovery is not simply a matter of will-power, and so on. Reason, however, is properly sceptical of 'what immediately seems to be the case'. We all understand that appearances can be deceptive. The sun *seems* to circle the earth, but we all now recognise that the opposite is the case - the earth spins and circles the sun. And so, with respect to cause and remedy, it should be admitted that most instances of mental disorder are easily distinguished from actual illnesses: functional mental disorder ('mental illness') is worryingly

¹⁶ See Henderson, LJ (1935) Physician and patient as a social system. *New England Journal of Medicine* 212 819-823.

irrational behaviour *in the absence of organic pathology*. Furthermore, in a hundred years of ‘scientific psychiatry’, no medical treatment has ever proved significantly more efficacious with the functional mental disorders than placebo or no therapy at all. For these reasons, as will be demonstrated throughout this book, the sick role is not only inappropriate for anyone diagnosed with this kind of malaise but instead tends to hinder recovery.

Faced with the problem of madness, proposals for somatic or conversational interventions have competed since antiquity: whether to tamper medically with the organism - forcibly if needs be - or to engage the person in some kind of interaction or discussion.¹⁷ This difference is nowadays couched in terms of Biology vs. Psychology, Medicine vs. Psychotherapy. One side views functional mental disorder as illness, the troubled or troublesome person as essentially a diseased object - a malfunctioning or sick brain; it goes without saying that someone with a diseased brain cannot be expected to comprehend his own sickness and heal himself, and so medical treatment is necessary. When there is no evidence of anything wrong with the individual’s neurological system, however - which is most often the case - the other side argues that mental disorder is a dysfunctional psychological defence responding to an overwhelming personal crisis; and the person will never recover his mental balance and autonomy if he does nothing more than submit passively to care and treatment by medical authorities.

In short, the psychiatric medical model insists that, because he is sick and lacks medical expertise, someone who ‘has a mental illness’ must neither think (‘worry’) about the nature and cause of his malaise nor, on his own initiative, try to implement a remedy. ‘Worrying’, and other unapproved self-activity, is ‘only likely to make the illness worse’. The psychodynamic approach requires exactly the opposite: if he is provided with material security and reassurance sufficient to quieten his immediate and extreme anxiety (couched as it is in bizarre ideas or behaviour), the person may be persuaded to consider the nature and reasons for his malaise more calmly; and if he can locate, acknowledge and transcend the trauma at the root of his anxiety, he is already on the road to remedying his emotional and mental troubles. The difference is between seeing the problem as a malfunctioning, unreflective object (a sick brain) or assisting the person as an intelligent subject who, under less oppressive circumstances, might take up again the reins of his own life. Few officials acknowledge it, but the two views of the mental health project are mutually exclusive: they cannot both be correct.

Because psychiatrists (and now various ancillary professionals) exercise their powers by law, they are not forced to answer any criticisms of their standard techniques. In fact, they are well-known for never replying reasonably to any such questions. When they do occasionally respond, typically they resort only to name-calling: ignoring specific research evidence or arguments, they simply assert that anyone who dares to criticise is ‘anti-psychiatry’ and therefore grossly irresponsible. Accusing critics of being ‘anti-psychiatry’ was always an over-simplifying distortion. To our knowledge, only one well-known anti-psychiatrist denied the need for some kind of organised assistance for those in emotional or mental distress.¹⁸ We argue that it is the apologists for the psychiatric medical model who are irresponsible and uncaring when they refuse to admit the lack of evidence for the poor practices that they advocate.

No matter. A best-selling textbook, for instance, is not at all embarrassed to dismiss out of hand any point of view that disputes the psychiatric medical model. In just two sentences, Cowen, Harrison and Burns summarise the considered and various arguments of the distinguished critics Thomas Szasz, RD Laing and Michel Foucault. They then continue:

...Over the last 50 years...criticisms of scientific approaches to aetiology have most often taken the view that psychiatric illness is defined by *social and political imperatives*, and

17 See the last section in this chapter: A brief history of the management of madness.

18 Thomas Szasz is the only famous anti-psychiatrist who was absolutely opposed to any kind of official response. A prolific writer, he consistently viewed psychiatry as interference in people’s private lives, inevitably degrading, and an infringement of their human rights. For example, see Szasz, TS (1963) *Law, Liberty, and Psychiatry: An inquiry into the social uses of mental health practices*. New York: Macmillan; also Szasz, TS (1984) *The Therapeutic State: Psychiatry in the mirror of current events*. Amherst NY: Prometheus Books.

represents at best a cultural value judgement and at worst an abusive means of social control... These ideas are sometimes called ‘anti-psychiatry’ to emphasise their fundamental contrast with the medical models employed by conventional psychiatry. Most psychiatrists have believed that these formulations do not advance the understanding of mental illness, and in fact provide rather poor explanations for the range of clinical psychopathology...¹⁹

Cowen et al offer neither the reasoned arguments of anti-psychiatry nor any kind of argued rebuttal. What a reassuring advert for ‘scientific’ psychiatry! No argument, no evidence - only complacent dogma. What these authors will say for anti-psychiatry (and very briefly) is that, yes, there was once political abuse of patients, in Germany under the Nazis, and that there is indeed a ‘...need for the *rights of patients to be respected* and their experiences understood in a personal and social context...’²⁰ Yet this represents only a tiny fraction of anti-psychiatry’s critique.

So our treatise is certainly intended as a textbook - a comprehensive survey, distillation and understanding of the professional knowledge of this topic. It seems to us, however, that it is necessary to deconstruct, piece by piece, the unevidenced assumptions, beliefs and methods which together constitute the rationale for today’s psychiatry. There are usually a number of unspoken or poorly explored and often questionable assumptions underpinning any activity which everybody takes for granted - and mental health provision based on psychiatry’s medical model is one such enterprise. We expose the assumptions upon which it is founded, and find them seriously wanting. As evidence accumulates to refute the standard psychiatric model, it seems futile to continue making ad hoc adjustments to it. Medical or ‘biological’ psychiatry is based on false assumptions and its theories and methods are unsupported by the evidence; altogether, it blocks a clear view of the topic in hand. With regard to functional mental disorder, the medical model must be discarded.

For all that, many of those who criticise this or that element of conventional psychiatry seem nonetheless to assume that the project is, in general, more or less well-conceived. On the other hand, there have been some critics of the whole mind-set and organisation of psychiatry, but they have often been strident and too abstract, and sometimes they do not seem to offer a plausible alternative. Ours, however, is an attempt to describe and criticise psychiatric theory, research and policy, *as well as* the practical routines, formal and informal, *and* to discern how and why the management of mental disorder came to take its present ideological form, *and* to outline a viable alternative.

In the meantime, and despite sporadic guerrilla sniping from a few critics, the medical model of mental illness remains well-entrenched as the ruling idea. The unevidenced belief that every functional mental disorder *must have* an organic cause, and that psychiatric medication ‘works’, is of course supported by the powerful pharmaceuticals lobby, which rubs its hands with glee at the year-on-year rise in psychotropic drug prescriptions. And yet, although there is general enthusiasm for the medical model, in the last three decades or so a few dissident professionals have allied themselves with a growing number of dissatisfied patients and ex-patients in order to oppose the medicalisation of every emotional, psychological or social problem. This movement supports those who nowadays often wish to be known rather as ‘consumers’ or ‘service-users’, or even ‘victims’ or ‘survivors’ of psychiatry. They prefer to be known as such so as to disavow the absolute passivity which is demanded of them as ‘patients’ expected to submit forever to the impositions, indignities and well-documented physiological and psychological dangers of medical power, and so as to begin at last to assert *their own* powers.

What is attempted in this book, in the service of this strengthening alliance, and by means of one sustained argument, is to pull together many of the previously disparate strands of criticism, theory

19 Cowen, P, Harrison, P & Burns, T (2012) *Shorter Oxford Textbook of Psychiatry (6th edn)*. Oxford: Oxford University Press, 89 (their italics). The publisher claims this book is ‘[w]idely recognised as the standard text for trainee psychiatrists...’

20 Cowen, P, Harrison, P & Burns, T, op. cit. (n. 19), 89. This is only lip-service: in any meaningful sense, concern for patients’ rights and understanding their experiences is promptly forgotten for the rest of their book. We discuss anti-psychiatry in the first section of Chapter 15, below.

and practice. It seems to us that this is necessary if opposition to the psychiatric medical model is ever to develop into a fully coherent and credible alternative. People must be persuaded that the medical model of mental illness is a failure - far too costly in both human and financial terms - and that a well-conceived and essentially non-medical response is an entirely practical alternative.

In Volume 1, then, we describe and criticise conventional mental health provision and the beliefs in which its notions and practices are based. In Volume 2 we formulate a theory of the person and of mental disorder which makes better sense than the rationale offered by mainstream psychiatry; and finally, drawing on ideas and practices already in existence, we discuss those kinds of response to functional mental disorder which appear far more helpful than those recommended by the dominant 'medical model'. We offer no blueprint for the future management or remedy of mental disorder. In the hearts and minds and activities of those who propose a humane and democratic alternative to conventional psychiatry, however, the re-invention of care and therapy is already underway.

The prevalence and costs of mental disorder²¹

Mental disorder may be defined as that excessively troublesome irrationality which an individual seems unable to prevent. In 2001, the World Health Organisation (WHO) reckoned there were 450 million people across the world receiving some kind of mental health treatment, although by 2016 it estimated the total for just three conditions - depression, bipolar disorder and schizophrenia - at 431 million.²² Not every country has a highly organised provision of mental healthcare, and so the number of those suffering from an emotional or mental disorder is undoubtedly much higher. It is estimated that in any society at least one person in four will at some time or another experience some kind of serious mental health problem;²³ in the UK, it is reckoned that one in four people will have a mental health problem in any given year,²⁴ while nearly half of the ill-health suffered by working-age people has a psychological basis and is profoundly disabling. A third of all families have a member suffering from a mental disorder, and mental health problems account for nearly half of all absences from work and nearly half of all those on incapacity benefits. And yet, at the end of 2011, only one-quarter of those who seemed to need mental health treatment were receiving it.²⁵

Depression is defined by WHO as 'persistent sadness and loss of interest in activities that people normally enjoy [and] inability to carry out daily activities for two weeks or more'; there is often also lack of energy, shifts in appetite or sleep patterns, substance abuse, anxiety, feelings of worthlessness and thoughts of **self-harm or suicide**. Globally, by 2015 there were 322 million people living with depression, up 18.4% from 2005. More women than men suffer from the condition, and it is thought to be the world's fourth most important cause of premature death. Loss of productivity and other medical problems often linked to depression add up to an estimated yearly cost of \$1trillion.²⁶

In 2012, a sample of general practitioners in the UK revealed that 84% of their consultations dealt with stress and anxiety, while 55% reported specific 'mental health issues'. In England, there were

21 The best sources for UK studies and statistics are Bird, L (1999) *The Fundamental Facts: All the latest facts and figures on mental illness*. Newport: The Mental Health Foundation; Halliwell, E, Main, L & Richardson, C (2007) *The Fundamental Facts: The latest facts and figures on mental health*. Newport: The Mental Health Foundation; and *Fundamental Facts about Mental Health 2015* (2015) London: The Mental Health Foundation.

22 *Mental Disorders* (2016) World Health Organisation. April.

23 See Marmot, M, op. cit. (n. 2), and McManus, S, et al, op. cit. (n. 2). Also Bird, L, op. cit. (n. 21), 5; Halliwell, E, Main, L & Richardson, C, op. cit. (n. 21), 7; Mental problems 'hit one in four' (2001) *The Guardian* 4 Oct. Other research indicates rates in the USA and New Zealand as high as one-in-two. However, those studies depended on self-reporting and probably reflect a very wide cast of the diagnostic net by including minor episodes where, for example, temporary grief counts as depression. See Horder, J (2010) How true is the one-in-four mental health statistic? *The Guardian* 24 April.

24 *Fundamental Facts*, op. cit. (n. 21), 7.

25 Bosely, S (2012) Scandal of mental illness: only 25% of people in need get help. *The Guardian* 18 June; this reports a study by the Mental Health Policy Group of the London School of Economics.

26 *Mental Disorders: Depression* (2016) World Health Organisation. April; Agence France-Press (2017) Depression is leading cause of disability worldwide, says WHO study. *The Guardian* 31 Mar.

nearly 3 million adults registered with local GPs for depression during the year to March 2014, and another approximately half-a-million for 'a severe and enduring mental health problem'. 1,746,698 people were in contact with secondary (psychiatric) mental health services during that year - 1 in 28 of the total population (nearly 4%).²⁷ The same year, throughout the UK, there were 121,499 admissions to a mental health facility; this was 5.8% more than the previous year, but there was also an increase in discharges, and the average occupied bed-days fell by fifteen. But relatively few people present to primary care for mental health problems or access specialist (i.e. secondary care) mental health services. For example, by 2014, while NHS England dealt with 1 million patients every 36 hours, approximately 1.7 million *per year* went for specialist mental health services. A great many people with serious mental health problems do not access any official support; for example, only 65% of people with a psychotic disorder are thought to receive treatment.²⁸

The dangers posed by a mental disorder are often a cause for concern. There is not much recent research but in 2002 a review of the literature found that 'evidence supports a small but independent association of violence with schizophrenia'; substance abuse considerably increased the risk. However, up until then, the amount of violent crime attributable to schizophrenia 'consistently [fell] below 10%'.²⁹ More generally, research indicates that the risk of violence from people with known mental health problems is comparatively low - from 3% to 5% of all such incidents. On the other hand, having a mental health problem significantly increases the chances of becoming a victim of violence. In 2013, a UK survey of people with severe mental health problems found that 45% had been the victim of a crime during the previous year, with 20% being assaulted. Someone with a mental health problem was three times more likely to be a crime victim (including violent assault) than those without mental health problems; women with severe mental health problems were *ten times* more likely to have been assaulted during the year than women in good mental health.³⁰

It has always been the case that members of the public are much more at risk of being assaulted and killed by someone who seems mentally well than by someone with a mental health diagnosis. In 2016 the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness reported that across the UK patients diagnosed with schizophrenia, psychosis or other disorders committed 870 homicides during the decade to 2014; this was 11% of all killings. There were 87 such events in 2004 and 94 the year after, but by 2014 the number had fallen to 67 - down 27% in ten years. Killings by diagnosed schizophrenics fell from 53 in 2004 to 43 in 2013 and then 36 in 2014. In all, 369 homicides were carried out by people with a history of schizophrenia or other delusional disorder. All the same, killings by mental health patients did not fall as fast as the overall drop in homicides. The 27% fall was less than the 37% drop seen in the latter. As a result the proportion of all killings committed by such patients had risen from 9% in 2001 to the 11% seen later in the decade; the Report felt that this was probably due to failings in care under the pressures of Austerity and the squeeze on funding for mental health care.

The authors of the survey hoped and thought that all the same there had been some improvements in clinical care, especially in improving the management of patients' substance misuse. However, according to in-depth analysis of 662 of the 870 cases, the Report raised questions about the supervision of patients after their release from hospital: almost two in five patients who killed someone (38%) did so after missing their most recent NHS appointment and so neither talked to a care co-ordinator or psychiatrist nor received drugs. The report also found that half (52%) of those who committed a homicide had previously been convicted of a violent crime and almost as many (48%) had been in jail; 24% had previously been involuntarily detained, or sectioned, under the Mental Health Act, and 6% had been in a secure mental health unit.

27 *Fundamental Facts*, op. cit. (n. 21), 69.

28 *Fundamental Facts*, op. cit. (n. 21), 68.

29 Walsh, E et al (2002) Violence and schizophrenia: examining the evidence. *British Journal of Psychiatry* 180 6 490-495.

30 *Fundamental Facts*, op. cit. (n. 21), 22. People with mental health problems were also more likely than the general population to report that the police had been unfair to them.

Mental health patients are a greater risk to themselves than to others. In the UK, around 1,700 take their own lives each year: between 2004 and 2014, 28% of all suicides were of people receiving NHS help for a mental disorder. About half had a history of drug or alcohol problems; additionally “there is evidence that economic factors are becoming more common as antecedents in patient suicides. Unemployment and homelessness have increased and 13% of patients who died by suicide had experienced serious financial difficulties in the previous three months”. Increased financial pressures on NHS care was thought to be increasing the risks taken with patients: about 200 mental health patients kill themselves every year after being put under the care of community-based crisis teams and looked after in their homes - a third after being discharged from hospital in the previous two weeks. This raises questions about crisis resolution/home treatment being the most suitable setting for care, and also concerns that crisis teams are increasingly resorted to because of pressures on other acute services, particularly in-patient beds.³¹

These statistics show that someone with a serious emotional or psychological problem is much more likely to be a danger to himself than to anyone else. In 2015 the National Inquiry into Suicide and Homicide by People with Mental Illness estimated that in the UK during the ten years to 2013, 18,220 people with a known mental health problem had taken their own lives.³² At the turn of the millennium, when employment in most countries was relatively high, the world suicide rate was 15.1 per 100,000 people; for males the rate was 24 per 100,000. By 2016, WHO estimated that more than 800,000 people die from suicide each year, three-quarters in low- and middle-income countries. Globally, suicide is the second most common cause of death among those aged 15-29. And of course, for every suicide there are many more who attempt it, and a prior attempt is the single most important risk factor for suicide in the general population.³³

In the UK, while there is a daily average of eight deaths on the roads, there are 17 suicides. Increased unemployment generally leads to an increase in suicides. Mainly driven by the behaviour of working-age men, the suicide rate in the UK fell steadily for the ten years to 2008, and then began to rise again. In 2004 there were 5,500 suicides, in 2010 there were 5,600, and by 2013 there were 6,233 suicides recorded for people aged 15 and older; of these, 78% were male. In 2015 the number fell marginally, to 6,188. This equates to a rate of 10.8 per 100,000: 16.8 for men and 5.2 for women; in 2014, men aged 45-49 were the most at risk, at rate of 26.5 per 100,000.³⁴

Due to stigma, it is difficult to calculate the incidence of behaviour like mental disorder or suicide. (In cases of suicide, for example, coroners might have their own private reasons for recording an open verdict or one of accidental death.) Doctors in the UK report that in any year about 10% of the total population present because they suffer from some sort of emotional or mental disorder (diagnosed as one or another ‘mental illness’). This is undoubtedly an underestimate since it only counts those who go to a doctor while obviously suffering from an emotional or psychological problem. In any event, as many people are diagnosed with a mental disorder as for heart and circulatory disorders, the biggest category of physical diseases. It is estimated that each year more than 20,000 people die in the UK as a direct result of their mental disorder. As we mentioned, in recent years the number of suicides has again exceeded 6,000 (one for every 10,000 of the population). Aside from unemployment, risk of suicide associates mainly with gender and age: it is higher for males and for older people.³⁵ Most of the other deaths are due to accidents resulting from

31 Campbell, D (2016) Number of killings by mental health patients falls. *The Guardian* 6 Oct; This reported publication of the *National Confidential Inquiry into Suicide and Homicide by people with Mental Illness* (2016) Healthcare Quality Improvement Partnership: Manchester.

32 *Fundamental Facts*, op. cit. (n. 21), 21.

33 *Report on Mental Health* (2001) Geneva: World Health Organisation; WHO publishes world suicide rates (2001) *The Guardian* 5 Oct; Halliwell, E, Main, L & Richardson, C, op. cit. (n. 21), 14; *Mental Disorders: Suicide* (2016) Geneva: World Health Organisation. Sept.

34 *Suicide: facts and figures* (2016) Samaritans website; *Fundamental Facts*, op. cit. (n. 21), 21.

35 As we mentioned, numbers rise and fall periodically, mainly correlating with economic cycles of bust and boom. The UK was in recession for most of the period 1980-1990, with high unemployment and low wages. Between those years, suicides of young males rose from 8 to 15 per 100,000, and for males aged 25-44, from 16

chronic mental disorders amongst the elderly. And each year there are also around 2,000 fatalities directly related to alcohol and drug abuse.

Difficulties in establishing clear facts about rates of mental disorder are due to non-presentation by those who suffer from it, and the categories and strategies for diagnosis and fact-gathering. For example, the existence of a problem does not officially register until it is recognised and provisions are made to meet it.³⁶ Also, mental health problems are often hidden behind physical symptoms. Independent surveys in the UK suggest that in any year one person in four will experience some kind of mental health problem - i.e., not 10% but perhaps 25% of the population presents to the health service with this kind of problem. It seems likely that one-in-six adults suffer from some kind of fairly serious neurosis, most commonly identified as anxiety or depression. At some time or another, more than one-in-ten of us are likely to be diagnosed with a disabling anxiety disorder; in 2007 the Adult Psychiatric Morbidity Survey (APMS) found that the one-week prevalence of generalised anxiety in England was 4.4%;³⁷ across the UK, women are nearly twice as likely as men to be diagnosed with an anxiety disorder.³⁸ In addition, 13% of the population suffers from some kind of phobia, and perhaps 2.5% from an obsessive compulsive disorder (OCD). Probably 10% of the population are currently prescribed some kind of anti-depressant medication; of these, half are depressed for more than three months, which is considered serious or 'clinical'. Each of us has a 15%-20% chance of presenting for depression at some time in our life, although two-thirds of those diagnosed are female. In the 2013 UK Wellbeing Survey, nearly 1-in-5 people in the UK aged 16 and older showed symptoms of anxiety or depression (21.5% of all females and 14.8% of males); most affected were people aged 50-60.³⁹

In 2013 there were 8.2 million cases of anxiety disorder in the UK, more than a million of addiction, and nearly 4 million of mood disorders (including bipolar mood disorder). According to the 2007 APMS for England, 16.2% of all adults met the diagnostic criteria for at least one common mental health problem in the week prior to being surveyed; more than half presented mixed anxiety and depression (9%), 4.4% met the criteria for general anxiety, and 2.3% the criteria for depression. From this survey it was estimated that 4%-10% of the English population will at some time experience a major depression. Women are more likely than men to have a common mental health problem (19.7% and 12.5% respectively); women's chances are higher across all categories of common mental health problems apart from panic disorder and OCD.⁴⁰

A constant factor in the incidence of mental health problems is socio-economic disadvantage. In 2006, results from WHO's Mental Health Survey across eight developed countries showed that low education, unemployment, poverty, and deprivation all associate with increased risk of a mental health problem. By 2013, a review of 55 studies examining the impact of socio-economic inequalities on children and adolescents found that across twenty-three countries the disadvantaged were two to three times more likely to develop mental health problems; there was also a stronger association for younger than for older children. Longitudinal studies confirmed this association, and also found that any improvement in socio-economic status led to a significant reduction in, and remission of, mental

to 25 per 100,000. At the same time, the rate dropped from about 30 to below 25 per 100,000 for those over the age of 70; this was probably due to the retired being comparatively better-off than they had ever been before. See Pilgrim, D & Rogers, A (1993) *A Sociology of Mental Health and Illness*. Maidenhead: Open University Press, 74-75. Of course, there are always many more attempted suicides.

36 Until well into the 19th century, in European societies, generally only the 'furiously and dangerously' mad were felt to require incarceration and treatment. However, as the state began to intervene to control the provision of management for the mad, and as the psychiatric profession emerged out of general medicine, the line between normality and abnormality was pushed back from overt and very troublesome psychosis towards less serious forms of neurosis and general nuisance.

37 *Fundamental Facts*, op. cit. (n. 21), 20.

38 *Fundamental Facts*, op. cit. (n. 21), 20.

39 Bird, L, op. cit. (n. 21), 5-18; Halliwell, E, Main, L & Richardson, C, op. cit. (n. 21), 13; *Fundamental Facts*, op. cit. (n. 21), 18 and 36.

40 *Fundamental Facts*, op. cit. (n. 21), 19.

health problems.⁴¹ This is confirmed by a UK study reporting in 2011, which found that children and adults living in households in the lowest 20% income bracket are two to three times more likely to develop mental health problems than those in the highest income group.⁴²

There are a variety of ways to calculate the incidence of more extreme misery and confusion. WHO estimates that bipolar affective disorder affects about 60 million people world-wide, and schizophrenia about 21 million.⁴³ In the UK, estimates vary between 0.3% and 1.5% of the adult population with 'a severe and enduring' mental health problem; almost half a million suffer from a diagnosed chronic or recurring psychotic condition.⁴⁴ At any one time, an estimated 4 out of every 1,000 adults (0.4%) show signs of a psychosis, while approximately 1% of the population will present for bi-polar disorder (formerly known as manic depression) at some time during their life, and 1% will be diagnosed with schizophrenia.⁴⁵ To these numbers should be added the official estimate of 1.5 million who suffer from a 'major depressive illness'.⁴⁶ This means that in the UK, in any year, at least 2 million people, but possibly one or two million more, are *severely* incapacitated by mental disorder. This is more than 3% of the population, but possibly 6%. Add to this nearly 2 million who suffer from a 'behavioural condition' or acute stress, and something over 3.5 million suffering from anxiety or depression.⁴⁷ This gives a total of nearly 10 million (15% of the UK population) receiving mental health care and treatment, in some form or another.

For various reasons of differential social pressure, prejudice and diagnosis - reasons addressed later in this Volume - there are a number of significant differences in the types and rates of incidence of functional mental disorders as between gender, social class, ethnicity and age. Women are generally more likely to be classified as mentally ill, as are the poor and certain ethnic minorities.

Anxiety and depression also manifest as recognised eating disorders, but mostly amongst women; probably 4% of all women experience anorexia or bulimia.⁴⁸ Anorexia is a serious condition among younger women - the third most chronic of all their health problems, and by far the prime cause of their premature deaths; older women tend to bulimia. Lately, one-in-five women, but only one-in-seven men, have been diagnosed with some kind of mental illness. Young women are the most likely to attempt suicide - usually with sleeping pills - but more than three-quarters of all successful suicides are by men. (1% of those who attempt suicide go on to succeed within the year, at a rate one hundred times that of the general population). Men are also three-times as likely to be alcohol-dependent, and twice as likely to be dependent on an illegal drug. In the UK it is reckoned that at least one-third of the homeless, more than one-third of the sentenced prison population, and two-thirds of those on

41 *Fundamental Facts*, op. cit. (n. 21), 57.

42 *Fundamental Facts*, op. cit. (n. 21), 58.

43 *Mental Disorders: Bipolar affective disorder* (2016) Geneva: World Health Organisation. April; *Mental Disorders: Schizophrenia and other psychoses* (2016) Geneva: World Health Organisation. April.

44 Bird, L, op. cit. (n. 21), 5-18; Halliwell, E, Main, L & Richardson, C, op. cit. (n. 21), 18. Of these, something over a quarter consist of senile and pre-senile dementia (which appear to have an organic basis), and a quarter is reckoned as schizophrenia; other types of functional psychosis make up the remaining cases.

45 Bird, L, op. cit. (n. 21), 5-18. Almost all hospitalisation for bi-polar disorder (manic-depression) is re-admission, and 80% of the clinically depressed undergo further episodes. Two-thirds of those diagnosed with schizophrenia experience multiple episodes, and 10%-15% develop severe long-term disabilities.

46 This is no doubt an underestimate: governments tend to collate statistics in a manner convenient to keeping down the costs of providing care.

47 Bird, L, op. cit. (n. 21), 21-25.

48 In a UK sample of nearly 10,000 women, 4% had a serious eating disorder. Treasure, J et al (2005) Mind the gap: Service transition and interface problems for patients with eating disorders. *British Journal of Psychiatry* 187 398-400. The recent alarming obesity epidemic is not considered a mental health or psychiatric problem, despite good evidence that overeating and obesity are often used unconsciously as comfort from, and defence against, physical, sexual or emotional abuse, or other kinds of emotional trauma. See Anda, RF & Felitti, VJ (2003) Origins and essence of the study. *ACE Reporter: A free research publication dealing with the effects of adverse childhood experiences on adult health and well-being* 1 1 April. This study is discussed in the text to footnotes 134-136 in Chapter 23 (Volume 2), and to footnote 24 in Chapter 24, below.

remand suffer from a mental health problem; 37% of sentenced men and 56% of sentenced women are reported to have a psychiatric disorder.⁴⁹

People of Afro-Caribbean descent are twice as likely as the general population to be diagnosed with a mental illness. They are three to five times as likely to be hospitalised for schizophrenia; they are also disproportionately diagnosed with a severe condition, far more often detained compulsorily, more likely to receive higher than average doses of medication, highly over-represented in secure units and prisons, and two-and-a-half times more likely than the mean to have a poor outcome from treatment.⁵⁰ A later study (published in 2008) found that for adults (aged 16-64), compared with their white British peers, Afro-Caribbeans or people of African descent were twice as likely to be diagnosed with a psychotic disorder, and this effect was still observed after controlling for socio-economic status. However, in 2017 a study of 687 young adults (aged 18-34) diagnosed with a psychotic disorder reported that after taking into account socioeconomic status, age, sex and other factors, those from ethnic minority groups born in the UK were overall nearly 2.6 times as likely to have a psychotic disorder as their UK-born white British peers; compared to the risk of a psychotic disorder for a white British young person, those of Afro-Caribbean origin had a risk 4.6 times greater, while the risks for those with Pakistani, black African or mixed ethnic backgrounds were 2.3 times, 4.1 times, and 1.7 times higher, respectively.⁵¹ Meanwhile, in 2003 the National Institute for Mental Health found that people of South Asian, African or Caribbean origin are less likely to have their mental health problems detected by their GP and more likely to have their physical problems incorrectly described as mental health problems.⁵²

Most mental health patients are adults, but it is estimated that each year 20% of all children and young people suffer so much from a mental health problem that they require professional help (about 10% at any one time). Boys are more likely to attract a mental health diagnosis than girls, and rates of mental health referrals among children increase as they approach adolescence. The young suffer from anxiety and depression, but they are also privileged to suffer from the fairly new social control categories known as ‘the hyperactivity and conduct disorders’. Boys are especially vulnerable - 17% of all primary school boys receive this diagnosis.⁵³ Additionally, the charity YoungMinds estimates that in the UK one-in-twelve (8%) of all young people deliberately harm themselves. Self-harm used to be practiced mostly by teenage girls and young women, but it is fast catching on with males. During 2011, 38,000 young people were admitted to hospital due to self-inflicted injuries, but one study found that fewer than 13% of 15-16 year-olds who self-harmed actually got to a hospital. All the same, in-patient admissions for self-harming young people increased 68% in the decade to 2011.⁵⁴

In 2013, WHO estimated that, in any given year, 20% of all adolescents are likely to experience a mental health problem. In 2005, a big US study found that 10% of all school-age children have a diagnosable mental health problem, including depression, anxiety or psychosis; this study determined that one-half of all mental health problems are established by the age 14, and three-quarters by the age of 24.⁵⁵ Nevertheless, in the UK an estimated 70% of all the children and adolescents who experience mental health problems receive no appropriate intervention at the time.⁵⁶

49 Bird, L, op. cit. (n. 21), 27-34.

50 Bird, L, op. cit. (n. 21), 27-34. As much as real ethnic differentials in the propensity to succumb to a mental disorder, the extent of these differences is perhaps a measure of unacknowledged prejudice amongst mental health officials.

51 Kirkbride, JB et al (2017) Ethnic minority status, age-at-immigration and psychosis risk in rural environments: Evidence from the SEPEA study. *Schizophrenia Bulletin* 43 3. This study was mainly concerned with migrants into rural areas but these statistics refer to general BME findings for the UK.

52 *Fundamental Facts*, op. cit. (n. 21), 42.

53 *Mental Health Statistics: Children & Young People* (2013) Newport: Mental Health Foundation.

54 *Self Harm* (2012) YoungMinds.org 23 Oct.

55 *Fundamental Facts*, op. cit. (n. 21), 31.

56 *Fundamental Facts*, op. cit. (n. 21), 8.

Suicide accounts for 20% of all deaths among young people, and the rate for young men nearly doubled during the hard economic times in the UK between 1980 and 1990. The risk of suicide also increases for middle-aged men and for women aged 75 or over. Suicide differentials correlate significantly with a history of a mental health problem. (Although an estimated 9% or 13% chance of suicide for those with a schizophrenia diagnosis was recently re-estimated at 4%.) In general, the likelihood of becoming depressed rises with age. And of course the old are susceptible to organic dementia. WHO's global estimate is 47.5 million people; with 7.7 million new cases every year, the number is predicted to double by 2030. In 2013, there were 815,827 people living with dementia in the UK; this is 1 in every 79 people, and 1 in every 14 aged 65 years or over.⁵⁷

The impact of mental health problems on physical health is generally unrecognised, which has significant consequences for both the people concerned and the wider health services. In the UK, 30% of those with a long-term physical health problem also have a mental health problem, and 46% of those with a mental health problem also have a long-term physical health problem.⁵⁸ An English study by the Nuffield Trust and Health Foundation found that people who have experienced mental health problems are five times as likely to be admitted to hospital in an emergency as those who have not had such problems: in 2013-14, for every 1,000 people with a mental health problem there were 628 emergency admissions, compared with 129 among those with no mental health problems. But most of the admissions of those with mental health problems were for physical ailments. Overall, just 20% of the admissions were explicitly linked to mental health, suggesting that too often mental health conditions are treated in isolation. Visits to A&E units were also three times higher, with more than 1,300 attendances for every 1,000 patients with a mental health problem.⁵⁹

Apart from these issues, a chronic mental disorder is likely to significantly affect the length of the person's life. Compared to the general population, people with severe mental health problems can expect an average reduction in life expectancy of 15 years for women and 20 years for men. Someone who has a schizophrenia diagnosis is two to two-and-a-half times more likely than the average to die prematurely; this is usually due to a physical illness, such as a cardiovascular, metabolic or infectious disease.⁶⁰ Searching the best systematic reviews of clinical studies reporting mortality risks for a whole range of diagnoses - mental health problems, substance and alcohol abuse, dementia, autistic spectrum disorders, learning disability and childhood behavioural disorders - a further analysis located studies that included over 1.7million individuals and more than 250,000 deaths. This revealed that many mental illnesses reduce life expectancy more than heavy smoking, where compared to the general population there is an average loss of 8-10 years: the reduction in life expectancy for those with bipolar disorder is 9-20 years, with schizophrenia 10-20 years, with drug and alcohol abuse 9-24 years, and with recurrent depression 7-11 years.⁶¹ Although suicide is a factor, most of these early deaths result from chronic physical medical conditions (e.g. cardio-vascular, respiratory and infectious diseases) and socio-economic and healthcare risk factors. By 2015, the figures for England showed that the mortality rate among mental health patients aged 19 and over is 4,008 per 100,000, compared to the rate of 1,122 per 100,000 for the general population.⁶²

Apart from the appalling emotional and psychological toll on the lives of the millions of sufferers and their carers, friends and relatives, worrying emotional distress and mental disorder has a high monetary cost. At least one-quarter of those with a mental health problem do not get to a doctor at the time; all the same an estimated one-third of all GP consultations are the result of psychological or

57 *Mental Disorders: Dementia* (2016) Geneva: World Health Organisation. April; Bird, L, op. cit. (n. 20), 27-30; *Fundamental Facts*, op. cit. (n. 21), 37.

58 *Fundamental Facts*, op. cit. (n. 21), 43.

59 Triggler, N (2015) Physical health of mentally ill people 'ignored'. *BBC News* 14 Oct.

60 *Mental Disorders: Schizophrenia...*, op. cit. (n. 43).

61 Fazel, S (2014) Many mental illnesses reduce life expectancy more than heavy smoking. *University of Oxford News* 23 May; these statistics are confirmed by Liu, NH (2017) Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry* 16 1, 30-40.

62 *Fundamental Facts*, op. cit. (n. 21), 89.

social problems, while 10-20% of GPs' time is taken up with problems which definitely concern the balance of the patient's mind. At any one time, 8% of the population regularly sees a GP for a diagnosed mental health problem, and 2% of the population are under psychiatric management and treated 'in the community'. Less than 10% of all cases are referred to secondary care in the specialist mental health service, but severe problems do tend to be so referred, and each year this includes about 8% of the population. About one-quarter of all NHS prescriptions are for mental health medications. In 1993 the direct cost of depression to the NHS was calculated at £420 million; by 1998 the direct cost of schizophrenia was £397 million, but the indirect cost, including housing and social services, was probably a further £1.76 billion; however, five years later a senior psychiatrist confirmed that the direct NHS cost of schizophrenia had reached £1bn.⁶³ At the end of the 20th century, the lifetime cost of conduct disorder was estimated at £91,000 per child. And at that time the direct cost of care for dementia in England and Wales was estimated at over £1bn per annum.⁶⁴

Mental health problems are a major contributor to the burden of disease worldwide. By 2014 they were estimated to cost a total of £1.6 trillion - more than cardiovascular disease, chronic respiratory disease, cancer and diabetes. In the UK, mental health problems are responsible for the largest single burden of disease - 28%, compared to 16% each for cancer and heart disease.⁶⁵ There is also a high social cost: among adults on long-term benefits due to ill-health, 43% suffer primarily from a mental health problem. Mental health constitutes the largest category of NHS expenditure in the UK, but only 13% of the total NHS budget is spent on mental health, and about 75% of people with a mental health problem get no treatment at all.⁶⁶

In 1999, the estimated expenditure on mental health care and treatment in the UK was £4.2 billion: 10% of the total cost of the NHS. Yet in 1998 the yearly cost of mental health problems in England alone was estimated at £32bn - equivalent to 18 months of the UK's defence budget. Apart from £4.2bn for NHS services, this figure included nearly £12bn for lost employment, £7.6bn for social security payments (although surveys show that nearly all former psychiatric patients would like to work), £2.8bn for informal care, £2.5bn for lost productivity due to suicide, £1.7bn for local authority social services, and £650 million for criminal justice.⁶⁷ Due to mental ill health (i.e. anxiety, depression and stress-related conditions), in the UK roughly 70 million days are lost from work each year, making it the leading cause of sickness absence.⁶⁸ By 2004, the UK's estimated yearly total of economic and social costs due to mental health problems was £98bn. This consisted of £17bn for health and social care, £28.3bn cost to the economy, and £53.1bn in 'human costs'; this was more than the cost of all crime, and more than the entire NHS budget for that year. In 2014 the OECD estimated the UK's yearly costs for mental health care, benefits and lost productivity at £70bn, or 4.5% of the national income (GDP). However, for 2013 the UK's Chief Medical Officer reckoned that mental health problems cost the economy perhaps £100bn: 20% of the total was attributed to health and social care, 30% to lost productivity, and the remaining 50% to human suffering. By 2016 the total economic costs to the UK were estimated at £105bn (5% of GNP).⁶⁹ Whatever the exact figures, the human and monetary costs are obviously considerable.

The psychiatric response

The UK's 1983 Mental Health Act required the exercise of psychiatric authority with respect to four categories: 'mental illness', 'psychopathic disorder', 'mental impairment', and 'severe mental

63 Interview (2003) National news. *BBC Radio 4* 24 March. This spectacular increase must be due to the decision to now administer only the much more expensive 'atypical' anti-psychotic drugs.

64 Bird, L, op. cit. (n. 21), 33-34.

65 *Fundamental Facts*, op. cit. (n. 21), 7 and 82.

66 *Fundamental Facts*, op. cit. (n. 21), 83 and 85.

67 Bird, L, op. cit. (n. 21), 34.

68 *Fundamental Facts*, op. cit. (n. 21), 9 and 83.

69 Halliwell, E, Main, L & Richardson, C, op. cit. (n. 21), 70; Singh, S, op. cit. (n. 3); *Fundamental Facts*, op. cit. (n. 21), 82; *The Five Year Forward View for Mental Health* (2016) Mental Health Taskforce for the NHS, 4.

impairment'; 'learning disability' also came within the Act if a patient's conduct was judged 'abnormally aggressive' or 'seriously irresponsible'. The 1983 Act removed from the psychiatric remit cases of 'promiscuity' or 'immoral conduct', sexual deviancy, and drug or alcohol dependence, unless there was a 'dual diagnosis' (i.e., where the individual was also judged to be 'ill, psychopathic or impaired'). In the amending Mental Health Act of 2007, the four categories of mental disorder were replaced by one catchall: 'any disorder or disability of the mind'.⁷⁰

Most psychiatric patients receive care and treatment in an informal capacity: ostensibly they are voluntary patients. In 2008 about 15% were detained and treated compulsorily. According to the official monitoring agency, the Care Quality Commission (CQC), in NHS England the number of patients detained for compulsory treatment had increased to a record of more than 50,000 by 2013. This was a 12% rise over five years, and about 30% had been detained after 'informal admission'. Due to funding problems since the economic crisis of 2008, the total number of beds has meanwhile been cut to leave no spare capacity, and with the trend towards ever more detentions by community treatment orders (CTOs) many units now find they cannot take everyone sent to them, and some patients have to be sent 'out of area', often far from home. The lack of capacity has other knock-on effects. For example, patients are increasingly being compulsorily detained just to secure them a bed, and in-patients are sent home before they can cope, so as to 'free up' beds. In the latter case, increased numbers are then quickly returning in full-blown crisis, but there are also documented instances of suicide and homicide. As a general consequence of the beds shortage, more dangerous inmates now take up much more space and time within facilities, and it is increasingly difficult to realise therapeutic intentions for any of the patients.⁷¹

Referral to psychiatric services is usually made by an Approved Mental Health Professional, but the nearest relative can also make the application. Normally, someone only becomes an in-patient as a last resort. If he does not co-operate, however, and it seems necessary because he seems to be a danger to himself or others, on the authority of two doctors he may be compulsorily detained and treated. Generally, this authority runs in the first instance for 28 days, but on the authority of one doctor, in an emergency, it can be for 72 hours; there is also provision for detention for up to six months, which may be renewed. The 2007 Mental Health Act created Approved Mental Health Professionals to take over referral from the Approved Social Workers introduced by the 1983 Act, while Responsible Medical Officers (doctors responsible for compulsory detention or treatment) were replaced by Approved Clinicians (including Responsible Clinicians); these roles may now be filled by specially trained psychologists, social workers, nurses or occupational therapists, as well as by doctors.⁷²

Most psychiatric patients now live 'in the community'. Between 1983 and 1997 the number of NHS psychiatric beds in England more than halved to less than 39,000. To date, the number is still falling, although the rate of decline has levelled off. In the whole of the UK fewer than 60,000 patients are now resident in NHS psychiatric facilities, and most in-patients are there for less than a year. After 1980 there was a marked trend towards patients spending shorter periods in psychiatric facilities. By 1999, more than 65% of those detained stayed for less than a month, and only 10% stayed for more than three months;⁷³ something over 350,000 attended out-patient departments, and there are a few day-care places, hostels, homes and day-centres which are mainly for those in the process of discharge from in-patient psychiatric care. By March 2014, out of the 1,746,698 people in

⁷⁰ *The Mental Health Act* (1983) London: HMSO; and *The Mental Health Act* (2007) London: HMSO.

⁷¹ The beds crisis (2008) www.mind.org.uk/ 22 May; Campbell, D (2014) Concern over record numbers detained for mental health treatment. *The Guardian* 28 Jan; Buchanan, M (2014) Patients sectioned 'because of pressure on beds'. *BBC News* 2 June; Deaths linked to mental health beds crisis as cuts leave little slack in system (2014) communitycare.co.uk 28 Nov. The 2014 CQC report also criticised procedures whereby some patients were detained after simply being told they were 'going for a cup of tea', 'for a nice chat', or 'to see a doctor'. Public services must 'wake up' to gaps in mental health crisis care, warns CQC (2015) London: Care Quality Commission.

⁷² *The Mental Health Act* (1983), op. cit. (n. 70); *The Mental Health Act* (2007), op. cit. (n. 70).

⁷³ Bird, L, op. cit. (n. 21), 28-29.

contact with the UK's mental health services during the previous year, only 10% spent any time in a psychiatric facility. Most care and treatment is administered 'in the community',⁷⁴ and most people who suffer from a mental disorder are dealt with by their GP. Patients look after themselves or are cared for by their family or voluntary carers; until discharged from psychiatric care, they are also visited by a community psychiatric nurse (CPN) or a social worker. Or they slip out of the system.

The medical specialism of psychiatry governs all the legal relations of anyone who, due to the severity of his or her emotional or mental disorder, is admitted or committed to care and treatment. Some people have the impression that the medical model entered terminal decline after criticism by the anti-psychiatrists during the 1960s. They seem to think that electroshock was abandoned, and they have no idea of the huge growth in the number of psychiatric drug prescriptions over the last sixty years. Instead, they fondly imagine an explosion of benign, state-funded psychotherapy. More realistically, they may note the expansion of counselling-type interventions, especially through the emergence in the last forty years or so of many more non-medical experts and organisations offering help - independent psychotherapists and counsellors, and charities such as MIND, SANE, Rethink, etc. Besides, replacing the big old insane asylums or mental hospitals with Care in the Community has the appearance of a significant liberalisation.

In fact, shock treatment (electroconvulsive therapy, ECT) is still fairly common. In England in the mid-1990s about one-in-four in-patients (20,000 every year) were given a course of at least five sessions of ECT. This had reduced to approximately 11,000 patients by 2003, but there is no regular audit to say how much the numbers continued to fall, and there are now signs of a recent resurgence in its use: in England the number of treatments rose by 11% between 2102 and 2016, when it was given to perhaps 2,800 patients.⁷⁵

The routine first resort and mainstay of mental health treatment remains medication. The number of psychiatric drug prescriptions has increased every year since the 1950s. Between 1990 and 1995, in England, the number of anti-depressant prescriptions grew by 116%, and between 2005 and 2015 the number more than doubled again to reach 61 million.⁷⁶ There does not seem to be a regular audit for the anti-psychotics, but in 1995 there were 4.5 million prescriptions in the UK. For England, there are statistics for the drugs used with psychoses and related disorders (including schizophrenia and bipolar disorder) 'in the community': the number of items dispensed in 2014 was 10.5 million; this was 5.2% more than the year before, and 59% more than in 2004.⁷⁷ In England, in 2014, there were 16.4 million hypnotic and anxiolytic items dispensed 'in the community'; bucking the trend, and in response to much adverse publicity about their prolific use, this was a slight reduction (-3.8%) from 2004.⁷⁸

It is true that by 1999 more than 1,000 mental health counsellors were employed, in just over half of all English general practices.⁷⁹ In 2008 the government introduced a national policy: Improving

⁷⁴ *Fundamental Facts*, op. cit. (n. 21), 71.

⁷⁵ Halliwell, E, Main, L & Richardson, C, op. cit. (n. 21), 60; ECT. West Eye View (2004) *ITV* 21 Oct. In 2003, 1,500 patients were given ECT against their will. There does not seem to have been a decline in the last decade, but not only is there no longer a UK audit of the number of patients administered ECT, it is now difficult to estimate the numbers except those treated against their will. For the most recent estimates see Davis, N & Duncan, P (2017) Electroconvulsive therapy on the rise again in England. *The Guardian* 17 April. Also see Thomas, P (1996) Electroshock Therapy. *What Doctors Don't Tell You (WDDTY)* 7 8. For further discussion, see Chapter 7, below.

⁷⁶ For a population of 54 million; of course, this must include repeat prescriptions. Bosely, B (2016) Why have antidepressant prescriptions doubled in the last decade? *The Guardian* 8 July. The statistics are from the Health and Social Care Information Centre.

⁷⁷ Bird, L, op. cit. (n. 21), 30; *Prescriptions Dispensed in the Community, England 2004-14* (2015) London: Health and Social Care Information Centre, 46.

⁷⁸ *Prescriptions Dispensed in the Community England, 2004-14*, op. cit. (n. 77), 78

⁷⁹ Holmes, J (1999) A gap in the national (mental) health. In S Greenberg (Ed) *Mindfield: Therapy on the couch*. London: Camden Press, 105-109.

Access to Psychological Therapies (IAPT).⁸⁰ Psychotherapy and counselling then expanded such that during the first two months of 2015 there were 224,000 referrals to the specialist IAPT service.⁸¹ On the premise that any sympathetic talk is better than none, this is a heartening advance, but really it amounts to a few drops in the medical ocean. How many patients get counselling before or instead of drugs? The clientele for the counselling services is also more often from the largely self-selecting, more mildly neurotic middle class, who need less help. The problems of the more extremely and chronically neurotic or psychotic, who are mainly from the working class (or perhaps proportionately mainly from what is now sometimes called ‘the underclass’), are still dealt with primarily by so-said medical means: the more serious the presenting symptoms, the more likely the patient’s problem is diagnosed as definitely a mental illness to be dealt with not by talk but by medication. By the end of 2011, NHS England estimated that there were 6.1 million people with treatable anxiety or depression, and only 131,000 (2.1%) had received any kind of talking therapy.⁸² A survey in 2014 found that of 2,000 people who tried to access a talking therapy, only 15% were offered the full range of therapies recommended by the National Institute for Clinical Excellence (NICE).⁸³

The recent growth in extra-psychiatric and GP counselling services is of course welcome, and it could help to prevent distressed people from otherwise descending into conditions requiring psychiatric intervention. But the IAPT service is not intended for use in specialist psychiatry: it is ‘...to increase the provision of such treatments for anxiety and depression by primary care organisations.’ It is also normally limited to just a few sessions of CBT, a didactic kind of counselling which takes for granted the medical model and refuses to address the psychodynamic or social causes of an individual’s distress.⁸⁴ A thorough critique of the medical orthodoxy remains urgent so long as it continues to hold centre-stage and dictate how the mental health project is defined.

There are legal powers by which psychiatric attentions may be forced on a person, if needs be, for those kinds of more serious irrationality considered a definite, dangerous and ongoing loss of reason. Anyone who seems to fall within the remit of the Mental Health Acts may be detained and treated in accordance with powers defined in various sections of the Acts. (By reference to these sections in the Mental Health Acts, compulsory detention is generally known as ‘sectioning’). At the same time, few people enter psychiatric care by genuinely free choice. A *Catch 22* paradox is integral to admission when almost everyone is taken into care under overt or covert threat of legal compulsion: psychiatry cannot help but present the individual concerned with a spurious choice of ‘coming quietly’ by agreeing to be a voluntary patient or of being compulsorily ‘sectioned’, anyway. Nowhere is it officially recognised that anyone who voluntarily accepts care and treatment might, by that token, be indicating that he is still reasonable - that he still has ‘mental capacity’ - and therefore *need not* be admitted to a psychiatric facility. Perhaps, in truth, it is *not* rational to volunteer since whenever someone agrees to voluntary admission he simultaneously subjects himself to the coercive power of psychiatry whereby, at the discretion of the doctors, he may then at any moment be *compulsorily* detained and treated, for renewable periods of time. In addition, since no-one becomes a psychiatric patient without a diagnosis, anyone who freely enters or is taken into care finds himself immediately stigmatised as ‘having a mental illness’, as well as subjected to what amounts to the absolute discretion of medical power. In reality, once referred to the specialist service, it is difficult for anyone to resist the process of being made into a psychiatric patient. Being introduced to a psychiatrist (or an Approved or Responsible Clinician) when in the throes of a psychological crisis must be a sobering experience which calls on all the wits a person can muster; subjected to the absurdist logic enshrined

80 *Improving Access to Psychological Therapies (IAPT): Commissioning toolkit* (2008) London: Department of Health.

81 *Fundamental Facts*, op. cit. (n. 21), 72.

82 Bosely, S, op. cit. (n. 25).

83 *Fundamental Facts*, op. cit. (n. 21), 71. The National Institute for Clinical Excellence (NICE) is the independent advisory body to the NHS.

84 We describe CBT more fully, and offer evidence and arguments for and against it, in the text to footnotes 35 to 42 in Chapter 27, and to footnotes 9 and 10 in Chapter 28 (Volume 2).

in the Mental Health Acts, if he does not wish for care and treatment he finds himself having to try to negotiate escape from between a rock and hard place.

The legal test for taking someone into psychiatric care is estimation of the likelihood of harm to the individual or to others. Part of the argument of anti-psychiatry was that doctors would sometimes diagnose serious mental illness and make people into psychiatric patients simply for having unusual ideas and transgressing social norms sufficiently to upset more powerful and apparently responsible persons (especially parents). There may be a fine line between harmless eccentricity and dangerous insanity, but these days the pressure on psychiatric beds means that the current concern is rather that some people in crisis who really require dedicated care and protection do not receive it. Nevertheless, the very act of psychiatric intervention is likely to make the reputed transgressor 'a case' - if not immediately an in-patient, then at least someone who seems to 'have a mental illness' and is therefore expected to accept psychiatric advice and treatment.

The psychiatric response should not be viewed as always or even primarily that of care, assistance and remedy. It is always a legal form of control - of administering those individuals perceived to have dangerously or too offensively lost their reason and self-control. To the detriment of all of those who are forced to submit to care and treatment, there is always a tendency for psychiatric practice to neglect their best interests in favour of re-establishing the social equilibrium. Backed up by the police, that can seem the easiest thing to accomplish in what might, on the face of it, appear to be a straightforward case of a crisis caused by one person's unaccountably unreasonable behaviour. We argue that the rationale for the mental health response is the intention to deliver medical assistance to individuals who desperately need it, but in practice it may easily become a kind of punitive social control. Consequently, rather than caring for patients and helping them with their troubles, psychiatry is as likely to prolong their misery and harm them emotionally, mentally and physically.

A brief history of the management of madness

Today's official response is not the necessary system of an enlightened management of mental disorder, an appropriate application of wonderful and indisputable advances in psychiatric medical science. This is clarified by comparing the way mental disorder is currently conceived and managed with the different beliefs and methods employed in the fairly recent past. Not for want of trying, biological science has discovered neither cause nor cure for any kind of functional mental disorder. Cause and cure (or management) remain matters of opinion.⁸⁵ Within just a few generations, a sequence of quite different views on the nature, cause and remedy of individual irrationality replaced each other as ruling principles for the organisation of care and treatment. It seems that fashions in this field reflect significant alternations in the dominant ideology of the wider society and are the result of conscious and unconscious moral or political choices, and are not only - or even mainly - due to developments in medical science.

Until the rise of the natural sciences, most people imagined that madness was possession by some or other external power, usually malign but sometimes benign: possession by another person's magic, by spirits, totems or ancestors, by gods, God, demons or the Devil. What the possessed person said or did was sometimes valued - for example, as intuition or prophecy - and he was not always restrained or excluded from society unless considered a particular nuisance. But life has long been ruled by the axioms of economic utility, and conspicuous individual irrationality is now generally perceived as an irksome emotional over-intensity and failure of the intellect or will. By consensus, anyone who 'has a mental illness' may deserve sympathy, but he is essentially capricious, self-destructive, perhaps a danger to others, and in general a useless burden to society.

⁸⁵ This does not mean there is not evidence and plausible argument to support some opinions, and little or no evidence and poor reasoning for others. It is just that - as we have pointed out - *by definition*, biological science *cannot* settle questions about functional mental disorder. These matters are only decided by ideological faith or discursive clarity. For if a real illness is discovered as the cause of a mental disorder, that immediately makes it a question of neurology, i.e., no longer a question of mental health but of organic health.

As we already mentioned, proposals for somatic or conversational interventions have competed since at least the time of Ancient Greece: whether to tamper with the body of the afflicted person (forcibly if needs be) or engage him in some kind of interaction or discussion. Generally, until the 19th century, the wisdom of the doctors was that both physical and mental health were governed by a 'balance of humours' within the body. For example, melancholy (depression) was said to be caused by an excess of black bile; conventional treatment was bleeding, purging or vomiting.⁸⁶

In Europe, systematic exclusion and confinement of the mad began in the 17th century when they came to be viewed not only as afflicted and deficient invalids but also as entirely surplus to urban social utility. This development was concomitant with the expansion of capitalist social relations, the beginnings of systematic science, and the rise of utilitarian Reason (which first of all served the interests of the emerging bourgeoisie).⁸⁷ By the end of the 18th century, every centre of European civilisation incarcerated the mad, most often willy-nilly with the indigent poor. Care was usually minimal and without theoretical pretensions. 'Pre-scientific' treatment for madness resorted fairly randomly to prayer, exorcism and various more or less violent devices of a supposedly medical or trickster-psychological nature. Or else the keepers of the mad simply employed unapologetic restraint, abuse and torture: an unknown but probably large number of madhouse inmates died of starvation, neglect or violence. In 1815 many inmates died in an English asylum fire which had been set by the owners in order to destroy evidence of their own corrupt and abusive practices. This event finally persuaded the powerful of the need for a parliamentary investigation of all the madhouses and asylums so as to prevent a repeat of such gross abuse, and also to find a response to madness more in accordance with the humanitarian and rationalist aspirations of the time.

Meanwhile, beginning in the latter part of the 18th century, a movement to medicalise the management of madness was already under way in parts of Britain, Europe and North America. Nurses and medical records were introduced, and inmates were referred to as 'patients', but this tendency was by no means universal. During the course of the 19th century the madhouses gradually came under state control and inspection, and at first any new institution was usually called an 'asylum' - to denote a place of refuge - and only later were the newest establishments more generally known as 'mental hospitals' - to signify places of medical treatment.⁸⁸

During the last two hundred years there were several more or less distinct phases in the principles governing the organised response to the chronic problem of individual irrationality. Despite their pretensions, and due to their haphazard methods and poor results, doctors of medicine were not well regarded until the last quarter of the 19th century; that is, until the introduction of bacteriology and germ theory, anaesthesia and antiseptic surgery, which at last provided the basis for trustworthy treatments. Until then, 'mad-doctors' or self-styled 'alienists' had been so unsuccessful and dubious - like most other types of physician - that they were widely regarded as charlatans.

We can discern perhaps four crucial moments in the establishment of specialist psychiatry as a reputable expertise and organisation. First, the rise of the Rationalist and philanthropic movements in European society between about 1760 and 1830; second, Antoine Baille's discovery of brain tissue deformations in one-third of his autopsies on the insane, as reported in 1832; third, by the end of the 19th century, the public's newly justified faith in medicine was coupled with a recognition that there

86 Our interest is particularly in psychiatry as it emerged as a branch of medicine in modern times. For accounts of the varieties of earlier ideas and treatments, see Alexander, FG & Selesnick, ST (1966) *The History of Psychiatric Thought and Treatment from Pre-Historic Times to the Present*. New York: Harper & Row; also Hill, D (1983) *The Politics of Schizophrenia: Psychiatric oppression in the United States*. London: University of America Press, 3-62. For an account of the period 1650-1850, and the political and economic motives and ideology involved in the emergence of psychiatry and in defining madness and its types, see Foucault, M (1965) *Madness and Civilisation: A history of insanity in the Age of Reason*. New York: Random House. For the establishment of psychiatry in Britain, see Jones, K (1955) *Lunacy, Law and Conscience, 1744-1845*. London: Routledge & Kegan Paul.

87 Within a century, the Romantics were arguing that Reason had become blind to anything which could not be quantified or did not turn a profit.

88 See Jones, K, op. cit. (n. 86), 55-56.

are complex but largely enigmatic mental processes, as first revealed by means of hypnosis; fourth, just before the Great War, the discoveries (in general medicine) of both cause and cure for syphilis, a degenerative disease that often resulted in general paralysis of the insane (GPI).

Regardless of the claims of a few ambitious doctors, the first significant movement towards the self-consciously rational or 'scientific' management of madness did not emerge out of general medicine but from a widespread increase in humanitarian sentiment. With respect to madness, this manifested as an attempt to answer the growing problem of what to do with the insane poor, and specifically as a response to revelations of many horrific abuses in the mainly private and only loosely governed madhouses. At the close of the 18th century, a new 'rational management' was announced in various locations, but most famously by Dr Pinel in Paris in 1793, and by the Quaker layman, Samuel Tuke, who established The Retreat at York, in 1796. The tenets of this movement were the liberation of the mad from restraint and arbitrary violence, and the control, care and cure of decently housed inmates by means of 'moral management'. This reform was a move away from brute containment towards protection and help - from madhouse to asylum - and it reflected the optimism of the rising class of capitalist owners and managers who substituted confident belief in control over their own lives for notions of fatalism or predestination which had prevailed hitherto.

The term 'moral' was meant in its widest psychological and social senses. 'Guests' at The Retreat were encouraged to learn to control their aberrant passions or emotions in order to rehabilitate themselves to normal social life. Pinel and Tuke made no secret of enforcing socially acceptable behaviour by what they considered a judicious use of the fear of punishment. However, this was distinguished from the actual use of force, which they viewed as an admission of the carer's failure with the inmate. By caring for him and rewarding his good behaviour, they wished rather to develop the inmate's sense of his own responsibilities. These pioneers were not at all interested in the processes of the inmate's mind but only in the conformity of his behaviour. Nor did they view madness as a medical condition. Contemporary physicians could only offer ineffectual medicinal remedies, and most often they favoured some kind of torture. In fact, they were so notoriously unsuccessful at curing madness that they were widely considered a dangerous nuisance, and except for treating inmates' physical illnesses they were usually prohibited from any institution run on 'moral' lines. 'Moral treatment' soon became the model adopted by every progressive asylum.⁸⁹ Just the same, it was not until 1839 that routine restraint was finally banned from all of the big English public institutions, and the padded cell kept only as a last resort.

By then the administrative class was used to the idea that punishing the mad was not only unjust but also counter-productive. The McNaughton Rules of 1843 gave legal recognition to the non-culpability of criminals regarded as insane. The basic system of Lunacy Law was completed during the same period. During the earlier part of the century, reforms and improvements had proceeded in a grudging, piecemeal and ad hoc manner, largely due to blocking by the powerful vested interest of doctors and other entrepreneurs who profited from the lucrative and corrupt private madhouse industry. By the Lunacy Act of 1845, however, it was established that the state would take a much more active part in encouraging provision, and all such institutions became subject to inspection and regulation, however desultory and deficient it may sometimes have appeared in its execution.⁹⁰

89 For a description of the regime at The Retreat, see Jones, K, op. cit. (n. 86), 45-55.

90 The main subsequent English legal reforms were: including a Justice of the Peace at committal proceedings in order to prevent abuses (1890); recognising and separating out provision for 'mental deficiency' (1913); introducing the categories of 'voluntary' and 'temporary' mental patients, along with moves to actively promote mental health (1930); trying 'to approximate the treatment of mental disorder as nearly as possible to the treatment of physical ailments' (when the National Health Service was set up, in 1946); and revoking the judicial oversight of Justices of the Peace and devolving all powers of committal to doctors (1959). While the 1983 Mental Health Act tried to close remaining loopholes in order to protect medical power, it also introduced the Mental Health Act Commission for investigating patients' complaints. The main effect of the Mental Health Act of 2007 was to delegate some medical roles to specially trained nurses and officials in ancillary professions. For the changes up to and including 1946, see Jones, K, op. cit. (n. 86), 196-202.

By the middle of the 19th century, moral management had proved a remarkable success. At that time it seems that ‘...the majority of admissions were for excitement, violence, incoherence of speech or delusions, either alone or in combination, and the next most common type of disturbance was melancholia.’⁹¹ There was a high proportion of short-term stays, especially for the private madhouses (which mainly served those for whom someone would pay), and so far as can be told, about one-quarter of those put into the more progressive madhouses recovered before leaving, and another one-quarter partly recovered. Considering that madness was viewed as all but incurable during the 18th century, and that many of the incarcerated would have suffered from organic (brain) diseases such as dementia and what was later recognised as syphilitic general paralysis of the insane, a surprisingly high proportion of inmates under enlightened managements seemed to recover - some asylum managers claimed success rates of better than 50%.⁹²

Even so, public asylums only slowly replaced private madhouses; by mid-century the latter still held half of all inmates, and many were still run on the old idea of restraint and punishment. And by then the numbers of the insane poor had begun to increase rapidly. This was a result of accelerating urbanisation and industrialisation, unchecked capitalist exploitation, and periodic economic crises - each exacerbating widespread chronic and unrelieved poverty and distress. In response, there was an increase in the size of the asylums or mental hospitals, and in the density of their populations. Facilities soon expanded far beyond the proportions in which close personal contacts between carers and inmates were any longer possible, and they began to ‘silt up’ with the chronically incurable. Under this pressure, the intimate and relatively benign system of moral management tended to disintegrate. During the last quarter of the 19th century it was steadily replaced by a bureaucratic-industrial form of patient assortment and control which lacked the resources for more than prison-like containment and minimal care, and provided little by way of cure.

In the meantime, doctors had always dabbled inconsequentially with herbal and chemical remedies and physical techniques. With the 18th century enthusiasm for mechanically produced electricity, shock machines had even been devised - but not to any clear purpose except to inflict pain and frighten the patient. So as to promote medical treatment for the troubled mind, soul or spirit, in 1808 the German physician JC Reil came up with the word ‘psychiatry’ (*psyche* + *iatros*), although at that time there was no reputable specialist knowledge or practice. And then, in 1832, Antoine Baille’s autopsy research revealed that about one-third of the incarcerated mad had a disorder of the layers of tissue surrounding the brain - the meninges. This was due to a disease he called *dementia paralytica* (later identified as a form of tertiary syphilis). Baille’s spectacular findings were used to authorise the development of the medical discipline of psychiatry, and in the second phase of the ‘scientific’ management of the insane the pendulum of opinion swung away from the proto-social-psychological approach known as ‘moral management’. Physicians who specialised as psychiatrists now considered that they practised a kind of rigorous medical science, and the more zealous began to proclaim that every case of madness was caused by a real disease - as if this was an established fact and not simply a hypothesis. Some of the new industrially manufactured chemicals were tried out on the patients, a few with apparent success; by the end of the 19th century, potassium bromide was widely used as a sedative. Managers of the mental institutions hoped to save on spiralling costs by the discovery of better medical techniques or potions which would meliorate or even cure madness.

Towards the end of the 19th century, in response to the crisis of the ever-growing number of chronic inmates, these factors combined to make the medical perspective the most popular among the general body of tax-payers. Sedation seemed the best solution to the problem of containing the burgeoning population of the insane. As a consequence, by the beginning of the 20th century, elements of ‘moral management’ tended to persist only informally or as vestiges within a system consisting mainly of prison-like incarceration; chemical sedation by potassium or sodium bromide,

91 Parry-Jones, WL (1972) *The Trade in Lunacy: A study of private madhouses in England in the eighteenth and nineteenth centuries*. London: Routledge & Kegan Paul, 286.

92 E.g., Connolly, J (1856) *The Treatment for the Insane without Mechanical Restraints*. London: Smith, Eider.

chloral hydrate or barbiturates was standard until the development of the new drugs in the 1950s.⁹³ There was still no cure for madness and it was only possible to suppress symptoms by drastically enervating the patient. Moreover, it became clear that the available drugs were quite dangerous - either toxic or addictive. The developing psychiatric discipline also lacked a coherent theory, but it was generally assumed that any mental disorder 'must have' an organic cause which affects the brain, and that scientific research would discover both causes and cures.

Parallel with these developments, awareness of mesmerism or hypnotism was widespread by the middle of the 19th century, and this began to feed into notions of madness and therapy. Like 'google' in the 21st century, Franz Mesmer's demonstration of what he called 'animal magnetism' was famous enough for his name to enter the language as a verb: 'to mesmerise'. When the effect was first shown, in 1784, 'animal magnetism' was so sensational as to be investigated by command of the king of France. Mesmer could certainly produce an unusual psychological and behavioural effect, but his theoretical ideas were vague and for many years there was debate as to whether or not 'animal magnetism' existed as a physical force, or whether Mesmer was a fraud. Serious interest was still directed towards the phenomenon in the early years of the 19th century, but more as a play of normal physiology and psychology rather than an invisible physical force flowing between the mesmerist and his subject. It is generally recognised that the Scottish surgeon James Braid gave mesmerism its scientific credibility. Known as 'the father of modern hypnotism', he was the first to use the term 'hypnosis'; this derived from *neuro-hypnotism*, 'nervous sleep', i.e., 'sleep of the nerves'. In 1841 Braid began to lecture on his pioneering work with hypnosis and hypnotherapy, but his work was far more influential in Europe than among English-speakers. While he viewed hypnotism as a conscious process of focussing attention on a dominant idea (or 'suggestion'), by the 1880s his ideas had been taken up by Janet and Freud who regarded the value of the hypnotic state as permitting access to what they called 'the unconscious'. In this manner, the idea emerged of the existence of complex but normally hidden psychopathological processes which might perhaps be discerned and remedied by professionals with the right scientific training, that is, by psychiatrists trained in both physiology and psychology.

Following Baille, however, in what proved a vain attempt to discover other types of brain lesion to correlate with other sorts of mental abnormality, almost all the psychiatric research of this period was vested in a massive effort of post-mortem brain pathology. This happened to correspond with the rise of the pseudo-science, Eugenics. This popular Darwinist ideology insisted that psychiatry should play a leading role in scientific and technical resistance to the problem of 'the deterioration of the race', which terrible development was supposed to be caused by the frightening fertility of the indigenous working class and by tainting contacts with 'inferior races'. For decades, both sterilisation of 'mentally sub-normal' patients and indefinite psychiatric incarceration of many women for 'moral turpitude' (for being unmarried mothers) were routine in most 'advanced' countries. This tendency only finally played out with the revelation of the wholesale extermination of at least one-quarter of a million psychiatric patients by their doctors, under the Nazi regime.⁹⁴

93 Boyle, M (1990) *Schizophrenia: A scientific delusion?* Abingdon: Routledge, Ch 2: Events leading to the introduction of 'Schizophrenia'. This book includes a summary of the development of psychiatry between 1800 and 1920.

94 Between 1920 and 1940 at least 15,000 psychiatric patients were sterilised in the state of California alone. An unrecorded number were sterilised in Britain. Under Nazism, in which the pseudo-scientific ideology of eugenics continued to buttress social power, fanatic psychiatrists sterilized an unknown number of patients; eugenics was carried to its logical conclusion during the war years - and not by orders from Hitler - when the psychiatrists took it on themselves to do their patriotic duty by systematically exterminating at least 250,000 of their German and Austrian patients. None of the doctors involved were later prosecuted and most of them continued to practice psychiatry, some in the USA. This murderous employment of psychiatric power was rationalised as 'scientific' and 'medical'. See Hill, D, op. cit. (n. 86), 8-15, who quotes from Wertham, F (1966) *A Sign For Cain: An exploration of human violence*. New York: Macmillan. Also see Breggin, P (1987) *The psychiatric holocaust. Asylum 2 2 2-6*. Breggin points out that until 1940 spokesmen for the psychiatric profession all over the world applauded the magnificent eugenic efforts of their German colleagues.

After the period dominated by the idea of moral management, and then the routine employment of ad hoc chemical sedation, the third phase in the development of ‘scientific’ psychiatry ran from about the beginning of the 20th century until mid-century. This phase was ushered in by two defining events, one in the field of biomedicine and the other in the politics and ideology of the profession.

Significant advances were made in biomedicine in the early years of the 20th century, and this profoundly affected psychiatric theory and practice. In 1905 the urge to medicalise the response to every form of emotional and mental distress was suddenly invigorated by the identification of the cause of syphilis, and hence of general paralysis of the insane: the spirochetal bacteria, *Treponema pallidum*. This was followed in 1909 by the tremendous discovery of a cure for that disease, the first ‘magic bullet’ of bio-medicine: a compound of arsenic (Arsphenamine or Neo-salvarsan 914). Salvarsan was toxic and difficult to administer; it required a long course of treatment, and only one-quarter of the patients ever received the full complement of injections. All the same, the discovery of this organic cause, and then a cure, was heralded as the dawning of the modern age of psychiatric medicine. Indeed, the great numbers of patients suffering from GPI at last began to diminish. Later, penicillin rapidly more or less eradicated syphilis as a significant disease.⁹⁵ This hastened the decline of GPI and hence the number of chronic and deteriorating psychiatric patients. Within a generation, the total psychiatric population reduced by about 25%.

At last it appeared that psychiatry was certainly a medical science: research had disclosed both cause and cure for a whole category of madness. Within the profession, *psychological* theory and research was now largely regarded as unscientific conjecture. This was unfortunate since the discovery of the cause of syphilis (and hence of *dementia paralytica*), and then a cure, directed nearly all subsequent psychiatric research into what turned out to be a fruitless pursuit of organic causes for other mental disorders, or for another chemical ‘magic bullet’. Emil Kraepelin, the great psychiatric authority of the early 20th century, was profoundly affected by the medical success with GPI. He had already described ‘a disease’ which he called *dementia praecox* (‘precocious madness’, soon renamed ‘schizophrenia’), but until laboratory tests for syphilis were developed it was impossible to distinguish *dementia praecox* from GPI because the two types of psychoses produced similar patterns of speech and behaviour.

Even before the success with syphilitic GPI, a powerful faction within the psychiatric profession had been busy trying to convince everyone that the discipline does not operate on the terrain of morality or psychology but is exclusively medical, technical, scientific. In the decade or so before the First World War there was a debate within the profession which resulted in triumph for the faction which, despite the absence of any evidence except with respect to GPI, asserted that every mental disorder *must be* caused by a disease. This victory was clinched by the arbiters of psychiatric knowledge simply mandating that, although its organic cause was yet to be discovered, *dementia praecox* (soon to be generally known as ‘schizophrenia’) is an illness. We should emphasise that this was only a *belief* which, in the optimistic and emotional heat of the moment, the profession refused to leave open to question: it is not a fact discovered by medical science at the time - or since. Once this belief was ratified by the psychiatric profession’s leading lights as an indisputable truth, however, it was presumed that every other kind of functional mental disorder also ‘must have’ an organic cause and ‘must’ require some kind of medical remedy. The unsubstantiated belief that ‘there is an organic basis to schizophrenia’ has served as the lynchpin to psychiatry’s medical dogma for the last century.⁹⁶

95 Protozoologist F Schaudinn and syphilologist E Hoffman discovered the organism *Spirochaeta pallida*; immunologist P Ehrlich discovered the chemical cure. Alexander Fleming discovered the anti-bacteriological properties of the mould *penicillium notatum* in 1928, but salvarsan remained the treatment of choice until 1943. In that year, H Flourey and E Chain purified and developed penicillin for clinical use as ‘a wonder drug’, and it was immediately used for syphilis. See Bynum, WF (1993) *The Companion Encyclopedia of the History of Medicine*. Abingdon: Routledge, Vol 2, 572-573.

96 This unscientific decision, based on a wish and made a point of faith by the victory of a political interest, is explored in Chapter 14, below, in the section: The invention of the mythological disease of schizophrenia. The

As well as providing a convincing rationale for the construction of a 'medical' ideology for the psychiatric profession, the marvellous discoveries of the cause of syphilis and its cure encouraged doctors to experiment on patients with newer drugs, and to develop physical and surgical procedures such as insulin coma, lobotomy and electroshock. The latter were crude assaults on the organism which nevertheless had the appearance of kinds of scientific medicine. Yet this phase was only an elaboration of the previous regime, in which a few simple drugs had been discovered by trial-and-error. Apart from the success with GPI - which in reality was a success for general medicine - when psychiatric medicine did seem to work it could only claim to manage the undesirable symptoms of mental disorder by debilitating the whole organism.

This did not prevent the medicalisation of the management of mental disorder proceeding apace under the impetus of the medical success with GPI and the professional subterfuge concerning the scientific status of 'a disease' which the psychiatrists called 'schizophrenia'. Yet it was still a matter of two steps forward and one step back. The eugenic 'tainted gene' theory of mental illness fell somewhat into disrepute during The Great War when it became clear that, in spite of supposedly coming from superior genetic stock, British officers were more prone than their men to psychological breakdown from shell-shock. This discovery accorded with the novel ideas of Sigmund Freud, who proposed that mental disorder is a response to psychic trauma. It was pointed out that officers also suffered proportionately greater physical casualties than the men; this was because they led the way towards the enemy's guns; and this implied that, other things being equal, their greater stress would cause them to suffer a higher rate of psychological casualty. Although he wrote mainly about the neuroses and not about psychosis, Freud maintained that functional mental disorder is not caused by organic dysfunction but is the product of pathological subliminal processes - that psychopathology is a response to unacknowledged, forgotten or 'repressed' emotional trauma. Recognising the doubtful scientific status of the so-called medical model, some psychiatrists became enthusiastic Freudians.

And so the inter-war years saw some attempts to incorporate the psychodynamic perspective into psychiatry, especially in the USA. In general though, it began to be established - as going almost without saying - that the neurotic patient (who seems amenable to reason) might benefit from a psychological therapy, but the psychotic patient (who is resistant to reasoning) requires chemical or physical treatment. Consequently, by the middle of the 20th century, psychiatry celebrated its 'eclecticism' - despite social and psychological ideas and practices always playing second fiddle to the bio-determinist ideology and medical treatments. Still, as part of the Freudian legacy, there were in the 1950s a few psychiatrists who disagreed with the general intention to suppress patients' symptoms by means of drugs, prefrontal brain lobotomy or shock treatment. Instead, some of them proposed psychological healing within small 'therapeutic communities' of patients and carer-therapists.⁹⁷ This idea clearly harked back to 'moral management'. In the context of the optimism of the post-war social democracy, though, rather than simply segregate, contain and overtly control or try to influence the patients, therapeutic community intended to listen to them, include them in activities, policy-making and their own psychotherapeutic recovery, and encourage them to help each other with their problems.

There was, then, a certain minority interest in psychodynamic ideas, although most psychiatrists remained convinced that their responsibilities lay first of all in suppressing the symptoms of any mental disorder. Doctors only specialise in psychiatry after extensive medical training, and most of them waited on the discovery of the next medical 'magic bullet'. In the early 1950s this wish seemed to have been answered when new brands of more effective and apparently safer tranquillisers appeared on the market. By the end of the decade new 'mood-lifting' anti-depressants were also introduced, so that both ends of the symptom spectrum were covered. Thereafter, the drug companies set about researching and producing new varieties of supposedly improved chemical concoctions with which doctors were always happy to experiment: ordinary mental health patients were the main

bad science and lack of evidence for the idea that schizophrenia has an organic cause is discussed in detail below, in Chapter 12 and its Appendix.

97 See Main, T (1946). The hospital as a therapeutic institution. *Bulletin of the Menninger Clinic* 10 66-70.

guinea-pigs. By this time it was generally agreed that 'hard science' and medicine was the appropriate response to every kind of serious psychological malaise. And whereas in 1890 it had seemed necessary to introduce judicial process in civil law so as to protect the vulnerable from being preyed upon by over-enthusiastic psychiatrists and the corrupt and unscrupulous, the apparent success of the new drugs created such an atmosphere of credulous optimism that the 1959 Mental Health Act removed judicial restraint on medical power: responsibility for commitment and treatment was devolved entirely to the psychiatrists.

During the 1950s, meanwhile, along with the introduction of the new psychiatric 'wonder drugs', Kraepelin's hopes for a scientifically rigorous system of diagnostic categories resurfaced with a vengeance. Since what determines the system of psychiatric diagnoses is certainly not the discovery of any actual diseases - there are no mental illnesses - the main influence on the runaway increase in diagnostic categories was (and remains) the symbiotic relationship between the doctors and the drug companies: i.e., each willingly assists or provides for the other. No professional is likely to pass up an opportunity to buttress his own power, influence and income, and doctors are no exception. The pharmaceutical giants recognise this and are adept at lobbying (i.e., bribing) psychiatrists to get them to endorse the existence of as many discrete mental illnesses as possible, so that they may then devise or 'discover' an ever-expanding number of specific remedies. The globally influential *Diagnostic and Statistical Manual of Mental Disorders* is published in the USA, where there is also the pressure of insurance accountancy which demands strict diagnoses and use of the immediately cheapest option (i.e., *not* counselling or psychotherapy); like the insurance companies, governments also favour medication because in the short-term it appears cost-effective.

The phase of competing models of malaise and therapy - or what the textbooks proudly announce as a pragmatic 'eclecticism' - finally played itself out during the 1960s and 1970s as a bitter conflict between those for and those against 'biological' psychiatry. The established view insisted that remedy consists in the medical suppression of the symptoms of the mental illness; against this stood critics who argued that the only way to supersede heartless social control and bring about a genuine and lasting cure is to permit the individual to express himself, and to interpret the symptoms of his psychological malaise. In the meantime, except for a 'hard-core' with apparently chronic conditions, and those suffering from organic diseases, most patients spent much less time in mental hospitals. This was due to an almost automatic use of the new drugs, which seemed like a cheap and cheerful way to cut costs and empty the big old institutions. In the face of the apparently great success of the new medications, those who proposed labour-intensive psychotherapy and therapeutic community found themselves with their backs against the wall. As a result, their ideas about empathy, democracy and psychological therapy escalated into the revolutionary demand of 'anti-psychiatry': this would overthrow the entire callous, over-controlling and medically-obsessed psychiatric status quo.

Even before 1960, though, evidence was beginning to emerge to support the arguments of anti-psychiatry. For too long the psychiatric profession refused to recognise the steadily accumulating research evidence, but a growing number of patients displayed painful, disfiguring and disabling signs of the physically harmful effects of long-term consumption of the new psychiatric 'wonder drugs'. Anti-psychiatry objected to the frighteningly totalitarian use by doctors of every option to administer legally to their patients, in the name of therapy and 'for their own good', whatever violent treatments or harmful drugging they wished, often against patients' wishes and disregarding their reports of the grievous ill-effects, and by taking advantage of their ignorance and vulnerability. Opponents of psychiatry viewed its standard techniques and routines as little more than an outrageous imposition on the vulnerable, on those already damaged emotionally and psychologically by unacknowledged oppressions; they viewed conventional psychiatrists as either stupid or cynical and dishonest schemers who, on behalf of the conformist forces of the family and the state, were ready to cause their patients physiological and psychological harm by employing a punitive kind of medical social control.

A significant element within the wider cultural revolution of the time, anti-psychiatry had some influence on a particular generation. Along with the general social ferment of the 1960s and 1970s, however, due both to a failure of sufficient commitment, theory and nerve, and the opposition of an

entrenched and overwhelming 'silent majority', the movement largely succumbed to the better organised forces of reaction. Nonetheless, anti-psychiatry made telling criticisms of the unfounded assumptions behind the notion of mental illness, of indiscriminate medication and shock treatment, and of the generally totalitarian nature of psychiatry, which seemed especially obvious on the locked wards of the big old hospitals. This found a response in widespread attempts to develop 'community-centred' psychiatric services, such as day centres, group homes, sheltered workshops and self-help groups.

By this time, a key factor in the conflict over appropriate forms of care and treatment was the steady rise in labour costs: in real terms they doubled between 1950 and 1970, and they continued to rise thereafter. This gave decisive ammunition to the proponents of 'the medical model', who proclaimed the undoubted efficacy and economies of drugging. By the end of the 1970s, though, the Nursing Process had been introduced from the USA, and to an extent this mitigated the urge to deal with every psychiatric patient as if by chance he had developed a bizarre type of illness and only required medical treatment. At the time, the Nursing Process seemed a fairly radical advance in both theory and practice: nurses were no longer simply to be the unreflective and unquestioning 'handmaidens' to all-knowing and all-powerful doctors. While insisting that nurses can be relied on to perform certain executive and managerial functions, the Nursing Process also recognised that ill health - including mental ill health - can result from the vicissitudes of a life. As well as their traditional duties, nurses should therefore collect data and diagnose the problem of the patient and his social situation, plan how to manage his affairs, implement the plan, and evaluate the results. This has to involve interviewing the patient and making a physical examination; nursing staff would need diagnostic data, a health history and a family history; and with that more comprehensive knowledge in place, they should continuously observe the patient and report on his state of mind and behaviour.⁹⁸

In this context, the policy of Care in the Community, introduced in the 1980s, was to an extent a residue of the notion that each psychiatric patient is a unique and sensitive human being who should not simply be locked away and medicated into submission. Rationalised in terms of reducing costs, but also by the social-psychological and sociological critiques of the so-called medical model and the old asylum system, the process of closing down and selling off the big old mental institutions proceeded apace, with the health authorities cashing in by divesting prime edge-of-town properties to private developers. As a result, the universal drugging of large numbers of patients gathered together in big old mental hospitals set amongst restful gardens, parks or countryside is now largely replaced by the universal drugging of patients living in their own homes in towns or cities, alone or in small groups. Chronic or acute patients are now concentrated in private care-homes and hostels, or in wards on crowded urban sites, purpose-built to seem like part of a general hospital.⁹⁹

Various policy initiatives during the last quarter-century are a further endorsement of the democratic and humane ideas of anti-psychiatry. These include: involving the patient in decisions about his care plan; devolving many decisions to psychiatric teams which include nurses, psychologists and other ancillary workers as well as doctors, or particular decisions to nurses and psychologists trained for those special responsibilities; improving liaison between mental health teams and social services; and registering histories of neglect or abuse during childhood.¹⁰⁰

This brings us to the present. The main problem remains: whatever changes are made to policy, they are implemented by officials who take for granted the medical model of mental illness. In spite

98 Schmieding, N J (1993) *Ida Jean Orlando: A Nursing Process theory*. Newbury Park: Sage Publications. Psychiatric assessment was soon regularised by interview-observation protocols, e.g., Krawiecka, M, Goldberg, D & Vaughan, M (1977) A standardised psychiatric assessment scale for chronic psychiatric patients. *Acta Psychiatrica Scandinavica* 55 299-308; also see footnote 9 to Chapter 11, below.

99 The implementation and consequences of 'Care in the Community' are discussed in Chapters 9 to 11, below.

100 Of course, the need to devolve decision-making was driven by a shortage of psychiatrists, and there were obvious financial savings with most of these policies. We discuss these recent developments in greater detail in Chapters 25 to 28 (Volume 2).

of the accumulating evidence of their ineffectiveness as compared to other therapies or responses, and of the widespread harm they cause, and despite lip-service to psychological forms of therapy by those officials who like to be considered open-minded or liberal, the treatment of choice remains mainly ‘medical’ - usually drugs, but also electroshock.

However, there is by now little doubt that the psychiatrists and the pharmaceutical companies are the main beneficiaries of the medical model of mental illness. The drug companies always hope to tailor a particular drug for each diagnostic category; curiously, they always manage to do so. The drug houses have wielded such influence within psychiatry, at least since the 1980s, that it has become clear that for each particular drug they now like to tailor a diagnostic category: they already have the chemical concoction, and they wish to bring it to market by having a mental illness invented, to which it may be applied as a remedy.¹⁰¹

During the last sixty years, mental health has grown into a major industry managed by a salary- and status-conscious profession (the psychiatrists) and supplied by a huge and extraordinarily profitable drugs industry. Or perhaps we should say: psychiatry serves the drugs industry. After all, it is clear that the drugs industry, doctors, university research departments and many lobbyists and politicians share an interest in persuading everyone that there are indeed many discrete mental illnesses, and specific chemical treatments for each.¹⁰² These alleged diseases are codified in *The Diagnostic and Statistical Manual of Mental Disorders (DSM)*.¹⁰³ (generally recognised as ‘the world bible of psychiatry’) and *The International Statistical Classification of Diseases and Related Health Problems*,¹⁰⁴ and taken for granted in drugs lists such as *the British National Formulary*.¹⁰⁵

Today, these self-serving professional and commercial interests seem to have achieved an unassailable political and ideological victory for ‘biological’ psychiatry as against psychosocial, interpretative or narrative perspectives. Undeterred by the absence of evidence, many doctors appear to believe that psychoactive drugs and electroshock can often cure functional mental disorders. These days, however, the official line tends to be the more subtle suggestion that medical techniques may not necessarily cure a person’s mental disorder but they do usually relieve symptoms and thereby ‘manage the illness’. In Chapters 6 to 8, below, we shall see that there is insufficient evidence to support either proposition. What is certain, however, is that the standard psychiatric treatments often cause various kinds of organic harm, drug dependency and particularly noxious and often irreversible deteriorations of the nervous system.

To summarise: In the 18th and 19th centuries (at least until about 1860), management of the mad was mainly provided by ‘the trade in lunacy’ - a cottage industry offering no more than low cost incarceration for troublesome individuals said to have lost their reason. This was gradually replaced

101 As reported by an insider to the American Psychiatric Association’s *Diagnostic and Statistical Manual (DSM)* committees. See Caplan, PJ (1995) *They Say You’re Crazy: How the world’s most powerful psychiatrists decide who’s normal*. Boston: Addison Wesley (in its entirety, but specifically 76-77). Details are provided in the text to footnote 23 in Chapter 5, below.

102 The drugs companies have always bribed doctors to use their proprietary medications rather than other brands (or no medication). And by 2001 one-third of the UK’s MPs were declaring payments from a pharmaceutical company. See Hubbard, B (2002) *Secrets of the Drugs Industry*. London: WDDTY Publications 51. Some MPs recently expressed alarm at the great influence exerted by lobbyists on parliamentary committees, particularly those of the arms, drinks and pharmaceutical industries. See MPs paid thousands of pounds from lobby groups (2013) *The Telegraph* 2 June.

103 The generally recognised benchmark for doctors and mental health professionals is *The Diagnostic and Statistical Manual of Mental Disorders: DSM-III* (1980) New York: The American Psychiatric Association. Subsequent editions have not radically altered the classification system; they have only expanded it, often by increasing the number of sub-types for each specified disorder. The latest edition is *The Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (2013) New York: The American Psychiatric Association.

104 *International Statistical Classification of Diseases and Related Health Problems: ICD-10* (1994) Geneva: World Health Organization. The much delayed *ICD-11* is due out in 2018.

105 *British National Formulary (BNF)* London: BMJ Group & Pharmaceutical Press. *The BNF* is published and updated every six months for The British Medical Association. Its biggest single section cites drugs which act on the central nervous system. See, for example, *BNF 72* (Sept 2016).

by the establishment of asylums which in the first half of the 19th century were increasingly run on the more humane and optimistic lines of 'moral management'. Then, with the establishment of the new discipline of psychiatry and ever-growing numbers of the insane poor, moral management was succeeded by a phase in which inmates were held, largely under chemical sedation, in bigger, barrack-like asylums and mental hospitals. For a while, around the mid-years of the 20th century, with the rapid reduction in the number of patients suffering from GPI and less general distress due to better welfare provision by the state, and even before the introduction of the modern psychiatric drugs, the numbers held in the mental hospitals declined.

Even so, the number of mental health patients has grown every year since the 1950s. In England, mental health prescriptions increased by an average of 6.8% a year between 1998 and 2010, and they constitute an ever larger proportion of all prescription drug costs; in 2010, for England alone, the total cost of medications dispensed for mental health problems (anti-depressants, anti-psychotics, anxiolytics, hypnotics and mood stabilisers) reached £8.8 billion. This inexorable rise in mental health drug prescriptions matches the global trend. Although not fully investigated, potential causes for these regular increases (for all but anxiolytics and hypnotics) include the greater reach of the mental health services and longer-term treatment per individual.¹⁰⁶ Today, when new kinds of 'mental illnesses' are regularly 'discovered', when every year there are more mental health patients, when 'care in the community' is celebrated for its enlightenment and humanity, and when lately the number of in-patients has also once more been on the rise, huge profits and a variety of professional careers are to be made by processing those incapacitated by their confusion and distress at some or other site within a veritable medical-bureaucratic-industrial complex of the mental health services and the pharmaceuticals companies.¹⁰⁷

The pernicious influence of this hand-in-glove medical-industrial complex may be illustrated by the implementation of the Quality and Outcomes Framework (QOF), a policy launched under New Labour in 2004. In response to lobbying by doctors' associations and the drug companies, this scheme rewards GPs for their 'performance' in meeting targets, and it was supposed to improve the nation's health, reduce hospital admissions and health inequalities between the rich and the poor, and 'save 30,000 lives'; rewarding 'performance' would also supplement GPs' pay, thereby encouraging badly needed recruitment. However, doctors could now hardly help but view every patient as a likely source of extra income. In practice, it encourages GPs to discern illnesses - including mental illnesses such as anxiety and depression - other than those intentionally brought to them by their patients; that is, to test, diagnose and prescribe for any abnormality they might perceive, many of which might not be serious or might be remedied simply enough by life-style changes (diet, exercise, association, etc.). QOF immediately boosted GPs earnings, some by up to 50%, but it never delivered on its promises. In the fourteen years since its inception there is no evidence that any lives have been saved and no improvement in the nation's health; few patients are aware of the performance targets, and the doctor-patient relationship is compromised by this covert cash nexus; consequently the prescription of most major types of drugs has accelerated since 2004, millions of patients have been over-prescribed drugs, and an unknown number have suffered iatrogenic illnesses from unnecessary medication. The scheme has so far cost about £2 billion a year (£25-30bn since 2004) - half in direct payments to GPs and half to the drugs companies for the extra tests and medications.¹⁰⁸

The psycho-pharmaceutical branch of this medical-industrial complex consolidated during the last half of the 20th century as an apparently unassailable symbiotic system based in a devious and unpublicised pact between the psychiatric profession and the drugs companies. The psychiatrists are

106 *Fundamental Facts*, op. cit. (n. 21), 88.

107 Dr Peter Breggin described this institutional complex. See Breggin, PR (1991) *Toxic Psychiatry: Why therapy, empathy and love must replace the drugs, electroshock and biochemical theories of 'the new psychiatry'*. New York: St Martin's Press, Ch 15: Psychiatry and the psycho-pharmaceutical complex.

108 Quality and Outcomes Framework (2018) NHS digital; Le Fanu, J (2018) Are pills killing us? *Daily Mail* 12 May, 16-18, adapted from Le Fanu, J (2018) *Too Many Pills: How too much medicine is endangering our health, and what we can do about it*. Boston: Little, Brown.

aided and abetted by other mental health professionals and workers, and by general medical practitioners; private care-providers and most patient-support organisations concur; the drugs companies pour money into advertising and public relations while surreptitiously perverting their own research whenever it suits them; and elected politicians are paid to look out for the drugs houses' legislative and regulatory interests and promote their 'biological' mental health propaganda - which is invariably endorsed by the state as unquestionably The Scientific Truth.

In the heyday of the private madhouses - during the century or so until about 1850 - it was natural to speak of 'the trade in lunacy' since that is exactly what it was: whether conditions of incarceration and treatments were humane or brutal, it was a trade carried out for profit, and the client was generally a paying member of the inmate's family or a justice of the peace. In the modern era of liberal democracy and state provision, the profit motive is lost from view and we speak of 'mental health' and 'the psychiatric services' - as if the patients make up a clientele who are much obliged and able to take or leave the attentions of the officials. This is misleading. While a mental health patient may choose to disregard his doctor's advice, once the psychiatric services become involved the person's right to choose is severely restricted, if not annulled. In reality, a psychiatric patient is rarely a client: others decide 'what is best' for him and he has little or no choice. Moreover, this process proceeds not according to anything that a patient might wish for or require in order to help resolve his emotional, mental, social or material problems, but *primarily* according to apparent public costs and apparent benefits to the social peace. In this book we will see that mental health and psychiatric provision is not so much a service aimed at helping very distressed and disturbed individuals as *an industry* which first of all serves other interests: various state agencies, doctors and the drugs companies, and perhaps members of the individual's family and community.

That Mental Health is best characterised as an industry organised to process emotional and mental dysfunction, rather than a service tailored to the true needs of the very distressed, is indicated not only by the great number of employees and the profits to be made but by the way in which vested interests have co-opted the whole enterprise to serve their own ideological and material ends. For, as we shall see (particularly in Chapters 4 to 8, and 12), there is simply no evidence that medical officials are particularly able to remedy mental illness - or even much help those suffering from emotional and mental or psychological distress. On the other hand there is much evidence of the harm regularly caused by psychiatric medicine. And all the while we see the vested interests of the drugs houses, the medical profession and the mental health and psychiatric workers organised in professional associations and trade unions. As long as the public is persuaded that there is such a thing as mental illness - rather than particularly intractable problems of living which mainly require an intelligent and humane non-medical response - this creates and sustains an ever-increasing need for psycho-pharmaceutical products and the whole existing mental health apparatus.

Towards the end of the 19th century, the sheer numbers of the insane swamped the system of 'moral management'. Ever since then, psychiatry has generally tried to devise methods whereby the patient is returned to a normally functioning life by suppressing the symptoms of his mental disorder and re-adjusting him to the social order - that is, by suppressing the person rather than supporting and encouraging him to comprehend the causes of his crisis, and thereby helping to liberate him from his emotional distress and mental turmoil. 'Moral treatment' seems to have been an anomaly in the history of the management of mental disorder. For even if it intends to provide a degree of care and welfare assistance, and however laudable the intentions of any individual official, psychiatry is impelled by law to view the patient primarily as a danger or social nuisance, and by medical and atavistic instinct to work on his brain or general metabolism so as to subjugate and silence him. In the following chapters we argue that while psychiatry and the mental health services are advertised as nothing other than the most beneficial medical assistance, they are first of all forms of control - political and ideological organs constituting what Thomas Szasz calls 'the therapeutic state'.¹⁰⁹

109 See Szasz, T (1984), op. cit. (n. 18).

Chapter 2: THE EXPERIENCE OF MENTAL DISORDER

The sleep of reason produces monsters.

Francisco Goya¹

What is it like to be afflicted by a serious mental disorder? The following personal reports are harrowing accounts of agonised feelings, states of mind and behaviour variously diagnosed as personality disorder (self-harm), depression (including depression resulting in suicide), bi-polar disorder (formerly known as manic-depression) and schizophrenia.

In Volume 2 (Chapters 18 and 19) the narratives from this chapter serve as case studies which are reprised, commented on and rendered intelligible by means of a non-medical, psychodynamic perspective.

Patients' accounts

In this chapter we try to give a sense of the sorts of problems that psychiatric officials are called on to manage and remedy. The standard textbooks and manuals provide dry lists of the symptoms associated with each diagnosis, but there are few accounts of what it is actually like to have to live with a serious mental disorder - and it seems to us that this is the kind of information that is essential for effective care and therapy.

Throughout the mental health services, care and treatment is provided in accordance with the precepts of psychiatry's so-called medical model. Officials are not required to take any great interest in what a patient has to say about his or her condition. After all, physical medicine is only minimally served by asking a heart patient how he² feels, takes even less interest in the details of his personal, social and imaginative life, and - unless he happens to be a fellow specialist - has no interest at all in any opinions he might have about what exactly is wrong and the best technical response. Besides, someone only becomes a psychiatric patient because he appears particularly irrational. It therefore seems reasonable that anything he might suggest about the nature of his problem, or its remedy - or almost anything else, for that matter - may be disregarded. There is an immediate and normal reflex to count anything a psychiatric patient may say that is not on the officials' agenda as simply irrelevant; if it is controversial, it is most likely to be heard as not only irrelevant but also nonsense, no more than another symptom of the mental illness.

However, we disagree with the psychiatric medical model. In this Volume we will see that the conventional ideas about incapacitating emotional distress and mental turmoil are not only shockingly unsympathetic but also unfounded, and that the standard official response is superficial, untheorised, unevidenced and hopelessly inadequate. By contrast, we hold that whatever a mental health patient has to say about his feelings and experiences is *the major resource* that needs to be tapped so as to understand how it is that he arrived at the impasse of his mental disorder. For without

1 This observation was to have headed Goya's series of prints depicting fantastic and terrifying images. Begun in 1792, they later appeared as *Los Caprichos* (caprices, fancies).

2 When we make general comments it would be clumsy on every occasion to write 'he or she', 'him or her' and 'his or her', but the language forces a choice of gender. The reader should not take offence if, during the course of an argument about principles, theories or systematic practices, the generalised psychiatrist is denoted 'he' (which is anyway most often the case) while the generalised patient may be denoted either 'he' or 'she'. In these circumstances, when we say 'he' we do not intend that female mental health patients are less significant than male; we are aware that in the UK the majority - at least 55% - are female, and that this is likely to reflect their greater overall oppression. We might refer to any of the actors in the mental health scene by the third person plural, as 'they'. But this makes 'them' sound distant and other from 'us' whereas, especially regarding the typical patient, we are convinced that 'There, but for the grace of God, go you or I'.

such an understanding it is impossible to identify and then address the individual's problems, and hopefully begin to solve them. It seems to us that, potentially, nobody could know more about the nature and cause of an incapacitating mental disorder than the person who lives it.

Here we offer just a few examples of the kinds of raw human material which psychiatry is required to mend or manage - but from the perspective of the patient. Unfortunately, of course, few who survive that kind of emotional and mental turmoil find it easy to describe or account for it in their later lucidity. Serious mental disorder manifests as a disastrous collapse of the more or less objective rationality of the person's normal adaptations to his daily life. The rush and flood of events, fears, misapprehensions, denial, drugging or other psychiatric attentions - all these might combine to remove the details of the crisis from clear memory or easy expression. Apart from that, the events are often too painful to be readily recovered for inspection or subjected to the logic of rational accounting. Were such crises easy for people to recall and reflect upon there would be less need for comprehensive social interventions and much less controversy about their nature. Still, some people who have lived through such experiences do manage to deliver vivid and informative accounts of what it is like.

Sooner or later, families, friends and members of the general public who witness these kinds of worrying behaviours are tempted to simply throw up their hands in despair, call it 'illness' and send for the doctor. Often the individual's ideas and behaviour are frightening, and most witnesses are unlikely to have much immediate interest in the precise form the disorder takes, or the possible triggers for it. Rather, everyone expects the doctor to reach into his bag for a drug to combat the deviant's troubling and perhaps dangerous behaviour. For his part, a psychiatrist's interest in the matter rarely extends far beyond what he feels he needs to know in order to assign the patient to a diagnostic category, so as to determine and as quickly as possible administer an appropriate medical treatment. It might not be surprising if the psychiatrist also strongly advised the subject to try to moderate his behaviour or even persuaded or forced him to submit to detention and treatment.

All the same, difficult as it may seem when events reach a crisis, there *is* often a possible strategy other than the purely medical. First of all, to take time to try to reassure and calm everyone around the individual by organising sympathetic and effective care; and then perhaps to more carefully observe and interrogate the deviant behaviour in terms of its possible *signification* as a response to traumatic experience. The second Volume argues for this perspective, and the material provided by the accounts in this chapter is used in Chapters 18 and 19 in order to illustrate the social-psychodynamic perspective.

In this chapter a few patients or former patients report their experiences. For reasons of space our choice was limited, but the following accounts are representative of the main kinds of mental disorder recognised by psychiatry. Psychosis is perhaps the most perplexing condition, while anxiety and depression are the most common. We do not give an example of the diagnosis of generalised anxiety since it only becomes critical if it develops into severe depression, mania, incapacitating hysteria or phobia, or another less common but equally troublesome kind of disorder. Disabling hysterias and phobias are now fairly rare; they are also extensively discussed in the psychoanalytic literature. Here we include examples of what psychiatry calls clinical depression, personality disorder, bi-polar mood disorder and schizophrenia, as well as depression leading to suicide.

When we reprise and comment on these accounts (in Chapters 18 and 19, Volume 2), it might be objected that they are so few as to provide no more than anecdotal evidence, far from sufficient to arrive at any general theoretical or therapeutic conclusions. Of course this is true, but there is now a substantial body of statistical evidence to support our wider argument, and we come to that in the second Volume (particularly in Chapter 23). Especially after we have examined and commented on them (in Volume 2), we hope the reader will see that the narratives in this chapter provide plausible support for our contention that the forms of mental disorder may be broadly typified (that is, 'diagnosed') for certain limited purposes of patient-management, but without investigating the unique contours of each individual's life it is impossible to arrive at a proper *understanding* of what impels him to manifest his *singular* disorder; and without such an understanding it is impossible to provide the person with significant and lasting assistance. We take a biographical approach precisely because

we do not believe that *any* instance of a functional mental disorder is ever explained as *only or essentially* a case of a type of disease: there is no material pathogen and it is not illness. A main intention of both Volumes of this book is to make this argument.

Readers must judge if the following accounts have the ring of truth and, when they are explored in detail later in the book, whether they really do illuminate the problems inherent to each specific case, as well as wider issues in mental health theory and practice. Once we have examined the notions and practices of conventional psychiatry throughout this Volume - and have demonstrated the woeful lack of evidence for their value - in Chapters 18 and 19 (Volume 2) we explore the possible *significations* and the *psychological meanings* of the following accounts.³ At the moment, however, in imitation of normal psychiatric practice, we leave open the question of what could possibly be the signification or meaning of these distressing experiences.

Depression

There are all manner of reasons for someone finding herself so depressed that she experiences agonising and continuous mental torment, feels generally awful, and yet is still just about able to function. The following piece, entitled 'Abused', is the account of an anonymous middle-aged woman. Reading as if she might be talking to her GP, it invites many more questions than it answers. If she had told her doctor the following he would almost certainly have listened to her - maybe for ten minutes or so - diagnosed depression, perhaps have made some sympathetic and encouraging noises, and then sent her away with a prescription for an anti-depressant drug.

People say they know how I feel, but they don't know what it's like to be all alone in this world of mine.

The darkness comes and goes. Someone tells me these are my kids, my family. But if they are, where are my feelings?

When darkness comes with pain and confusion, the feelings that get hold of me. I'm so frightened, I can't get hold of this life. It comes so bad no-one can help me.

All I know is people say 'You've got a family, get on with your life.'

I'm so frightened [when] I wake up. I'm not the person I was. There is no love, I don't know how to love. Who is this man I get into bed with? He is a stranger, I don't really know my husband.

I'm an old woman, things are changing, my body is not the same. I know that things about him have not changed. He's taken over my mind, my thoughts, he wants to know what they are. But he does not understand and grins as if it's all a big joke.

When depression comes then the darkness comes. I'm no good to anybody. Death comes easy, wanting to die, to stop the pain that's eating away inside. To ride through, but who's there to go through with the pain, feelings I can't control. There's no-one there but me. I had my dad, but now he's gone, he's at peace. How much longer can I go on?

I try to live hour by hour. People say I've got to think of the kids. I really try to, but all I do is cooking and cleaning. Someone tells me what to do and I do it.

It's just this body of mine, telling me things are changing. I think I'm going through the change. My head tells me it can't be true, I'm finished with life before I started. I'm so frightened my time is coming to an end. I've lost so many years.

X talks to me about Christmas. I can't look forward to it. I don't know where to start. So many things going on in my head, I just want to be left. How long have I got before darkness comes again? God only knows where's my life.

How can I love when I don't know how to love or be loved? Love is just a word. God help me, I'm frightened of the dark days to feel I can't go on, never felt so bad as wanting to die. Someone help me through those days.

³ All, that is, except the account of bi-polar depression. The author of that account makes it clear that she objects to any kind of interrogation of *the meaning* of her malaise. This is unfortunate, but it has no substantial effect on our general argument.

There are two tunnels. I feel I'm going crazy. Which one will I take? One leads to death, the other one, who knows? I'm lost in this world. I keep trying to hold on to it and something happens and I slip away from it again.

When will my feelings come back? When will my mind be my own?

There's someone here with me, but I turn around, he's gone. Sometimes there's two of me, I sometimes talk to the other me in my head. We both get angry, it calls me 'stupid bastard'. I can't do anything right. I say things in my head, hoping no-one's around when I get angry with myself. So people don't hear me talking to myself.

Men make me sick, they're no good, they just use me, they are bastards for what they've made me. I'm going crazy, I know I am. What's left, what hope? I don't know any more.⁴

Bi-polar disorder (manic-depression)

Nearly forty years ago it was decided that manic-depression should henceforth be known as 'bi-polar mood disorder'⁵ (but it is generally referred to as 'bi-polar disorder' or simply 'bi-polar'). Those suffering from this malaise display archetypal 'craziness' - not only frenzied, insomniac and irrational hyper-activity, to the extent of psychotic hallucination and delusion, but also the crash into deep depression.

The following passages are taken from Kay R Jamison's *An Unquiet Mind*.⁶ As an adolescent and young woman, and in the face of increasingly powerful disruptive moods of mania and depression, Kay Jamison continued to work hard to become a clinical psychologist. Then, just as she was appointed to her first post in a department of psychiatry, she found herself accelerated into an uncontrollable frenzy. Throughout her adult years she continued to experience the turmoil of alternating manias and depressions, and most of the time she was heavily medicated. Despite this, she managed to hold onto her job, and even progressed to become joint-head of a psychiatric facility. After many twists and turns in her life she ended up marrying the Chief of Neurosurgery at the American National Institute of Mental Health.

Jamison suffered years of overpowering, frightening and debilitating mental affliction. She was under psychiatric treatment for most of her adult life. And yet she always continued to live and work as a professional trying to alleviate the mental anguish of other people, and she ended up at the heart of the psychiatric establishment. In her autobiography she passionately endorses the prescription of lithium, which was a publicity coup for biological psychiatry. The title of her book recalls William Sargant's classic, *The Unquiet Mind*, which is an unapologetic celebration of the most 'hard-nosed', 'unsentimental', anti-psychotherapeutic kind of medical-model psychiatry.⁷

Jamison's twin roles - sufferer and psychiatric worker - make her account doubly interesting. This would not be the case were she not also a lively and honest writer who provides a wealth of fascinating biographical detail. She bravely recalls terrifying episodes most of us would rather forget, as well as the context of the life in which those events unfurled.

Her manias

...at least in their early and mild forms, were absolutely intoxicating states that gave rise to great personal pleasure, and incomparable flows of thought, and a ceaseless energy that allowed the translation of new ideas into...projects...⁸

At the age of fifteen, however, she began to feel 'totally adrift' and 'deeply unhappy', tearful and furious with her father for changing his job and moving the family far away from a secure home and environment. At the same time her parents' marriage hit the rocks. Her father became depressed, took

4 Anon (1991) *Abused. Asylum* 5 2 7.

5 See *DSM-III*, op. cit. (n. 103, Ch 1), 205-224.

6 Jamison, KR (1995) *An Unquiet Mind: A memoir of moods and madness*. London: Picador.

7 Sargant, W (1967) *The Unquiet Mind: The autobiography of a physician in psychological medicine*. Oxford: Heinemann.

8 Jamison, KR, op. cit. (n. 6), 6-7.

to the bottle and sometimes, having lost his previously sympathetic and playful character, raged at everyone around him. As for Jamison herself, two or three years later

...it became clear that my energies and enthusiasms could become exhausting to the people around me, and after long weeks of flying high and sleeping little, my thinking would take a downward turn toward the really dark and brooding side of life.

I was a senior in high school when I had my first attack of manic-depressive illness; once the siege began I lost my mind rather rapidly. At first everything seemed so easy. I raced about like a crazed weasel, bubbling with plans and enthusiasms, immersed in sports, and staying up all night, night after night, out with friends, reading everything that wasn't nailed down, filling manuscript books with poems and fragments of plays, and making expansive, completely unrealistic plans for my future. The world was filled with pleasure and promise; I felt...really great. I felt I could do anything, that no task was too difficult. My mind seemed clear, fabulously focused, and able to make intuitive mathematical leaps that had up to that point entirely eluded me. Indeed, they elude me still. At the time, however, not only did everything make perfect sense, but it all began to fit into a marvellous kind of cosmic relatedness. My sense of enchantment caused me to fizz over... I found myself buttonholing my friends to tell them how beautiful it all was...⁹

These friends told her to slow down, she was exhausting them.

I did, finally, slow down. In fact, I came to a grinding halt... [T]he bottom began to fall out of my life and mind. My thinking, far from being clearer than a crystal, was tortuous. I would read the same passage over and over again only to realise that I had no memory at all for what I had just read. Each book or poem I picked up was... incomprehensible. Nothing made sense. I could not begin to follow [lessons] and I would find myself staring out the window with no idea of what was going on around me. It was very frightening...

Now all of a sudden my mind had turned on me: it mocked me... it laughed at all my foolish plans; it no longer found anything interesting or enjoyable or worthwhile. It was incapable of concentrated thought and turned time and again to the subject of death...why live? I was totally exhausted and could scarcely pull myself out of bed in the mornings. It took me twice as long to walk anywhere... and I wore the same clothes over and over again, as it was too much of an effort to make a decision about what to put on. I dreaded having to talk to people, avoided my friends... and sat...virtually inert, with a dead heart and a brain as cold as clay... Laced into the exhaustion were periods of frenetic and horrible restlessness... running brought [no] relief... I drank vodka... I thought obsessively about killing myself... and it was several months before the wounds could even begin to heal.¹⁰

Attacks like this continued throughout four years of college when

...these periods of total despair would be made even worse by terrible agitation. My mind would race from subject to subject, but instead of being filled with the exuberant and cosmic thoughts that had been associated with earlier periods of rapid thinking, it would be drenched in awful sounds and images of decay and dying.¹¹

In graduate school, and having married, Jamison at last began to feel secure, and 'underwent a remission'. Nevertheless, fairly soon the marriage broke-down and she found herself alone again. She was in her first probational academic post, had too much work and was getting too little sleep, and entered a crescendo of mania. Her life became chaotic. She went on pointless shopping sprees, never tidied up, and instead strewn hundreds of scraps of incoherent writings everywhere around her. One day she put on a record and her perception of the classical music became exquisitely, poignantly and finally unbearably beautiful, clear, intense and sad. So she abandoned that to crank up some rock

9 Jamison, KR, op. cit. (n. 6), 35-37.

10 Jamison, KR, op. cit. (n. 6), 36-40.

11 Jamison, KR, op. cit. (n. 6), 45.

music, scattering records everywhere in 'a search for the perfect sound' until she 'could no longer process' what she heard. This confused, disoriented and scared her.

Slowly the darkness began to weave its way into my mind, and before long I was hopelessly out of control. I could not follow the path of my own thoughts. Sentences flew around my head and fragmented first into phrases and then words; finally only sounds remained. One evening...I looked out at a blood-red sunset... Suddenly I felt a strange sense of light at the back of my eyes and almost immediately saw a huge black centrifuge inside my head. I saw a tall figure in a floor-length evening gown approach the centrifuge with a vase-sized glass tube of blood in her hand. As the figure turned round I saw to my horror that it was me and that there was blood all over my dress, cape, and long white gloves. I watched as the figure carefully put the tube of blood into...the centrifuge [and it] began to whirl.

Then, horrifyingly, the image that had previously been inside my head now was completely outside of it. I was paralysed by fright. The spinning of the centrifuge and the clanking of the glass tube against the metal became louder and louder, and then the machine splintered into a thousand pieces. Blood was everywhere. It splattered against the windowpanes, against the walls and paintings, and soaked down into the carpets. I looked out...and saw that the blood on the window had merged with the sunset; I couldn't tell where one ended and the other began. I screamed at the top of my lungs. I couldn't get away from the sight of the blood and the echoes of the machine's clanking as it whirled faster and faster. Not only had my thoughts spun wild, they had turned into an awful phantasmagoria, an apt but terrifying vision of an entire life and mind out of control. I screamed again and again. Slowly the hallucination receded.¹²

She phoned a psychiatrist friend who introduced her to

...endless and terrifying days of endlessly terrifying drugs - Thorazine, lithium, Valium, and barbiturates - [before they] finally took effect. I could feel my mind being reined in, slowed down and put on hold. But it was a very long time until I recognised my mind again, and much longer until I trusted it.¹³

I felt infinitely worse, more dangerously depressed, during this first manic episode than when in the midst of my worst depressions. In fact, the most dreadful I had felt in my entire life - one characterised by chaotic ups and downs - was the first time I was psychotically manic. I had been mildly manic many times before, but these had never been frightening experiences - ecstatic at best, confusing at worst. I had learnt to accommodate quite well to them. I had developed mechanisms of self-control, to keep down the peals of singularly inappropriate laughter, and set rigid limits on my irritability. I avoided situations that might otherwise trip or jangle my hypersensitive wiring and I learnt to pretend I was paying attention...when my mind was off chasing rabbits in a thousand directions...

Although I had been building up to it for weeks, and I certainly knew something was seriously wrong, there was a definite point when I knew I was insane. My thoughts were so fast I couldn't remember the beginning of a sentence halfway through. Fragments of ideas, images, sentences raced around and around in my mind... Finally, they became meaningless melted pools. Nothing once familiar to me was familiar. I wanted desperately to slow down but could not. Nothing helped...not running for hours...or swimming for miles... Sex became too intense for pleasure, and during it I would feel my mind encased by black lines of light that were terrifying... My delusions centred on the slow painful deaths of all the green plants in the world... Their screams were cacophonous. Increasingly, all of my images were of black and decaying. At one point I was determined that if my

12 Jamison, KR, op. cit. (n. 6), 79-80.

13 Jamison, KR, op. cit. (n. 6), 83.

mind...did not stop racing...I would kill myself by jumping from a nearby twelve-storey building...¹⁴

Having already called on the informal psychiatric help of a friend in the profession, Jamison finally went for a formal consultation with a psychiatrist who she already knew and trusted. She submitted to heavy sedation which, she says, finally 'reined in' her mind.

The author of this account makes very clear her antipathy to psychological analysis or conjecture. This means we are not free to make connections or draw any conclusions about the influence on her emotional and mental life of relationships and events revealed in her autobiography. All the same, she makes claims about the efficacy of lithium which, in Chapter 6, we certainly dispute. Interestingly, she also displays a clearly irrational faith in medical-psychiatric authority; we explore this blind faith in Chapter 8 below, where we discuss the powerful role of faith and placebo in psychiatric care and cure.

Depression and suicide

A famous modern case is that of the poet Sylvia Plath, who made the first attempt on her own life when she was twenty-one. Almost a decade later she wrote an autobiographical novel about the experience, and gave it a title to evoke the muffled and suffocating feeling of clinical depression: *The Bell Jar*.¹⁵ Biographies of Plath depict someone who suffered from constant alternations of high energy and depression. This is similar to the experiences of manic-depression described above, but with the mania perhaps less intense and focused more rationally on socially approved occupations, and thereby made to seem plausible as 'high productivity'. After her first suicide attempt, nobody paid much attention to the details of Plath's case. The routine psychiatric diagnosis at the time reads: 'obvious depression' and 'no trace of psychosis and no schizophrenia'.¹⁶

The Bell Jar accounts for Sylvia Plath's attempted suicide and the events leading up to it. It takes the deadpan, cynical, detached and amused tone of liberal-educated American youth. It is not often very explicit about either depression or the motives for her attempted suicide. Rather, mania and depression are suggested by clues scattered through the story of a bright, successful and attractive high-flying young woman who cannot find satisfaction in the hardest of work and play, even at the most glamorous and prestigious of locations. True, the story does begin with morbid thoughts: the narrator is appalled by the US Government sending two Communist spies to the electric chair, and she also recollects attending a medical dissection of cadavers. Moreover, she is habitually 'numb' and 'very still and very empty, the way the eye of a tornado must feel, moving dully along in the middle of the surrounding hullabaloo'.¹⁷

However, melancholy is swiftly put aside as she proceeds to describe the hullabaloo. Only towards the end of the book is the reader made fully aware that the young woman is so seriously depressed as to go to a doctor for help, to submit to the horror of unmodified electroconvulsive therapy (ECT: shades of political/judicial execution by the electric chair) and then to try to kill herself. When she finally becomes conscious of her depressed feelings, the narrator

...thought how strange it had never occurred to me before that I was only purely happy until I was nine years old... After that...I had never been really happy again.¹⁸

Returning exhausted from a prestigious college-cum-work assignment, and already close to the edge, Plath suffered a setback to her career plans, the first glitch in her entire academic career. Her externally-structured routines broke down and she found, for the first time, that she was required to make her own decisions. In crisis, she lost all motivation and became insomniac. When the sleeping pills prescribed by her GP failed to have any effect she was referred to a psychiatrist.

14 Jamison, KR, op. cit. (n. 6), 82-83.

15 Plath, S (1963/1996) *The Bell Jar*. London: Faber.

16 Wagner-Martin, L (1987/90) *Sylvia Plath: A biography*. London: Cardinal-Sphere, 107.

17 Plath, S, op. cit. (n. 15), 2-3.

18 Plath, S, op. cit. (n. 15), 71.

I was still wearing Betsy's white blouse and dirndl skirt. They drooped a bit a bit now, as I hadn't washed them in my three weeks at home. The sweaty cotton gave off a sour but friendly smell. I hadn't washed my hair for three weeks, either. I hadn't slept for seven nights.

...I was so scared, as if I were being stuffed farther and farther into a black, airless sack with no way out... I couldn't read and...couldn't eat and...everything people did seemed so silly, because they only died in the end.

...When I took up my pen, my hand made big jerky letters like those of a child, and the lines sloped down the page from left to right, almost diagonally, as if they were loops of string lying on the paper, and someone had come along and blown them askew.

She had

...thrown up a scholarship at a big eastern women's college and mucked up a month in New York and refused a perfectly solid medical student for a husband who would one day [have prestige and] earn pots of money.¹⁹

She 'summoned' her 'little chorus' of accusing voices that find fault with her:

You know, [Sylvia], you've got the perfect set-up of a true neurotic.

You'll never get anywhere like that, you'll never get anywhere like that, you'll never get anywhere like that.

I thought the most beautiful thing in the world must be shadow, the million moving shapes and cul-de-sacs of shadow.²⁰

Plath looked in vain for an explanation of her condition in sources as diverse as scandal sheets and psychiatric textbooks. She found no listening psychiatric ear, and went three weeks without sleep before finally and 'experimentally' cutting herself. Her mother then took her for out-patient shock treatment. This rather put her off psychiatry, did not clear her depression - which remained bleak - and inclined her further to thoughts of suicide. The insomnia extended to a month. She began to lose perceptual grip, and tried on different occasions to throttle, hang and drown herself. Finally, having visited her father's grave, she stole the full bottle of sleeping pills that her mother was hiding from her and only failed to commit suicide by taking too many: when she became comatose, she vomited. She was found hidden away, still unconscious, two days later. In the casualty ward and afterwards, the depression persisted:

...Wherever I sat I would be sitting under the same glass bell jar, stewing in my own sour air.

...To the person in the bell jar, blank and stopped as a dead baby, the world itself is the bad dream.²¹

A friendly young female psychiatrist was able to persuade Plath to have more shock treatments. Finally, after one session,

[a]ll the heat and fear had purged itself. I felt surprisingly at peace. The bell jar hung, suspended a few feet above my head. I was open to the circulating air.²²

Plath later said that she thought her novel finished with a hopeful rebirth, but the optimism is so fraught and ambivalent that a reader might have difficulty recognising it. Her journals reveal that her depressions recurred after any setback.

Every now and then there comes a time when the neutral and impersonal forces of the world turn and come together in a thundercrack of judgement. There is no reason for the sudden terror, the feeling of condemnation, except that circumstances all mirror the inner doubt, the inner fear.

...All the edges and shapes and colors of the real world...built up again so painfully with such a real love [can] dwindle in a moment of doubt, and suddenly 'go out'.

19 Plath, S, op. cit. (n. 15), 122-127.

20 Plath, S, op. cit. (n. 15), 141.

21 Plath, S, op. cit. (n. 15), 178 and 227.

22 Plath, S, op. cit. (n. 15), 206.

...I feel like Lazarus. That story has such a fascination. Being dead, I rose up again, and even resort to the mere sensation value of being suicidal, of getting so close, of coming out of the grave with scars and the marring mark on my cheek [from her first suicide attempt] which (is it my imagination?) grows more prominent.

...I need a father. I need a mother. I need some older, wiser being to cry to.

...A life is passing. My life.

In one instance, three years after the attempted suicide:

...A lousy sinus cold...blunted up all my senses... And atop of this, through the hellish sleepless night of feverish sniffing and coughing, the macabre cramps of my period (curse, yes) and the wet, mussy spurt of blood... This was Friday, the worst, the very worst. I couldn't read, full of drugs which battled and banged in my veins. Everywhere I heard bells, telephone not for me, doorbells with roses for all the other girls in the world. Utter despair.²³

This was after she had moved to England, and just before she went to see a new psychiatrist, who was able to cheer her up. Then, two months later, still alone in a new country, she again suffered what she called 'a hectic suffocating wild depression'.²⁴ As for a strategy for dealing with her 'profound terror of an inner chaos she constantly suppressed', a biographer points out that a poem Plath imagined she had written about someone else seemed to fit Plath herself very well:

And round her house she set
Such a barricade of barb and check
Against mutinous weather
As no mere insurgent man could hope to break
With curse, fist or threat
Or love, either.²⁵

Plath reckoned that:

I myself am the vessel of tragic experience.²⁶

Depressions blighted her life. She always tried to fight them.

Last night I felt...the sick, soul-annihilating flux of fear in my blood switching its current to defiant fight. I could not sleep, although tired, and lay feeling my nerves shaved to pain & the groaning inner voice: oh, you can't teach, can't do anything. Can't write, can't think. And I lay under the negative icy flood of denial, thinking that voice was all my own, a part of me, and it must somehow conquer me and leave me with my worst visions: having had the chance to battle & win day by day, and having failed.

I cannot ignore this murderous self: it is there. I smell it and feel it, but will not give it my name. I shall shame it. When it says: you shall not sleep, you cannot teach, I shall go on anyway, knocking its nose in. Its biggest weapon is and has been the image of myself as a perfect success: in writing, teaching and living. As soon as I sniff nonsuccess in the form of rejections, puzzled faces in class when I'm blurring a point, or cold horror in personal relationships, I accuse myself of being a hypocrite, posing as better than I am, and being, at bottom, lousy.

...I have this demon who wants me to run away screaming if I am going to be flawed, fallible. It wants me to think I am so good I am perfect. Or nothing. I am, on the contrary, something: a being who gets tired, has shyness to fight, has more trouble than most facing people easily. If I get through this year, kicking my demon down when it comes up, realising I'll be tired after a day's work... and it's natural tiredness, not something to be

23 Stevenson, A (1998) *Bitter Fame: A life of Sylvia Plath*. Harmondsworth: Penguin, 70-72. This quote is from McCullough, F (Ed) (1982) *The Journals of Sylvia Plath*. New York: Dial Press, *Journal* for 1956.

24 Stevenson, A, op. cit. (n. 23), 97.

25 Stevenson, A, op. cit. (n. 23), 101. This is a quote from Spinster, in Hughes, T (Ed) (1981) *The Collected Poems of Sylvia Plath*. London: Faber.

26 Stevenson, A, op. cit. (n. 23), 109. From McCullough, F, op. cit. (n. 23), *Journal* for 1958.

ranted about in horror, I'll be able, piece by piece, to face the field of life, instead of running from it the minute it hurts.

The demon would humiliate me, throw me on my knees before...everyone, crying: look at me, miserable, can't do it. Talking about my fears to others feeds it. I shall show a calm front & fight it in the precincts of my own self, but never give it the social dignity of a public appearance, me running from it, & giving in to it...²⁷

Even so, Plath was unequal to such a struggle with the 'sick naked hell' of her depressions. It was ...as if my life were magically run by two electric currents: joyous positive and despairing negative - whichever is running at the moment dominates my life, floods it. I am now flooded with despair, almost hysteria, as if I were smothering. As if a great muscular owl were sitting on my chest.²⁸

Added to that, she still contained a deep anger. In response to one unpleasant social incident:

I have a violence in me that is hot as death-blood. I can kill myself or - I know it now - even kill another. I could kill a woman, or wound a man. I think I could. I gritted to control my hands, but had a flash of bloody stars in my head as I stared that sassy girl down, and a blood-longing to [rush] at her and tear her to bloody beating bits.²⁹

The biographies include many accounts by friends and relations who bore the brunt of one of Plath's hot or cold, and (they say) unreasonable, furies. Her anger, depressions and death-wish are often clearly expressed in the second collection of poems.³⁰ Many of the poems are famously bleak, especially those written in her final year (when her marriage had broken-up) and even more so in the brief creative burst just before her successful suicide, almost ten years after her first attempt:

...[T]he far/ Fields melt my heart./ They threaten/ To let me through to a heaven/
Starless and fatherless, a dark water.
...this troublous/ Wringing of hands, this dark/ Ceiling without a star...
...I am appalled by the death smell of everything...
...I am unattached, I am unattached.
...There is no terminus, only suitcases...
...Once one has seen God, what is the remedy?/ Once one has been seized up/
...Used utterly.../ What is the remedy?
...The mirrors are sheeted...

Meaning: there is death in the house.

And, in her final poem, written a week before Plath's suicide, at the age of thirty:

The woman is perfected
Her dead
Body wears the smile of accomplishment,
The illusion of a Greek necessity
Flows in the scrolls of her toga
Her bare
Feet seem to be saying:
We have come so far, it is over.
...
The moon has nothing to be sad about,
Staring from her hood of bone.
She is used to this sort of thing.
Her blacks crackle and drag.³¹

27 Stevenson, A, op. cit. (n. 23), 114-15. Quote from McCullough, F, op. cit. (n. 23), *Journal* for 1957.

28 Stevenson, A, op. cit. (n. 23), 134. Quote from McCullough, F, op. cit. (n. 23), *Journal* for 1958.

29 Stevenson, A, op. cit. (n. 23), 136. Quote from McCullough, F, op. cit. (n. 23), *Journal* for 1958.

30 Plath, S (1965) *Ariel*. London: Faber.

31 From the poems: *Sheep in Fog*; *Child*; *Totem*; *Mystic*; *Contusion*; *Edge*. All in Hughes, T, op. cit. (n. 25).

Personality disorder (self-harm)

It is difficult to calculate the actual prevalence of self-harm, but in 1995 there were 142,000 hospital admissions, and the numbers rise every year. It is reckoned that the UK has the highest rate of self-harm in Europe, with an estimated incidence of 0.4% of the population (4 in every 1,000) in 2002. Of course, there are likely to be many others who do not present at a hospital. Self-harm used to be almost exclusively female, but it is noticeably increasing among males. Young people (aged 11-25) account for most cases; according to a recent Lancet Commission, in the UK self-harm is the largest cause of death among those aged 20 to 24: 329 died in 2013. This compares favourably with 626 in 1990, but it reflects a very much improved official response and treatment in the intervening years rather than a reduction in the incidence.³²

Sharon Lefevre's book about her experiences, *Killing Me Softly*,³³ is typical of much courageous writing by psychiatric survivors. ('Survivors' is how ex-patients refer to themselves when they are conscious of having survived both mental disorder and the unwanted attentions of psychiatry). Her account is not a cool, detached, systematic and explicit analysis of the condition to which she found herself subjected. Instead, it is a soliloquy that can hardly bear to speak of the pain of the crisis.

After a brief but harrowing description of the act of self-harm, Lefevre's book settles quickly to two themes, both of which are rational reflections, and hence, although difficult, at least easier than confronting either the act itself or its precipitating trauma. Both of the themes Lefevre addresses are essential to establishing or re-establishing mental well-being after the crisis. The first is the most difficult for the reader. It is an extended, almost impenetrable rumination on the problems of establishing a new sense of reality, crucially including those behaviours appropriate to express and receive mutual and mature love and affection, when the person's first constructions of reality have had to develop in a context where the pathological behaviour of powerful others - cruelty and abuse - was always normal. Obviously, the ability to be able to relate to others with less difficulty is most important for recovery from any kind of emotional or mental crisis.

The second theme is a more public, a more obvious and an easier denouncement of the medical and psychiatric responses. In her experience, these consist of angry and spiteful medical aid and officials refusing to listen to the self-mutilator until she will commit herself to stop doing it. As if the 'ungrateful' self-mutilator does it to annoy others and could easily take the reasonable decision to stop her behaviour; as if anybody could freely decide not to become so incapacitated by their distress as to invite the attentions of psychiatry. But of course, self-harm is quasi-suicide, and it raises in the minds of those who routinely deal with it all kinds of challenging feelings and questions - not only strictly professional questions of care and treatment, but defensive notions of the self-harmer's culpability, selfishness, effrontery and moral error.

Both main themes of the book are important for someone trying to recover her equilibrium and establish or hang on to her sanity. But what about the pathological act itself? In Lefevre's account of her own habitual self-damage, only the first four pages are given to a description of the act of self-harm, and the images, feelings and intentions that accompany it. Since she says so little about the event itself, it is difficult to glean much information.

Nevertheless, in her account of the act of self-mutilation the author implies an ambivalent kind of approval of her own pathological behaviour. She insists it is an act of survival and not an attempted or failed suicide. The cutting appears obsessive and ritualised, and in her case it is performed in surroundings which she has prepared almost clinically; it is a compulsion enacted in a scene which she proudly claims as her own space and her own achievement.

As she cuts and slashes her arm with a razor-blade she is immediately aware of her own vitality - her heartbeat increases and her breathing becomes deeper and louder - her jaw sets in determination, and 'there is only a loud melody in my head and like a demonic voice, it wails and urges, orders me

32 Bird, L, op. cit. (n. 21, Ch 1), 19; *Self-harm* (2016) The Mental Health Foundation website; which can find no statistics after 2002; and Bosely, S (2016) Self-harm the 'biggest killer of people in their early 20s' in the UK. *The Guardian* 10 May.

33 Lefevre, SJ (1996) *Killing Me Softly: Self-harm - survival not suicide*. Gwynedd: Handsell.

to continue'. Which she does, with more determination. The blood pours out, there is a thudding in her ears, and momentarily she feels faint. She steadies herself, concentrates on the sound of rain outside the house, and her pulse races. She feels compelled to continue because she 'must please everyone, can't be selfish'. Already she feels 'so much more energized'.

She unwraps a fresh, sharper razor-blade which 'always remind of men [sic], certain men, *whom I know.*' [All italics are Lefevre's.] She forces herself to do greater damage to muscle, tendon and artery - and then a spurt of blood makes her jump. She has hit '*the flow of life force of my spirit, see inside my broken dreams and find myself and... Oh! A spurt! A little fountain!*'

She tells us that this act is 'not about absent friends, *love or hate, money or poverty, success or failure!*', but that it is about something abstract: 'time'. She cuts a bit deeper and suddenly it is enough. In her head a voice says: '*My darling child you are so brave, so beautiful, so soft, so tasty.*'

Then she realises that she needs medical help. She remembers her son upstairs, asleep in bed. She dreads the disapproval of the doctor and the neighbours. She frets over how much her son loves her, but reassures herself that, despite this compulsion to cut herself, she does provide him with love. Calmly and rationally she attends to her wounds.³⁴

Schizophrenia

John Modrow was diagnosed with schizophrenia after a psychotic episode when he was sixteen. Because his father was in the Army, he was taken to its psychiatric facility. Yet when he was very young his mother had already determined to have his mental condition diagnosed. He was five when she took him to a local psychiatrist who pronounced him fully normal. This did not satisfy her. A year later she took him on a one-hundred-mile trip to university psychiatrists who tested him and pronounced him 'very disturbed'. She maintained they had told her that they could not exactly name his condition, but if he were not immediately put into a psychiatric facility he would certainly 'develop a full-blown psychosis within the year'. If for no other reason than the prohibitive cost of private care, his parents did not have him put away at that time. In the event, he did not develop a full-blown psychosis until ten years later. Nonetheless, because they remained constantly worried about his behaviour, at the age of ten Modrow was sent by his parents for regular psychiatric testing which, after almost a year, resulted in him being certified normal. Now, at sixteen, he had certainly undergone a psychotic episode in which he experienced paranoid hallucinatory visions and developed bizarre delusions.

It is likely that the psychiatrist took account of the youth's psychiatric record and had a certain knowledge of the family. A great-grandmother had died in an asylum; Mr Modrow was an Army prison warder who appeared normal; Mrs Modrow was a housewife, a little agitated maybe, but understandably so with her son gone mad; there were no psychiatric records for Modrow's apparently normal older brother and younger sister. It is doubtful that much more information would have been available or was solicited since family secrets and the emotional and mental conditions of parents did not then (and still do not) routinely enter into psychiatric investigations. There is no hint that any of the doctors who dealt with him ever took an interest in the social or psychological processes of either John Modrow or the members of his family. Perhaps the doctor was aware, as a matter of no great concern, that the father had been an officer and some years previously had been discharged from the Army for being drunk on duty; he had re-enlisted as a private, and apparently had not been the cause of any subsequent complaints.

The following is a précis of the main elements of the story of the *immediate* event of John Modrow's psychotic breakdown, which is all that concerned those around him at the time. It summarises John Modrow's recollections more than thirty years later.

One hot summer's day, while wandering on his own along the railroad near the city dump, he met and talked at length with a strange but friendly old tramp. This man took great interest in him and gave him much advice, including the admonition that aside from reading the Bible, as he already did, he should go to church and Sunday school. Modrow resisted this idea. After their initial friendliness,

34 Lefevre, SJ, op. cit. (n. 33), 8-11.

the two parted with some misunderstanding and hostility. This left the boy feeling bitter and troubled. Walking further down by where the hoboes lived, he suddenly 'felt sadistic' and, seeing that nobody was around, he entered and vandalised one of the shacks. Then, 'as if waking from a dream' he recognised with mounting shame the 'sadistic and cowardly nature' of his action, following as it did so close on the heels of talking about his bible-reading and his belief in God.

My shame was so great that I felt it as a palpable physical sensation throughout my entire body - as a nervous spasm coupled with an agonising sense of inner defilement. In my eyes my actions unmasked me as some kind of moral monster - as a vicious and cowardly lunatic whose actions were wholly inexplicable even to himself.³⁵

At this point, the young Modrow's

...security operations (defence mechanisms) were in a state of total collapse... Trembling uncontrollably, I stumbled out of the shack. By the time I was outside the cabin my shame and self-loathing had become so uncontrollable that I wanted to...disappear forever from the face of the earth and be submerged a mile deep under the ocean. I visualised the waters of the ocean closing over me and suddenly everything around me grew a little dim. As I struggled back up through a steep and narrow pathway...I imagined myself being buffeted by the currents of the ocean and that the bushes I was holding onto for support were seaweed.

Upon reaching the railroad tracks I relinquished my fantasy of being on the bottom of the ocean - perhaps because I felt it wasn't making me feel any better. However, the very instant I shed this fantasy I completely lost control of my mind. Thoughts began to race through my mind at a faster and faster rate, and to fragment and lose all meaning or coherence. I could actually *hear* my mind racing out of control and *see* my thoughts as swirling blue comets or sparks colliding against each other. As I walked down the railroad tracks I was giggling uncontrollably while tears ran down my cheeks. My mind was one mad, racing kaleidoscope of totally random fragmented thoughts. I remember during this time having but one coherent thought: *This is it; I'm going insane!*³⁶

He finally calmed down, only to find his chaotic thoughts had resolved into a lengthy mantra-like quotation from the Song of Solomon. This concerned vanity, vexation of the spirit, folly, madness, and the perception:

...For in much wisdom is much grief: and he that increaseth knowledge increaseth sorrow.

Modrow felt 'overcome with grief' and yet somehow soothed and exhilarated. As the strange mixture of melancholia and elation faded, however, he became 'haunted by a certain indefinable sense of dread'. He phoned his one and only friend. This boy had recently become a tiresome religious fanatic whose proselytising Modrow had been forced to tolerate for the sake of his company. Although he expected no sympathy from him, this youth actually reassured him by sensibly playing down the seriousness of the damage to the shack. All the same, Modrow remained 'on the verge of panic'. He spent that night at his uncle's house, but did not sleep. The next morning he felt so energetic that he went for a thirty-mile hike through a blazing hot day, and still had the energy to swim in a lake in the evening. That night he got about four hours sleep; this was more than he would average for the next seven weeks.

The boy now found that he had entered a state in which he was deprived of sleep and experienced heightened anxiety. A few days after the initial panic attack, the dip in and out of fantasy, the manic exertions and the beginning of the insomnia, his mother 'ran away from home again'. She took Modrow and his sister to a friend's house. In a strange bed, still suffering great turmoil, Modrow was suddenly 'overcome with a profound sense of resignation'. He 'turned to God and repented his sins'. This immediately calmed him down and he slept better. The next morning the 'crushing sense of guilt' had lifted.

35 Modrow, J (1995) *How To Become A Schizophrenic*. Everett: Apollyon Press, 119.

36 Modrow, J, op. cit. (n. 35), 120.

This 'religious conversion' brought scant relief from his insomnia, however. During this period Modrow usually did not sleep at all; occasionally he slept 'no more than two or three hours' during every twenty-four.

At first he found the absence of sleep 'rather pleasant'. His

...focus of attention was still relatively broad - broad enough at least to permit the existence of a rich and satisfying fantasy life...although of various kinds...most often [involving] my identification with King Solomon and John the Baptist...³⁷

He discovered Solomon as a hero because of his wisdom and pessimism, and John the Baptist because he seemed greater than Jesus: John had received the Holy Spirit when still in his mother's womb, while Christ only received the Holy Spirit and derived his authority later, and at The Baptist's bidding. As his prolonged sleeplessness continued, the teenager's desire to become like The Baptist slipped into 'recognition' of the similarities between them: the independence and forcefulness, the wish for an uncompromising life of seclusion in the wilderness. Modrow had long day-dreamed about that kind of life, and the shared name seemed significant.

Early in this insomniac phase, Modrow also had vivid daydreams of being purified and achieving inviolability. At the same time, though, he felt 'profoundly helpless': 'a human atom swept along in the current of an onrushing Cosmic River - this River, of course, being God'. He walked around in a 'euphoric daze', feeling that God completely controlled both his life and, as a special favour to him, the world about him.

He then decided that he had 'become a Christian'. He tried very hard 'to be good'. As the psychosis developed, those close to him - especially his parents - thought he had become 'wonderfully improved'. But this desperate preoccupation with becoming a good person was only an immediate response to recent threats by his mother to have him incarcerated in an insane asylum.

By that time I had repressed my own needs and individuality to such an extent that I came to view the world almost exclusively through my parents' eyes. Their moods, emotions and attitudes toward me reverberated through my entire being, often bringing a strong visceral response. At this time I was simply overflowing with love for my parents. They seemed to me to be wonderful, flawless people who could do no wrong...³⁸

Even when his father invaded the bathroom when he was on the toilet, it seemed to Modrow 'a part of the natural order of the universe'. This was more than passive acceptance; he also burst into tears when he heard that his parents could not afford dental work for his older brother.

At school Modrow felt 'so tired and disorientated that I could barely find my way around'. Naturally, he could not keep up with the timetables and the work. He soon found himself 'a virtual sleepwalker', prone to visions, such as walking down a railroad towards a locomotive that had a demonic searchlight eye which controlled his mind, and that he knew would destroy him. Anxiety attacks followed in the days after this vision; also a pressure 'which I could almost feel as a tangible force bearing down on top of my head'. Aware of failing at school, that and other 'indescribable fears' oppressed him, and

...I had a vague but ominous feeling that something terrible was about to happen to me: that somewhere in my mind there were demons waiting to burst forth from their cages...³⁹

As his fears grew, Modrow became obsessed with the notion of having to proclaim The Second Coming of Christ. He ruminated this tremendous task, praying to God for guidance and The Wisdom of Solomon. After several nights he finally 'knew' he had been granted his prayer when he became convinced that his mind worked perfectly and that he had become 'profound'. He then plunged into theological cogitations, pondering 'day and night', and studying the question of why at the end of his life the very wise Solomon had renounced God and become an idolater. This led him to a passage in the Old Testament which 'proved' that God was vicious and contemptible, and that Solomon had been right to deny Him. However, this guilt-laden realisation, so offensive to God, precipitated

37 Modrow, J, op. cit. (n. 35), 124.

38 Modrow, J, op. cit. (n. 35), 126.

39 Modrow, J, op. cit. (n. 35), 126.

another panic which threw the boy to the floor, grovelling and whimpering and begging God to forgive his guilt and worthlessness.

I started to scream and roll around on the floor in a paroxysm of terror. I stayed on the floor for close to an hour crying, pleading for mercy, and trying to flatter God by telling Him how powerful He was and how much I feared Him. Finally I grew confident that my show of abject servility and fear had placated God's wrath, and so got up from the floor in a much calmer state of mind but still profoundly shaken.⁴⁰

That night Modrow feverishly turned over 'the darkest and grimmest thoughts'. It had become obvious to him that God was a sadistic monster who had created humanity in order to torture everyone in Hell; He had turned Satan loose on the world so as to inflict pain. Moreover, if He had humiliated, tortured and murdered His own Son, what would He not do to a mere insignificant boy? For the next few days Modrow 'lived on the edge of the abyss', hating God and fearing the consequences. When he was on his own he would 'cringe and cower' with his arm above his head for protection. Sometimes he would 'roll on his back and whine like a frightened dog', seeking to pacify God, in fear of 'His menacing Presence closing in' on him. His only comfort was that Solomon had said that the fear of God was the beginning of wisdom.

All the same, Modrow understood that his only chance of avoiding Hell was to love God. So he persuaded himself that his perception of God's cruelty was a symptom of his own sin. Incessant Bible-reading nevertheless revealed new atrocities committed on the innocent by the Old Testament God, and the stricken youth now oscillated between 'blasphemous' thoughts and panic-stricken attempts to abase himself before The Almighty. This consisted of going into a wood and flinging himself onto the dirt and pleading to be forgiven. He would do this until he felt a 'tingling sensation' in his spine, which he interpreted as the descent of the Holy Spirit. This would afford him 'tremendous relief' and he would pick himself up feeling 'greatly exalted'.

At this time, Modrow also took to walking at night into car headlights. This gave him an 'eerie pleasure' from a sort of 'auto-hypnosis'. He told himself that these were demons' eyes which looked deep into his soul. Believing himself inspired by the Holy Spirit, he wrote a Prophetic Letter to his religiously-inclined friend, replete with all the stock Old Testament apocalyptic exclamations.

By this time Modrow did manage to get to sleep, but only to dream that he was a great evangelist leading his school flock in a hearty rendition of the hymn 'Rock of Ages', in fervent, delirious praise of - he suddenly realised - not God, but himself! He woke up 'in a cold sweat with an ominous feeling which soon escalated into stark terror'.

I saw a huge pair of eyes staring at me from out of the darkness less than two feet in front of me. I felt certain that these eyes could only belong to the Rock of Ages Himself, for they seemed to radiate infinite power and fury, and had a certain primordial and almost reptilian quality to them... They blinked, and I could see that the eyelids were extremely crinkled and lined with blood veins... I felt the judgement of God upon me, for those wrathful eyes gazed into the very depths of my soul and saw all the rottenness concealed there. Never in my entire life had I experienced such excruciating terror!⁴¹

The vision faded. A second, similar, but less angry pair of eyes appeared and vanished. Modrow took them to be Christ's. A third pair appeared, full 'of boiling blood which flashed with rage as flames of fire issued from them'. These were the eyes of 'a ferocious demon', and they shot towards him and 'merged with' his own eyes. A fourth pair of 'very sinister, Satanic' eyes, 'like diamonds', with 'an eerie light radiating from them', lingered and faded. A fifth pair of mysterious, 'questioning' eyes appeared near the door. Modrow took them to be the eyes of John the Baptist; they seemed to ask him sympathetically if he would have the 'moral and spiritual stamina' to endure the trials of his special mission. These eyes faded, causing a feeling of loss, since they were the only sympathetic eyes in the vision.

Then,

40 Modrow, J, op. cit. (n. 35), 128.

41 Modrow, J, op. cit. (n. 35), 132.

[i]n a few moments, to my horror, the glittering searchlight eyes reappeared, and soon an entire face and figure materialised. It was Satan himself. Satan's body and face were human-like, but his mouth had fangs and a forked tongue which flickered like a snake's. His skeletal hands moved in an unnatural stroboscopic fashion. Light radiated from his entire figure, but was especially concentrated in his eyes.

Satan stretched forth his right arm, and I could almost feel his skeletal hand closing round my throat like cold steel. Then he withdrew his hand and looked deeply into my eyes. As I stared into those radiant glittering eyes I felt myself beginning to dissolve.

I found that I had become a disembodied spirit walking in the night through a desolate snow-covered terrain. Soon I was no longer walking, but gliding over the snow. I was travelling in the midst of a heavy blizzard and apparently I was carrying a flashlight, for as I moved over the snow my path was illuminated by a beam of light. I was clearly looking for something, but exactly what...was extremely unclear. Finally, I spotted a dark figure some distance ahead of me, standing under a black and withered-looking tree. Upon my shining my light on that person Satan turned his crystalline eyes upon me and in that very instant I saw my own reflection: *I was Satan!*

The next thing that I became aware of was that of lying in bed, looking up at the ceiling. It was pitch-black and thousands of stars were looking down upon me. I felt the eyes of the entire universe upon me. I had been given a sacred mission.⁴²

In the morning Modrow expected to find that his hair had turned white. Instead, what he saw in the mirror was a 'reddish glow' in his eyes. He took this to mean that a demon dwelt inside him. He gravely told his parents he was not going to school that day, and wanted to talk to them. Quite incoherently, he tried to explain his vision and his mission. Somehow he found himself trying to explain the symbolism on a dollar bill. Then the All-Seeing Eye of God at the top of the pyramid on the dollar note reminded him of the night's horror and reduced him to silence - something of a blow to his new certainty. Next he told his father that the visionary eyes had also looked like his eyes. His father mumbled a defence that there was good and bad in everyone. At the time this made no sense to Modrow. Only now, looking back over the years, he thinks that his father, at least, was trying to express some awareness of his part in driving his son towards psychosis. At the time, both his mother and father insisted that their son had made a 'miraculous' change. His mother seemed especially pleased with her son's declared 'mission'.

The boy then went for a walk in which he experienced an intense technicolored vision, felt exhilarated, and was 'caressed by the spirit of God' (in reality, the breeze). He considered himself God's prophet, 'one of the most important persons ever to have walked on the face of the earth!' He wrote another bizarre letter to his friend, explaining that he had suffered, died and been reborn, and that his wise parents '...out of sheer love for me...had torn me apart both physically and mentally in order to purify me of all my selfishness and moral depravity', so that he might die and be reborn. Modrow still had some good sense of reality, though: having posted the letter he immediately felt depressed when he considered that his friend would not find it very coherent.

The hallucination-nightmare which confirmed him in his mission also calmed Modrow enough for him to be able to get to sleep that night, and subsequently. As he became more rested and less agitated, his delusions took on what seemed to him a strikingly logical form. He was still absorbed in his own thoughts, but he felt calmer in the belief that his newly-discovered superior knowledge was due to the spiritual nature of the demon within him; that, after all, Satan was only a finite servant of God; that the figure of Good can only stand out against a necessary ground of Evil - and such-like theological-cum-metaphysical ruminations.

After the night of the visions, Modrow felt in 'a state of mystical exaltation which lasted at a high level of intensity for several weeks'. In that heightened state everything seemed more beautiful and alive. He believed he could see through people's eyes and into their minds, but he 'only saw innocence and goodness'. Once, out of the blue, Modrow stood up in class and seemed to enrapture

42 Modrow, J, op. cit. (n. 35), 132-133.

everybody, including the teacher, with an apparently entirely plausible ‘symbolic parable’ that he felt was guided by ‘something greater than myself’. His assurance to the boy next to him that he had indeed seen God was apparently accepted at face value.

In this state of delusion and sleeplessness, Modrow continued to read and re-read the prophetic books of the Bible, and he prayed to God to deliver him from the awesome tasks of his ‘mission’. He took up church-going. Usually he was careful not to divulge his delusions to anyone in authority. One Sunday, however, he found himself telling the minister about his vision of Satan. The minister replied that the boy was overwrought from too much studying. Modrow continued to act crazily at school, playing psychological games with his fellow pupils. At the same time he considered himself very wise, and in fact in possession of a ‘supersanity’ in which he viewed everybody else as verging on madness. At school he was by then notorious as a crank, but the teachers were not amused. One complained to his father, who proceeded to harangue him about his bizarre ‘preaching’. He demanded that his son should once again see a psychiatrist. Modrow says that this resurgence of his father’s criticism did not cause him anxiety since it meshed with his delusional system: he had expected hard trials ahead.

When he felt elated and mystical Modrow identified with John the Baptist; when he was melancholic and pensive, with Solomon. He went as Solomon to the first of these latest psychiatric interrogations, in fact conducted by a clinical psychologist. However, he failed to answer any of the questions on the meanings of common proverbs. This severely dented his belief in both his identification and his sanity. He was then passed on to a psychiatrist. Despite having revealed the full extent of his delusions to no-one except his friend, he now felt ‘profoundly shaken’ in his beliefs. He immediately blurted out that God had given him the Wisdom of Solomon. The doctor responded with ‘icy and contemptuous silence’, at which:

...as if a dam had burst inside me, I went into what I later came to understand as a ‘sick act’. I began bawling that I was tormented by visions. Like a small child trying to placate an over-bearing father, I had anticipated what this man expected of me, and told him exactly what he wanted to hear.⁴³

The doctor’s manner immediately thawed and was replaced with one of ‘benevolent fatherly concern’. After diagnosing schizophrenia, he wrote a prescription for Stelazine and sent Modrow home. Thus began his long career as a medicated schizophrenic.

Summary

In only one of these cases is there a sign that anyone ever seriously entertained the idea that the mental disorder in question could be a psychological response to personal crisis, and possibly a result of unbearably oppressive events during the individual’s emotional and psychic development, and perhaps continuing in his or her present circumstances.⁴⁴ On the other hand, in each case the doctors were quick to diagnose a specific mental illness supposed to afflict the patient. According to the medical model of mental illness, of course, categorisation is an essential prerequisite to the proper management of the disorder: how else decide the correct remedy? However, as already mentioned, we will soon see (in Chapter 5) that the supposedly medical diagnoses of psychiatry are not based on creditable evidence.

More than this, except for watching for signs of what the officials consider mental or behavioural deviance, so as to confirm the presence of mental illness - that is, an organic pathology which fails to register on any medical tests, and is simply *assumed* to exist and cause the manifest disorder - *in principle* the medical model takes no interest in what the patient says, believes or does. This is oppressive and a deplorable waste of a crucial therapeutic resource. At the same time, and by the same token of speaking of an illness, the medical model encourages everyone - officials, families, the

43 Modrow, J, op. cit. (n. 35), 146.

44 Only one among the various psychiatrists who saw Sylvia Plath seems to have suggested that her irrationality was a response to overwhelming interpersonal and emotional issues. See Stevenson, A, op. cit. (n. 23), 257.

community, the patient himself - to ignore those unacknowledged oppressions which lie behind psychological crises, and to live instead in irrational hopes of a medical cure.

In Chapters 18 and 19 (Volume 2), we return to the cases outlined above. There we add more biographical detail where this is possible, and we make our own commentary and analysis. By these means we are able to demonstrate that, from a psychodynamic perspective, each of the above apparently absurd irrationalities in fact contains its own fair reasons.

Meanwhile, in the next chapter, we begin to address the shortcomings of the medical model of mental illness and treatment, starting with its fundamental misperception and confusion of the entire mental health project.

Chapter 3: IMAGINARY ILLNESS

It is customary to define psychiatry as a medical speciality concerned with the study, diagnosis and treatment of mental illness. This is a worthless and misleading definition. Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social and ethical problems of living... We now deny moral, personal, political and social controversies by pretending they are psychiatric problems....

The traditional definition of psychiatry places it alongside such things as alchemy and astrology, and [makes] it...pseudo-science. In the past, men created witches; now they create mental patients... Psychiatry is a continuation of the Inquisition. All that has really changed is the vocabulary and the social style.

Thomas Szasz¹

In the great majority of cases, no somatic abnormalities are found in those who appear worryingly irrational. While the person seems incapable of functioning adequately, nothing is wrong with the structure or workings of his brain, and that is why he is said to be afflicted by a functional mental disorder. In this chapter we see that conventional wisdom is thoroughly confused about the nature and appropriate management of all those cases of incapacitating emotional or psychological malaise for which there is no evidence of an organic cause. This confusion is due to the failure to properly register and address the crucial implications of the distinction between neurological (brain) illnesses and functional mental disorders.

Accordingly, there is an urgent need to examine the ill-conceived pseudo-medical routines, assumptions and so-said science of all that standard mental health care and treatment which takes for granted the psychiatric medical model. A novelty of our approach is to suggest that there are powerful but unacknowledged emotional, psychological and cultural motives for the perennial allure of the unfounded medical model as an apparent explanation for every kind of mental disorder, and a satisfactory guide to dealing with them. (This part of our argument is amplified in Chapters 13 to 15, below.)

For, as we shall see, doctors insist that those persistent undesirable states of thinking, feeling and motivation for which no organic cause can be found - those overly disturbing beliefs and behaviours - are nevertheless the signs of a curious kind of illness which has no organic markers, i.e., mental illness. Since there is no evidence to support the notion that every functional mental disorder is certainly an illness - a mental illness - this is simply a point of professional dogma which in practice does little to help desperate people with their problems, whether real or imagined. More than this, insisting on diagnosis and treatment according to psychiatry's medical model often heightens anxieties by adding to everyone's perplexity and causing the individual organic harm or further psychological distress.

Here we begin to explore and resolve the conundrum of so-said mental illness. We also preview our wider critique of the current forms of the mental health response - the normal organisation of care and the various routine treatments. Inevitably, this suggests an alternative and more suitable perspective on functional mental disorder, one which indicates more humane and more practical kinds of response. (Volume 2 explores those ideas in detail.)

¹ Szasz, TS (1961) *The Myth of Mental Illness: Foundations of a theory of personal conduct*. New York: Hoeber-Harper, 17 and 269, and Szasz, TS (1970) *The Manufacture of Madness*. New York: Harper & Row. Introduction.

A critical approach

In Chapter 1 we said we would see that rather than providing understanding and the most helpful kind of therapy based on scientific methods and findings, the medical model of mental illness is unfounded and most patients are not very happy with their treatment. Here we begin to present the arguments and evidence for our assertion that the psychiatric medical model neither makes sense nor delivers much benefit to those who suffer from incapacitating emotional distress and mental disorder. Furthermore, it is not just that conventional ideas about the nature of mental disorder and the appropriate forms of treatment derive from poor theory and bad science, but official practice often positively obstructs the recovery of patients and too often causes organic and psychological harm. Chapters 4 to 12 consider in detail various aspects of today's mental health response, and put flesh on the bones of what we contend in this chapter.

In psychiatry, the medical model both generates and depends upon the myth of mental illness. Chapters 13 and 14 explore the myth and the model as they arise out of broader mythological notions of Science. These imaginings generate a consensus about which kinds of propositions concerning emotional, mental, personal and social life are reasonable for understanding and managing individual irrationality, and which are not. Orthodox mental health care and treatment is derived from this set of taken-for-granted beliefs, and we argue that it can only be comprehended as pathological and ritualised: although masquerading as scientific medicine, it is best understood as a naïve and poorly theorised reflex to everybody's deep-seated fears of madness and what it may disclose.

In the Introduction we saw that there is little chance of any of us getting through life without being directly affected by a serious mental disorder - either our own crisis or that of someone close to us. Suddenly faced with this kind of event, people are likely to recall ideas they have heard about the types of mental illness and the various treatments. Nevertheless, we deny both the reality of mental illness - as *illness* - and the adequacy of much of the standard response. This is not to deny that there *may be* disease entities (e.g., viruses or genes) causing mood or mental disorders such as depression and schizophrenia, or predisposing certain individuals; it is just that there is no clear evidence for this idea. And until there is, it seems reasonable to employ the psychodynamic hypothesis: that any functional mental disorder is essentially a failed psychological accommodation to emotional trauma.² Therefore, in this chapter we begin to interrogate that psychiatric medical model in terms of which every kind of mental health patient is presently assessed, categorised and processed.

As already mentioned, we take a critical stance towards the topic in hand. However, the first problem for a critic of any established and apparently indispensable organisation is that everyone tends to resist any ideas which question their own preconceptions. Moreover, resistance is likely to increase if a critique also threatens the complacency with which people like to view matters they might rather wish were kept private and unexamined. Trusting that the reader is willing to keep an open mind, we still feel we had better explain how we approach the controversial topic of mental disorder and the official response, and that we should engage pre-emptively with probable objections.

The whole of mental health care and treatment is of course a complex and evolving field, and as guides to this terrain, the standard textbooks may appear daunting. Dry and heavy tomes supposed to encompass all the details of every significant psychiatric category and routine, they present a bewildering array of ostensibly scientific and technical matters: the diagnostic categories and their sub-types - depression (endogenous or exogenous), anxiety, OCD, panic disorder, schizophrenia, bipolar disorder, PD, BPD, ADHD, etc., etc. - and almost as great a complexity of clinical routines and medications. These texts are not intended to provide the public with readily accessible information but to introduce already trained physicians into an exclusive club of specialists who wield an esoteric practical knowledge.

All the same, as we have already suggested - and will demonstrate by offering evidence and developing our argument throughout this Volume - that body of professional beliefs and procedures is neither authentic medical science nor - so far as most patients are concerned - the most useful response. It seems to us that psychiatric wisdom is not primarily a means to best help the troubled

² See text to footnote 8, Chapter 1.

individual regain his emotional and mental balance, to reduce his misery and increase his autonomy. Instead, it articulates a set of rhetoric and rituals, an ideology and a practice which *first of all* serves various unacknowledged but vital emotional, psychological and material interests *other than those of the patients*.

Meanwhile, in daily life, each of us encounters a variety of *particular* people and events. This is why, in Chapter 2, we introduced the local, the personal and the anecdotal - specific experiences of incapacitating emotional distress and mental turmoil. We hope this gives a more immediate feeling for what happens when an individual find himself in the throes of a personal crisis and subjected to psychiatric authority. We reprise and examine those accounts in Chapters 18 and 19 (Volume 2). As they arise in each narrative, this approach also allows us to indicate various pitfalls in the present mental health system and give pointers to other possibilities for care and treatment.

We believe our approach is not only more accessible to the reader than the usual textbooks but also more accurately reflects the reality of the mental health enterprise, which is not in fact very precise and scientific but inevitably approximate and 'rule-of-thumb'. Also, in our account of mental disorder and the normal forms of care and therapy, we do not make unfounded pronouncements about illnesses and causes. Instead, we hope to give a better sense of how things really are. For example, each and every mental health diagnosis is based in nothing more than conjecture: *there is no material evidence* that there are a number of discrete mental illnesses, each requiring its own specific medical treatment. For some purposes it might be useful to the organisation of care to discern broadly contrasting types of aberrant behaviour and ideation, but we will see that no patient can hope to find relief from his misery and confusion unless the *unique* contours of his own psychodynamic and social context are explored and appropriately addressed according to his own *singular* needs. In our view, and for the purposes of helping the person in question, precisely *naming* his disorder is not so very important; in fact, mental health diagnosis is not precise and scientific, and it is very often distracting and counter-therapeutic. We pursue this argument as the book proceeds.

For the sake of lucidity, it therefore seems logical to introduce various particularities before we advance the more general arguments which, towards the end of this Volume, come together as a comprehensive critique. At some point, though, some kind of critical overview cannot be avoided. For it is certain that either we rely on general ideas about a topic, but only unconsciously or semi-consciously and by taking for granted assumptions which are perhaps dubious, or we make our assumptions explicit, examine them, and then argue a case for this theory rather than that. Only the latter approach can generate the clarity required for responsible action. And although criticism consists first of all in exposing inconsistencies in the received wisdom, why an institution takes the form that it does remains a mystery unless we view matters from the perspectives of psychology, sociology, cultural analysis and history. Therefore, towards the end of this Volume, in Chapters 12 to 15, we deconstruct the rickety edifice of orthodox mental health theory and practice, based as it is in the unevidenced medical model. Only then is the ground clear for the construction of a feasible alternative, which we formulate in Volume 2.

And so, in place of the idealised version offered by the standard textbooks, we try to show what actually goes on in the current organisation of mental health care. On the side of sympathy, empathy, care and recovery, we are compelled to make a number of telling criticisms and suggest some entirely practical reforms. Broadly, we make three points:

First, in the interests of humanity and scientific credibility, it is time psychiatry opened itself up to criticism. The profession needs to become democratic - accountable to criticism from within and without. A whole century of research has failed to confirm *any* of a variety of hypotheses about biological causes for the functional mental disorders, and yet the psychiatric profession remains myopically 'pre-Copernican' in its outlook and refuses to seriously entertain any other point of view. This is not true to the spirit and practice of science, which *encourages* criticism.

Second, and as a corollary to the first point, in the majority of cases there is no evidence that the mental disorder is due to a diseased brain. In which case, rather than dismissing out of hand every apparently irrational, undesirable or inconvenient thing that the patient says or does - as the rambling, nonsensical signs of brain dysfunction - his behaviour and beliefs should routinely elicit an attentive

therapeutic response which respects what he says and does as *potentially signalling a significant but undisclosed underlying anxiety, the root cause of the mental disorder*.

Third, we certainly recommend that there should be a helpful social response to mental disorder. However, it is simply deluded to believe that medicine (or any other natural science) will be able to legislate a series of steps in the therapy of every case of functional mental illness diagnosed as type a, b or c. To begin with (again, for reasons which we hope will become clear as the argument unfolds), we have little faith in the present system of psychiatric diagnosis and treatment. Instead, we believe that, in a future in which they are better trained and more responsible agents, mental health workers will be encouraged to work out ways to best help each person to overcome his disabling emotional or mental condition, taking into account his unique psychological, material and social needs - and *not* by reference to the unfounded and stigmatising medical model.

This is why in this Volume we offer a thoroughgoing critique of psychiatry, and then in the second Volume suggest an approach quite different from the ill-conceived 'medical model plus eclecticism' of the mental health mainstream. We will see that, far from being based in exact techniques informed by scientific evidence, the official response to personal crisis is entirely tentative, negotiated, ideological, political, and 'rule-of-thumb'. We deny that the conventional textbooks are based in sound medical science and best describe the real causes of emotional distress and mental disorder, or that they recommend the most advisable forms of care and treatment. We show that it is misleading to insist that every mental health patient 'has an illness', and that this belief tends to add to a person's problems rather than helps him face and deal with them. More than this, we will see that the psychiatric medical model is not only mistaken and reductive but profoundly dehumanising. This is because, without proof, it proclaims an *essential difference* between the condition and constitution of the psychiatric patient and the rest of humanity, the supposedly normal majority.

The reader might now see that it was impossible for our book to conform to the usual pattern of a mental health textbook. A seemingly medical-scientific presentation would be inappropriate to the evidence and propositions offered here as a necessary *critique* of the current dispensation, and an *alternative* to it. Our critique, in this first Volume, demonstrates that although the psychiatric consensus imagines itself medical and scientific, that is far from the truth. It would be more accurate to characterize the recommended mental health routines as *pseudo-medical*. And because we do not believe the dogma which masquerades as knowledge in conventional psychiatry - in our view it is naïve error, myth and ideology - neither can we appropriately employ much of its language and style, which is shot through with mystifying jargon and pretension.³ No doubt these heretical views would be shocking to anyone who believes that of course mental health should be served by psychiatry's medical model. But it is impossible to please everyone, and we can only hope our text is as accessible as possible and has the coherence of a clear train of dissenting logic.

In opposition to the prevailing mental health ideology, we argue for a social- and psycho-dynamic explanation for incapacitating emotional distress and mental disorder. We readily admit this is not original, but we do try to pull together into one connected schema the best ideas of a number of disparate thinkers. In support of this perspective, an essential moment in our argument is a comprehensive critique of the research cited by that psychiatric mainstream which advertises itself as a type of medical science, while denigrating psychological approaches for being unscientific.⁴ We also highlight the pivotal but rarely acknowledged significance of placebo or faith-healing in mental health treatment outcomes: in Chapter 8, we submit that almost *every* claim to the efficacy of psychiatry is called into question by the barely explored role of blind faith in the allegedly medical-scientific management of mental disorder. Beyond this, and crucial to understanding the style of today's psychiatry and the persistence of the unexamined dogma used to justify the normal mental health procedures, in Chapters 13 and 14 we try to account for the extraordinary tenacity of the

³ Again, the case for this assertion is fully argued in Chapters 12 to 15.

⁴ For example, Chapter 12 and its Appendix are based on the detailed research and argument of a leading authority on psychiatric biochemistry, Professor Alec Jenner.

misplaced blind faith in psychiatry as an authentic medical science - a myth which grips the imaginations of professionals and public alike.

If they recognise them at all, the standard textbooks hardly touch on these issues. Even so, it is impossible to make sense of the present organisation of mental health care and treatment without comprehending the unsubstantiated ideological assumptions which underpin the enterprise and are peppered throughout its theory and practice.

By contrast, our approach may be characterised as critical and informed by social-psychodynamic theory. We are not concerned with how we wish to be known or to which particular school of thought we might be assigned. Rather, the contributors to this book are united by an interest in making better sense of mental health provision than the hopelessly unfounded set of beliefs known as 'the medical model'. In Volume 2 we acknowledge the ideas of various psychiatric dissidents. Freud is discussed at some length, for instance, but this does not make the authors a collection of any specific kind of Freudians - there is no wish to promote any particular diagnostic or analytic idea.⁵ On the other hand, we do believe that introducing much more genuine democracy and mutuality to the mental health system would lead to immediate improvements in both theory and practice.

We try to avoid using much of the abstruse terminology of the psychiatric medical model. Mental health officials habitually employ unnecessary and confusing jargon. We contest the idea that the enterprise requires that kind of arcane, allegedly technical language; besides, it is patently used to intimidate the non-initiated and persuade them that what the officials say about mental disorder and treatment must be true because it is couched in terms which sound medical-scientific. Contrary to the bombastic assertions of many of those entrenched within psychiatric power (and their academic allies), this is a field in which very little is scientifically certain - except that the dominant medical model is not supported by the research evidence. That is why we write this book, and why we feel there will be little improvement in the official mental health project until people begin to recognise its reactionary ideological colouration. For it seems to us that 'science' is quite misconceived by most of those in the mental health services. Compared to physics, chemistry or general medicine, psychiatry manages to deliver only poor research and half-baked theory. Far from displaying an indubitable purchase on a difficult reality, most psychiatric 'facts' and 'theories' reflect little more than the wishful thinking and unproven suppositions of those who cannot imagine that mental disorder is not necessarily (or even usually) the symptom of a disease. Anyway, outside of an official context, and even when they seem very bizarre, mental and emotional events are almost invariably represented or described by using everyday speech. Consequently, we are not persuaded that the best way to comprehend mental disorder and its remedy is to translate everyday ways of speaking about the issues into an arcane, scientific-sounding jargon, but rather to write as plainly as possible.

Any approach alternative to a prevailing dogma always courts controversy and outright enmity. This is not necessarily because the alternative is biased and incorrect - in this case, 'politically motivated anti-psychiatry', as defenders of the so-called medical model assert with dreary monotony but precious little reasoned argument. Rather, ours is a heresy which embarrasses established power by asking awkward questions and proposing more plausible descriptions, theories and practices. Psychiatry is a field in which the science is poor and yet the power of the doctors is great: in effect, the law makes them accountable only to their colleagues. But there has never been a *scientific* consensus about the methods of psychiatry, which are often quite brutal and demonstrably harmful. From about the mid-1960s, and for the next two decades, great passions were released in a conflict between those defending positions for and against the orthodox perspective. The opponents of psychiatry tended to bitterly despise it - after all, 'care' and 'treatment' is too often experienced as degradation and gratuitous assault. The intensity of this opposition was matched by the lofty disdain of most of those professionals with an interest in keeping tight the reins of their well-protected psychiatric power, but also by the unreasonable, name-calling fury of those publishing defences of the indefensible from positions within the profession or the universities. This was always an unequal struggle. Since misery and madness lie on the margins of society and evoke great dread, those who

⁵ We characterise the psychodynamic perspective and mention Freud in the text to footnote 8, Chapter 1.

oppose the arbitrary power of the psychiatrists are bound to be fewer and relatively powerless, whereas those defending established power are always more numerous, secure, well-paid, well-organised, and fully endorsed by the consensus and the law.

However, as mental health provision continues to undergo changes to its organisational structure, and as the sorts of questions posed by this book inevitably continue to arise, the monolithic power of the doctors might at last be vulnerable to erosion. The sheer exhaustion of the old paradigm (that is, the lack of evidence for the psychiatric medical model and for the efficacy of the normal procedures), the continuing resistance of many patients and their allies, the dissent of some mental health workers (nurses and psychologists) not so fully committed to the medical model and who may already have taken on some of the powers previously held only by doctors, difficulties recruiting psychiatrists - each of these factors might weigh against the orthodoxy which has failed so many patients for so long.

No doubt the high ground of psychiatric power is still held firmly by those who subscribe to the medical model. As a result, most people still believe in the myths which sustain medical power: they believe that every mental disorder is an illness and the proper response is medical treatment. All the same, doctors have lost some of their authority due to the piecemeal expansion of entrepreneurial psychotherapy and counselling since the 1960s, and those kinds of practitioners now also have a better foothold inside the official organisation. Perhaps medical power is also on the cusp of a decline due to changes in mental healthcare structures and funding. This is not necessarily because those who oppose psychiatry's medical model have won any arguments based on logic or the scientific evidence, so much as due to cash-strapped politicians and fund-holders waking up to the fact that the normal mental health response has been unable to prevent costly long-term welfare dependency for so many people. Organisational changes offer opportunities for each of the associated professions to bid for more responsibilities, in competition with the doctors. Additionally, within the ranks of the psychiatric and social services professionals, and often allied with mental health charities and self-help groups of psychiatric patients and ex-patients, there has already been organised resistance to medical power sufficient to force policy-makers to take notice and respond. During the last quarter of a century there have been a number of officially sponsored local and national initiatives to develop advocacy, patients' councils, patients' charters, etc., and generally at least to make it *appear* that patients and carers are included in the processes of mental health decision-making.

Finally in this section, and as a recommendation, something should be said about a collaborator on this book. In his day, Alec Jenner held a unique position in British psychiatry. Every psychiatrist is trained in general biology and medicine, but few have much experience of the sciences of chemistry, biology or genetics. This does not prevent them from alleging that those disciplines are able to provide evidence to support their belief in a biological cause for every mental disorder. Professor Jenner, on the other hand, was an eminent psychiatrist who first of all trained in biochemistry, then carried out important clinical drug trials, and thereafter continued to follow the on-going research with an expert eye: for many years he was Honorary Director of both the UK's Medical Research Council Unit for Chemical Pathology of Mental Disorders and the MRC Unit for Metabolic Studies in Psychiatry. Whereas the prevailing professional belief is that every functional mental disorder 'must be' due to a biochemical imbalance or a genetic anomaly, over the years, on the grounds of the lack of evidence to support this 'biologism', Alec Jenner came to the conclusion that this presumption is simply wrong. Added to which, it seemed clear to him that most psychiatric biochemical and genetic research is based on mistaken ideas about science and causality, and this calls into question almost the entire research effort, as well as many routine forms of treatment. His argument, summarised in Chapter 12, is crucial for establishing the unfeasibility of the psychiatric medical model - and, by implication, the viability of the alternative, social-psychodynamic 'model'.

The confusions of the psychiatric medical model

Without bothering to comment on its peculiar premises, logic and nature, invariably the standard psychiatric textbooks celebrate the alleged virtues of the discipline's so-called medical model.

What do they mean by ‘model’? In science, a model is a conceptual representation of the topic under investigation; a model works from certain assumptions and with a certain well-defined method to abstract, simplify and formalise particular features or parts of the world so as to be able to make calculated interventions. To have value, any such model must include a coherent articulation of well-defined concepts which are used to distinguish, measure and correlate relevant objects, processes or events. More than this, it should have the potential for generating predictable applications in the objective world: it should give rise to testable theories or hypotheses. Obviously, the psychiatric medical model is concerned with the various mental disorders and their causes, progress, treatments and treatment outcomes.

Today’s medical model of illness and treatment - that is, of illness in general - was established in the middle of the 19th century, along with the development of the germ theory of disease. Doctors now presume that any disease or illness is caused by a specific physical agent such as a virus, a bacterium, a parasite, a deficiency or a genetic aberration. Restoring someone to health is then a matter of counteracting the malfunctioning part of the body by means of a biological, chemical or physical technique. In the medical model, the body is viewed as an intricate biological machine; illness is a malfunction or breakdown of some part of that machine, and that part becomes the target for a technical intervention. In general medicine, it is normally beside the main point that the patient is also an agent, someone who is constantly trying to negotiate a complicated and dynamic material, social and psychological environment by reflecting on it and modifying his ideas and behaviour, according to how he sees things.

Before we consider whether it is adequate to functional mental disorder, this classic medical model may already require certain provisos. For instance, with its rigorously licensed professionals and reliance on ever-more elaborate techniques, modern medicine displaces most alternative and folk remedies, some of which may be effective, cheap and readily available. Apart from opium, probably the best known is white willow bark, which has been in use for millennia. It is now known that, along with some powerful anti-inflammatory plant compounds (flavonoids), willow bark contains salicin, a chemical similar to modern medicine’s most popular drug, aspirin (acetylsalicylic acid); herbalists maintain that salicin is pain-relieving and anti-inflammatory. Again, the medical model developed mainly in response to infectious diseases, whereas nowadays healthcare systems have to cope increasingly with chronic and non-infectious diseases, and with what used to be seen as the inevitable problems of aging (e.g., cancer, heart problems, Alzheimer’s). It is therefore clear that it is not productive to regard every malady as simply the body’s reaction to a pathogen: many therapies are likely to be more effective when the patient is also viewed as a person who inhabits a particular material, social and cultural environment, and has his own emotional and psychological needs. It seems clear, for example, that soaring levels of obesity are not due to any specific physical disease, and yet the attendant illnesses are fast becoming an alarming burden to many healthcare systems.

As we will see throughout this book, however, functional mental disorder (usually called ‘mental illness’) is a completely different order of malaise from real disease, i.e., organic malfunction. The medical model is inappropriate for framing the conceptualisation and therapy of that kind of mental disorder since - by definition - it is *not* malfunction of any part of the body (the brain, for instance) but *behavioural and mental deviance*: the presenting problem is not a sick body but a disturbed or disturbing *person*. This fact - that the problem is a worrying kind of ideation and behaviour, not a malfunctioning part of the body - is not just *relatively* more important for mental health care and treatment than for general medicine: it is the point of an *absolute difference* between the two therapeutic projects. As our argument develops through the succeeding chapters, it should become clear that the model or conceptual scheme which is most appropriate for comprehending and helping most of those who behave in a troublingly irrational manner is one which puts centre-stage precisely those attributes which are usually of little or no concern to general medicine. That is to say, central is the fact that every person is *reflective* - he is an agent existing in a specific material, psychological and social context, and he trails a unique past and imagines a particular present and future.

As things stand, however, influence within the psychiatric system reflects the legal power devolved to doctors. In modern societies they have the first, last and by far the weightiest word on

any aspect of the management of someone's 'mental health'. Furthermore, anyone who is first of all trained for years in medicine - as are all psychiatrists - is almost bound to assume that mental disorder is due to some kind of brain malfunction, that it is the result of an illness. Hence, when doctors fail to discover signs of actual disease, and when they cannot perceive or imagine a sufficient emotional or social cause, their medical training leads them to assume that the worryingly aberrant things that a person says and does (which indicate for them a functional mental disorder), must *nevertheless* be due to brain malfunction. In those cases they assume that, as opposed to a structural disorder - one which is physically, chemically or genetically discernible - all the same there must be that medically bizarre phenomenon, a 'mental illness'. Within the psychiatric profession, and among general practitioners and psychiatric workers, dissent to this illogical conventional wisdom is negligible. It only registers occasionally, for example when a maverick doctor refuses to toe the orthodox medical line and endorse the indiscriminate medication of his mental health patients; he then finds himself persecuted by some or other medical authority.⁶

We oppose this conventional wisdom or 'common sense'. It is a step too far to assume that individual irrationality *must be*, at root, a brain malfunction. In point of fact, nothing outside of the range of normal organic functioning registers for the brain of someone diagnosed with any of the so-called mental illnesses - otherwise he would be sent for diagnosis and treatment by a neurologist. Strictly speaking, the individual is not ill. He may appear mentally or behaviourally deviant to a worrying degree, but only metaphorically is he sick; strictly speaking, it may only be correct to say that the person is mentally or behaviourally *deviant* or *abnormal*. And yet the whole of conventional mental health treatment is based on confusing metaphoric illness - so-called mental illness - with real illness, and on wishing to explain - or *explain away* - otherwise unaccountably grievous anguish, confusion and behavioural deviance as 'really' the product of a peculiarly elusive organic disorder.

The mental health or psychiatric medical model is constructed upon this confusion of metaphor with reality. In the textbooks there is no discussion of the model's assumptions or axioms, and there is no well-formulated theory. Neither, since it could not be, is the model grounded in any clear evidence. Nor do those who propose the medical model of mental illness - and hence the purported necessity for medical treatment - offer convincing arguments to support their beliefs. Instead, they make sweeping and unfounded declarations which follow from their prejudice that, even though none has been discovered, still there simply *must be* an organic cause for every serious mental disorder.

Why is it that, despite the lack of evidence, those who advance this unscientific 'model' refuse to question their blind belief? We have already suggested that doctors have a powerful emotional and material interest in believing that their ideas about mental health and its management are as scientifically legitimate as the ideas pursued by general medicine. It seems to us that this fallacy holds sway amongst psychiatrists, mental health officials and GPs because - along with most of the public - they dearly *wish* it were so. Critics who oppose the universal employment of the psychiatric medical model generally argue that the notion of 'mental illness' and its medical treatment serves certain political, economic and professional interests. There would seem to be some truth to this. Yet there is also no denying that serious mental disorder stirs up profound fears among witnesses - especially those who are immediately involved, but perhaps also among those whose profession it is to respond. Out of powerful fears and desires, strong but irrational wishes are born.⁷

Unfortunately, the errors in logic and science which psychiatry commits - and will never admit that it commits - are pivotal to the whole organisation of the mental health response. Whether wittingly or not, when psychiatrists convince everybody that metaphoric illness - so-called mental illness - is *actual* illness, they conduct an ideological sleight of hand whereby their bizarre medical model appears to be the most natural set of ideas and routines in the world. Many patients have not

6 RD Laing was the UK's most famous dissident psychiatrist. When the general political culture had taken a distinctly right-turn, and (as it turned out) towards the end of Laing's life, the General Medical Council finally engineered 'striking him off' the register of accredited doctors.

7 That there is a tight grip exerted on psychiatry by unfounded and wishful thinking - by magical thinking - is argued in detail below; see Chapter 13: The Psychopathology of Psychiatry.

found this trick amusing, however, since in effect the medical model of mental illness serves as the rationale for the routine maltreatment of distressed and confused persons, and denial of their human rights.

Never mind - the lack of evidence of an organic cause for functional mental disorder, or for the utility of the standard medical treatments, has had no perceptible influence on the training of doctors, psychiatrists and mental health workers. The advice to all doctors in their mandatory but brief psychiatric training may be summarised as: The more severe the mental illness (the more spectacular, vexatious or potentially dangerous the irrationality), the more certain there is a genetic or biochemical aetiology (cause), and the greater the need to employ chemical or physical medicine.⁸ Nowadays, it is fashionable to recommend cognitive behavioural therapy, counselling or even self-help groups for less serious cases of mental disorder - although this may not play out effectively in well-funded practice. But the textbooks never question the idea that those techniques which invade the organism - *those which have the appearance of authentic medicine*, i.e., drugging and electroshock - are essential for treating every more serious or chronic case.

So as to understand what psychiatrists and their co-workers might be thinking when they deal with cases of functional mental disorder - that is, psychological malaise, not brain disorders or actual illnesses - we invite the reader to examine the following extract from an influential textbook for trainee psychiatrists.

Several models are used in psychiatric aetiology but the so-called medical model is the most prominent. It represents a general strategy of research that has proved useful in medicine, particularly in studying infectious diseases. A disease entity is identified in terms of consistent patterns of symptoms, a characteristic clinical course, and specific biochemical and pathological findings. When an entity has been identified in this way, a set of necessary and sufficient causes is sought... [There follows an example of a real illness.]

This narrow kind of medical model has been useful in psychiatry, though not for all conditions. It is clearly relevant to syndromes with a well-defined organic aetiology, for example psychiatric conditions related to obvious cerebral disorder or a general medical condition. It is also applicable to severe psychiatric disorders such as schizophrenia and bipolar disorder. Until recently such disorders were called 'functional' in contrast to organic because the assumption was that brain dysfunction was present but the pathology (with current methods) could not be observed. Recent studies on the aetiology of schizophrenia have shown that this view is essentially correct. However, social and cultural factors also play a role in the presentation and course of the illness.⁹

We have no quarrel with the first paragraph which is a fair characterisation of the medical model employed in general (organic) medicine. However, the second paragraph becomes increasingly muddled and confusing, and some of what it says, and what it seems to intend, is simply not true.

Consider the declarations that '[this narrow kind of medical model] is...applicable to severe psychiatric disorders such as schizophrenia and bi-polar disorder'; and that '[r]ecent studies on the aetiology of schizophrenia have shown that this view is essentially correct.' This conjunction seems to be what the authors intend us to understand, although between the two sentences they interpose another which is ambiguous but does clearly express a half-truth: '...the pathology...could not be observed.' For while it is true that psychiatrists *used to assume* that brain dysfunction was present even when 'the pathology could not be observed', in fact they *still* make that assumption *and it is still unwarranted*. As opposed to what the authors seem to imply, it is not true that presuming brain dysfunction/pathology was a canny professional intuition all along because recent research now provides the evidence for it: *there is no such evidence*.

⁸ This is the gist of a best-selling introduction for doctors in their general training: Stevens, L & Rodin, I (2010) *Psychiatry: An illustrated colour text (2nd edn)*. Oxford: Churchill Livingstone.

⁹ Gelder, M, Harrison, P & Cowen, P (2010) *Shorter Oxford Textbook of Psychiatry (5th edn)*. Oxford: Oxford University Press, 85.

Meanwhile, this confused way of expressing things seems to go half-way towards contradicting the general gist of their own argument - and that only seems to confuse things further. The problem is that nowhere in the second paragraph is there any reference to research which might support what the authors obviously wish to suggest. In point of fact, there could not be any such reference, for notwithstanding a century in which researchers have tried to discover an organic cause, there remains no evidence whatsoever for any organic pathology causing the development of those typical deviant *psychological* conditions that psychiatrists diagnose as schizophrenia and bi-polar disorder. Neither is there evidence of an organic cause for any other type of functional mental disorder. So why do these esteemed authors seem to suggest that it *is* now known that brain pathology causes those serious psychiatric conditions? How could they be so ill-informed? Falling short of evidential proof, perhaps they could offer other good reasons for their belief? Evidence and argument are both conspicuous by their absence.

Staying with that second paragraph, there is the pronouncement that '[u]ntil recently such disorders were called "functional" in contrast to organic because the assumption was that brain dysfunction was present but the pathology (with current methods) could not be observed.' Why the assumption that brain dysfunction was present? Lacking evidence, why *assume* anything at all? If there is no proof of organic pathology, why not admit normal brain function but examine *psychological, personal* or *inter-personal* dysfunction? No matter how much psychiatrists and others might wish it, there are no epistemological (or technical) means to reduce mental events to brain events - and no need to, either. Quite another sense of the category 'functional mental disorder' is that the brain works well enough - which research shows that it does - but the person's *ideas* and *behaviour* are dysfunctional: the brain functions as well as any other but *the person* does not.

As well as this dubious assumption of brain dysfunction/pathology, we have already mentioned that the authors employ the past tense in the phrase '...but the pathology (with current methods) could not be observed...' Surely this is meant to imply that whereas previously, before all the latest technical advances, it was only *suspected* that functional mental disorder had an organic cause, nowadays it is possible to observe an organic (brain) pathology. And this is simply untrue. In support of their claim that the medical model '...is also applicable to severe psychiatric disorders such as schizophrenia and bi-polar disorder', and the suggestion that it is now known that these mental disorders are indeed due to brain dysfunction/pathology, the authors refer us only to an assertion later in their book that '...about 80% of the risk of schizophrenia [is] inherited.' No research is cited as evidence for any of these pronouncements, either; the unsubstantiated figure of 'about 80% inherited risk of schizophrenia' has been bandied about by the champions of biological psychiatry for decades. In fact, there is no evidence to support *any* of these authors' assertions about the part played by inheritance (genes) in the genesis of schizophrenia and bi-polar disorder.¹⁰

To be quite clear about this matter: *there is no evidence of an organic cause for any functional mental disorder*. What has changed in recent years is that, precisely under the pressure of the lack of evidence, pronouncements by mental health officials about organic causes for functional mental disorders have become more circumspect. Nowadays, the notion of 'determination' (measurable and absolute cause) is replaced by the less forceful and conveniently non-committal suggestion of 'risk factors'.

Qualification of the psychiatric medical model is also apparent in the last sentence of the second paragraph that we quote: 'However, social and cultural factors also play a role in the presentation and course of the illness.....' This vague suggestion is a cursory nod to social psychiatry, which reached its greatest influence within the profession around the middle of 20th century. But this proviso is

10 The brief quotes about schizophrenia are from Gelder, M, Harrison, P & Cowen, P, op. cit. (n. 9), 281. As an aside, at that point they inform us that this is not to say that if you have the wrong genes you will necessarily contract the terrible illness of schizophrenia, but rather that '...the genes act as risk factors, not determinants of illness.' This further unevidenced assertion permits the authors to seem to be nuanced scientists without their actually *being* scientific. The concept of schizophrenia, and the absence of any evidence for an organic cause, is examined in detail in Chapter 12, below.

quite unspecific, and in addition it is not thereafter in any way coupled theoretically or evidentially with the general 'medical' notion that the authors propose. Precisely which factors and what kind of a role? And exactly how much influence do they exert on 'the presentation and course of the illness'? The authors rehearse no arguments about this matter, but by mentioning 'social and cultural factors' they imply that of course they are not such cold and aloof technicians as to be unaware that there is a case to be made for extra-medical events impacting on emotional and mental life. As well as implying a 'fully-rounded' or 'eclectic' approach, this perfunctory aside is also useful as a caveat for 'the so-called medical model'. It lets the authors have it both ways: if in any particular case the medical model of diagnosis and treatment seems to fail, then it must have been one of those unspecified 'social and cultural factors' that caused the mental disorder or prevented its remedy or management.¹¹

There is one more puzzling element to the above quotation, i.e., the way the authors qualify the psychiatric medical model *as they introduce it*: '...Several models are used in psychiatric aetiology but the so-called medical model is the most prominent.' What can they mean by saying it is 'so-called'?

There would seem to be only two possible intentions. When a specialist feels his audience might not be familiar with a concept or technique used regularly in his field of expertise, so as to draw attention to how it is called by the specialists, he may say that it is 'so-called'. When delivering a lecture to the general public, for example, an astronomer might say that the idea that all the planets circle the sun is 'the so-called heliocentric model'.

On the other hand, the qualification 'so-called' is just as often used to indicate that the speaker feels that correspondence between the term or phrase and the thing to which it refers is questionable - that the concept is not suitable or true to its object, that it is in fact dubious and misleading. These authors do not introduce any of the other terms that they use in this manner, and yet many will surely be new to their readers - after all, a major purpose of any textbook is to acquaint trainees with the specialised terminology of the discipline. For example, they do not introduce the concepts schizophrenia and bi-polar disorder as 'so-called schizophrenia' and 'so-called bi-polar disorder'.

In which case, our suspicions are raised. It seems to us that in this instance the qualification 'so-called' could be an unconscious but revealing 'slip of the pen' - albeit that to speak of the medical model as 'so-called' is a qualification that is *often* voiced when psychiatrists mention the conceptual basis to their enterprise. Whether the medical model of mental illness and treatment should count as evidence-based scientific medicine, or that it is only *called* a scientific model and is only *said to be* medical, when in fact it falls short of the rigours of science and is not medicine as we usually understand the term, is surely a question fundamental to the entire mental health project.

Unless they explain what they mean - which they do not - we cannot tell exactly what the authors intend when that say that the psychiatric medical model is 'so-called'. (Just as we cannot tell what any other doctor intends when he makes the same qualification.) Do they mean that it is well-known - or at least that *these authors strongly suspect* - that the medical model concerning the causes and treatment of all those mental disorders which frustratingly appear to have no organic origin *is not in fact feasible*? Is it that the model does not really amount to a scientific theory because it simply cannot be made to work, i.e., in terms of experimental testing or generating a high level of reliable mental health predictions (prognoses) and treatment outcomes? And, if this is the case, is it because the model is not (or cannot be) adequately formulated? Like every other psychiatrist, the authors must have trained first of all in general medicine, which is to say, authentic medical science. Do they use the phrase 'so-called' inadvertently, thereby indicating that they repress from their own awareness, or

11 The confused but revealing second paragraph (which we quote in full), was not included in the next edition: see Cowen, P, Harrison, P & Burns, T op. cit. (n. 19, Ch 1), 87. That edition (the 6th) simply *makes no attempt whatsoever* to explain why 'the medical model' is appropriate for dealing with psychological (non-organic) malaise. And despite the publisher's claim that the new co-author brings a social-psychiatric perspective to the latest edition, neither does it make a better attempt than the 5th edition to reconcile a grudging acknowledgement of possible social or biographical causes with its unfounded bias in favour of biological determinism.

fail to admit, their knowledge that in reality there is no evidence at all to support the psychiatric medical model, and therefore that it is in fact only an unfounded and hazy belief based in wishful thinking?

As we will see in the following chapters, the psychiatric medical model should not be dignified by association with medicine, or with any bona fide science, no matter how imprecise (e.g., models of ecological-systems or weather-patterns). And after all, if the psychiatric medical model is not really a model, or not one that is adequately defined, thought-out or scientifically-grounded, and if it is not founded in evidence-based medicine, and if it does not generally work by being indisputably helpful to those individuals who suffer from mental disorder - why continue to believe in it and why insist on employing it as first, main and last resort?

It is curious that the reader seems to be alerted to the possibly dubious nature of the psychiatric medical model at the very point of its introduction. We might assume this was indeed a 'slip of the pen' since the authors proceed immediately to other matters without commenting at all on this strange qualification. They do not say why, *as distinct from the model employed by general medicine*, the conceptual scheme which underpins psychiatric theory and practice is articulated only as a 'so-called' medical model. Instead, Gelder, Harrison and Cowen promptly forget for the rest of their textbook that they seem to have called into question the medical model of the cause or causes of functional mental disorder, and hence its utility for understanding and therapy. Henceforward, for these authors - and for almost every psychiatric or mental health official and general practitioner - 'the *so-called* medical model' loses its ostensibly questionable logical and scientific status, and magically morphs into that 'medical model' upon which they rely, as an unquestioned and unquestionable matter of blind faith.

The psychiatric medical model is unproven, unhelpful and harmful

It is doubtful that the psychiatric medical model is often well formulated in the minds of many mental health officials. They are *health* workers, so of course they deal with illness: *mental* illness. While practicing by reference to a set of authorised yet unsubstantiated beliefs about the nature and origins of functional mental disorder, and its appropriate treatment, officials who employ the medical model as a matter of standard routine are unlikely to consciously articulate it, *and certainly not as a theory which ought to pass the usual tests for its scientificity*. The medical model of mental illness is usually an unscrutinised reflex - for professionals and public alike, it simply goes without saying.

This means that the attributes of the psychiatric medical model are mainly to be inferred from various atheoretic sources. First, there are the taken-for-granted working practices - except, since most are not based in sound science, they might more accurately be characterised as *magical rituals*: it is an article of faith for those who believe in the orthodox mental health paradigm that it is both unreasonable and highly irresponsible to try to deprive abnormally disturbed individuals of *medical* help by questioning the dogma that every kind of mental disorder is explained by medical science and needs the attentions of a physician. Next, there is what practitioners say when they try to persuade patients, carers or other interested parties to accept the diagnoses, prognoses and treatments which they offer or insist upon: officials affirm the undoubted existence of the many types of mental illness, and of bio-chemical brain imbalances and genetic predispositions, and they predict dire consequences for any patient who will not submit to the treatment they recommend. Then there are those rare occasions when an official is forced to explain his beliefs and actions (e.g., before a court of law). Lastly, the medical model of mental illness and treatment is to be inferred from the bias or 'thrust' of the textbooks and research.

We live in a culture which celebrates muscular, unreflective 'pragmatism', and is wary of 'intellectualism'. Consequently, the medical model is simply taken for granted by psychiatric and mental health workers at every level: it generates practices which have the look of scientific-medicine - routines in which something is manifestly done to patients, and which everybody agrees 'work'. This ideology and these ceremonies are so convincing that few mental health professionals are likely to be aware that they even make any assumptions, let alone that they might question them - or really

ought to do so. The operations of the psychiatric medical model are like the default settings of a prodigious and admirable machine. Nobody is able to provide a convincing rationale for them, but as long as the machine seems to do more or less what is expected of it, neither does anybody give them a thought. Why even look at the settings/routines, let alone change them? As with any bureaucracy, of course, for mental health practice 'what works' tends to be defined as whatever causes the least disruption to the peace of those responsible for managing things; in this case, the 'things' happen to be all those individuals who present with alarming emotional and psychological difficulties. As we will see during the course of this Volume, a consequence of the normal uncritical acceptance of the mental health medical model is that although current practices might seem less obviously inhumane than some of those employed in the past, often only minimal benefit to the patient is expected of any official intervention.

On the odd occasions when it is discussed by those who believe in it (in textbooks, for example), the psychiatric medical model is only ever 'so-called', and it is never adequately described or explained. Since it is not a well-formulated model or theory, and it has not been found reliable when tested, it is really only by inference that it is a theory or model at all. In fact, it only seems to reach any degree of coherent formulation by its critics, who are forced to clarify its contours as they can best discern them. In which case, it feels right to any critic that references to the psychiatric 'medical model' do need the phrase to appear between quotation marks. The idea that it is a *genuine* model or theory based in medical science, in the usual senses of medicine and science, is simply ridiculous.

Critics feel the same way about the notion of 'mental illness'. The assumption that every mental disorder is indisputably a kind of illness is fundamental to the psychiatric medical model. Surely a medical model must refer to illness? In this case: mental illness. It follows that mental illness 'must' exist materially, just like every other kind of illness. Few psychiatric or mental health officials are likely to argue with the belief that every serious functional mental disorder must have an organic cause - must *really* be the sign of a disease - even though the pathogen is not yet discovered. After all, that is what the textbooks say, and why else would someone in psychological crisis be made into a patient obliged to submit to medical treatment?

However, as psychiatrist Thomas Szasz pointed out nearly sixty years ago, mental illness is only metaphorically illness. Whereas thoughts and behaviour may be said to be in a state of *disorder*, a mind cannot be *ill*: to say that someone 'has a mental illness' is to jump illogically from one category of events to another - from abstractions, i.e., mental states (irrational ideas and intentions) to demonstrable organic processes, i.e., actual diseases. An individual's ideas may appear seriously unreasonable or dysfunctional, but if there are no discernible signs of neurological disease, by definition he *does not* suffer from an illness.¹²

Yet whenever the metaphoric nature of so-said mental illness goes unrecognised - which is to say, most of the time - this immediately results in illogical ideas and practices with regard to managing serious personal distress and confusion. Despite the absence of organic markers (symptoms) of true illnesses, doctors and other mental health workers insist that all the same their emotionally and psychologically disturbed patients suffer from conditions requiring medical treatment. And despite the absence of organic markers, research psychiatrists forever wish and search for them, hoping for a discovery which will at last prove that some or other kind of functional mental disorder always was an organic (brain) illness, all along. This confusion of real with metaphoric illness means that whenever officials deal with an individual's aberrant beliefs and behaviour as if his brain really were diseased - by 'diagnosing' a specific 'mental illness' and making this or that chemical or physical intervention - they act like someone who objects to the contents of a perfectly well-delivered television program and decides to fix his problem by tinkering blindly inside the live set with a screwdriver.

That the psychiatric medical model is incompatible with science and reason was already recognised by some doctors at the beginning of the 20th century. In spite of that, along with the best

12 See Szasz, TS (1960) The myth of mental illness. *American Psychologist* 15 113-118; also Szasz, TS (1961) op. cit. (n. 1).

organised lobby within the profession, the great psychiatric authorities of the time - Janet, Kraepelin and Bleuler - refused to engage with any arguments which threatened to confound their scientific aspirations, and stubbornly committed the whole discipline to the unproven medical model. In 1907, on returning from a conference of eminent psychiatrists, where the newly formed group of self-styled 'psycho-analysts' had tried in vain to put across their *psychological* approach, Jung reported to Freud: ...The rest of the proceedings at the congress were, as usual, futile. Once again I discovered...that without your ideas psychiatry will inevitably go to the dogs... Anatomy and attempts at [diagnostic] classification are still the rule - sidelines that lead nowhere..¹³

Very little has changed in the meantime. Modern treatments may seem less crude, but the agenda of the founding fathers of 'scientific psychiatry' remains firmly in place. However, the rationale for the psychiatric medical model nowadays tends to be more subtle than simply insisting on its validity and refusing to discuss matters. It is usually made more acceptable, allowing it still to govern mental health theory and practice, by the lip-service of allying it with the more reliable hypothesis of the social-psychodynamic perspective. From that point of view, anyone who becomes a mental health patient is not an individual who is simply fated to contract or develop a brain malfunction: he is someone who suffers from an emotional and psychological trauma. As a result, it is now common for mental health professionals to attempt to exercise their authority by creating the impression of adopting or being open to both the medical model *and* a social-psychodynamic perspective (as do the authors of the textbook quoted in the previous section). More than this, the psychiatric authorities are proud of their 'eclecticism', and most mental health workers would have it recognised that the ability to employ both models is a credential that signifies their standing on a kind of intellectual and moral high ground. By claiming not to be beholden to any single model, professionals can persuade themselves (and anyone with whom they have dealings) that they have no need to reflect on any criticisms - such as that it often seems that they are neither particularly open-minded nor scientific, nor particularly careful or caring. In practice, however, the social and psychodynamic approach falls by the way when dealing with more pressing cases, and doctrinaire adherence to the so-called medical model takes over. We noted that the authors of the textbook we quoted allow that '...social and cultural factors also play a role in the presentation and course of the [mental] illness...' But they do not specify exactly what role, thereby rendering that information operationally useless.

An example of the kind of half-hearted recognition of extra-medical factors 'in the presentation and course of an illness' is provided by the Recovery Model. Recently, at least notionally, it became the touchstone for good mental health practice. This model has been described as

...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles... A way of living a satisfying, hopeful and contributing life even within the limitations caused by illness..¹⁴

On the face of it, this seems laudable. Mental health professionals might be able to provide tangible benefits if they were to embrace the idea and, with sympathy and empathy, engage patients in discussions about their lives, so as to give them all the practical assistance they needed.

In 2009 the recovery model became part of official policy for the UK..¹⁵ However, it is clearly intended as a kind of add-on, to run alongside the medical model but not replace it. Thereby, policy now legislates a contradiction in the mental health project. Rather than only submit passively to treatment - as demanded by the medical model - the recovery model asks the individual to definitely *do* something: to change his attitudes, feelings, way of living, and so on. Presumably he can only do any of that by exerting his will; and yet he is still said to suffer from an illness, i.e., some or other

13 Freud, S & Jung, CG (1991) *The Freud/Jung Letters: The correspondence between Sigmund Freud and CG Jung* (Ed McGuire, W) Harmondsworth: Penguin, 79. Freud's ideas about the method that psychiatry should employ (i.e., psychological analysis), and the narrative nature of its accounts, are encapsulated in the quotation (note 45) in Chapter 16 (Volume 2), and elucidated and commented on in Chapters 21, 22 and 26 (Volume 2).

14 Anthony, WA (1993) *Recovering from mental illness: The guiding vision of the mental health system in the 1990s. Innovation and Research* 2 17-24.

15 *New Horizons: A shared vision for mental health* (2009) London: Department of Health.

diagnosed mental illness. By definition, however, illness is precisely a condition from which a person is unable to recover by sheer force of will - by changing his attitudes, values, feelings, goals, etc. Consequently, rather than a radical and positive realignment of mental health therapy, the recovery model amounts to little more than a handful of ill-considered, supposedly inspirational, self-help 'sound-bites' thrown into the 'eclectic' psychiatric mix - a mix still dominated by the medical model.

In any general comprehension of the mental health enterprise, it tends to be overlooked that psychiatry's proclaimed eclecticism consists of no more than a few pinches of non-medical salt thrown into the great pot of medical model porridge, so as to make it more palatable. The true force of the psychiatric medical model, which is to say its strict government of mental health practice, goes largely unchallenged because officials like to operate by 'having it both ways'. The so-called medical model is generally endorsed as 'a matter of common sense', and yet this same common sense could equally suggest that the cause of any patient's distress and mental disorder is obviously his inability to cope with specific apparently intractable personal or social problems. Logically, that view would employ an alternative belief system, one which presumes social and psychological reasons for mental disorder *instead of* a medical cause. In practice, however, and without much evident forethought, officials tend to 'cherry-pick' either kind of 'common sense' understanding. By unconsciously 'flip-flopping' between the two models, they develop an ad hoc or 'off-the-cuff' strategy towards the care and treatment of each patient - one said to 'depend on the patient's progress'. This is celebrated as 'being pragmatic', and it supports the image of mental health care and treatment as consequent to a robust science and yet also sensitive and humane. In this scenario, the psychiatric medical model is offered as no more than an important component within an open-minded, moderate and broad-based approach, operating in tandem with social and psychological awareness. The net result, though, is mainly the production of a dubious alibi for drugging the great majority of mental health patients, as well as subjecting a significant minority to electroshock. The social-psychological component of this 'eclectic' and 'common sense' ideology serves largely to legitimise medical treatment as 'realistic' in the context of the unfortunate necessity of 'adjusting' most patients to the situations which triggered their crises in the first place.

By their training, then, those who practice mental healthcare and psychiatry are indoctrinated into the belief that they 'cover all the bases'. It remains the case, however, that the main use of the social-psychodynamic idea is to confuse the issue by masking and making acceptable a poorly theorised, unsubstantiated and oppressive hypothesis: the psychiatric medical model.

Meanwhile, every standard psychiatric textbook presents itself as an up-to-date authoritative account of purportedly medical - that is, *scientific* - practice, theory and research about which every expert is (or soon will be) in full agreement. Psychiatry is represented as a historically accumulating consensus of ever more scientifically reliable solutions to the fairly well understood problem of the various kinds of mental illness. If a different theory of emotional distress and mental disorder is presented - such as that informing psychotherapy - it is not generally explained, argued or criticised as a refutation of the so-called medical model of mental disorder, i.e., as entailing an entirely different kind of explanation, care and treatment. Instead, it is simply added to the eclectic 'toolbox', while care and treatment remains essentially run along lines that are *said to be medical*. But this consensus based in medical science - as vouched by the conventional texts - has only ever existed in the wishful thinking of those who wield psychiatric power. We will see that the general belief that medical psychiatric practice is based in sound scientific evidence is, in fact, false. As this Volume proceeds we refute the testimonies of those who support the medical model, and discuss in more detail the muddled and disingenuous nature of what is offered as 'broad-minded eclecticism'. (The failure of research to confirm the psychiatric medical model is a particular focus of Chapter 12: Is schizophrenia really an illness? and its Appendix.)

If it is not revealed for what it is, this grand deception - the so-called medical model - makes the whole of the mental health enterprise endlessly difficult to fathom. In point of historical fact, psychiatry has developed hardly at all as a type of theoretically-informed science but rather as a hit-and-miss practice which simply follows the most practical chance precedents that seem to prove useful, to a degree, while not too often being too spectacularly harmful to those forced to accept

treatment as patients. In addition, utility or efficacy is measured first of all by how much the techniques help control behaviour judged to be a nuisance or a danger, rather than by the extent to which the patients' well-being and quality of life really is improved. Psychiatric medicine is not like other branches of medicine, in which there is usually a reasonably clear cause for each manifestation of a specific illness and hence, for each case, a fairly clearly indicated technical intervention and a reliable way to evaluate the outcome. By contrast, with regard to the functional mental disorders which make up most of the work in hand, mental health medicine is inadequately theorised and has never been able to point to any evidence establishing an organic cause or clearly proving the value to the patients of any of the treatments.

It is therefore not true that the standard psychiatric responses - medication, electroshock and occasionally lobotomy - improve brain function or correct biochemical imbalances. On the contrary, they *cause* biochemical imbalances and brain dysfunction: their only therapeutic value is precisely *to disrupt* brain function. These interventions appear effective only if doctor, family, patient and society view a degree of cerebral impairment in the target individual as beneficial. Psychiatric medicine 'works' by causing mental disabilities such as amnesia, lethargy or euphoria; depending on a patient's original 'high' or 'low' condition, this is interpreted as improvement. At the same time, the continued employment of medication is to an extent determined by the fact that withdrawal often produces severe psychiatric symptoms such as anxiety and depression: i.e., it is too painful and difficult for people to stop taking the drugs.

More than this, Peter Breggin argues that there is

...*medication spellbinding*, which is the capacity of psychoactive drugs to blunt the individual's appreciation of drug-induced mental dysfunction and, at times, to encourage a misperception that he is doing better than ever when he is, in fact, doing worse than ever. In the extreme, medication spellbinding drives individuals into bizarre, out-of-character destructive actions, including suicide and violence. Medication spellbinding is an aspect of the brain-disabling principle that explains why so many individuals take drugs of all kinds, from antidepressants to alcohol, when they are causing them great harm and even destroying their lives.¹⁶

As our argument unfolds, it becomes clear that psychiatry fails as scientific medicine. Nor is there much chance of success in the future. This is because its topic - individual irrationality - is fundamentally misconceived as a *medical* problem rather than what it really is, i.e., a problem with psychological, existential and social dimensions.

Despite advances in technology - EEGs, scanning, etc. - we know little about how brain states correspond to mental states and even less of any psychiatric significance. As mentioned in Chapter 1, even if we knew a lot this might simply pose a chicken-and-egg conundrum: does brain abnormality cause dysfunctional mental constructs (mental disorder/mental illness), or vice versa, is a discernible brain abnormality the product of aberrant emotion and ideation? In this Volume we will see that most of psychiatry's science is hopelessly flawed and its medicine highly dubious. Orthodox psychiatry simply prejudges (i.e., guesses) the question of aetiology (cause) in favour of physiology - 'biochemistry' or 'genetics'. It is true, of course, that a medical intervention may temporarily influence a person's mood or capacity for consciousness: a sedative may quieten a patient (and also debilitate him and cause slurring and confusion), and a euphoric might 'raise' his mood (and disinhibit him). Likewise, shock treatment may sometimes appear to remedy a mental disorder, to an extent, by lobotomising the patient (or perhaps by intimidating him). In other words - and in the short term - psychiatrists are sometimes able to alter the biochemistry of the brain (or coerce the patient) sufficiently to change his priorities, distance him from his problems or change his attitude towards them. Otherwise, if psychiatry appears beneficial, this is as much *in spite of* medical treatment: benefit is provided by placebo or non-medical factors such as respite and care.

16 Breggin, PR (2008) *Brain-Disabling Treatments in Psychiatry: Drugs, electroshock and the psychopharmaceutical complex* (2nd edn). New York: Springer Publishing. (Our emphasis.)

For, unlike any other medical specialty, the first effect of psychiatry is not treatment but *the social intervention*. It is therefore not possible to teach good psychiatric practice by starting from basic principles and proceeding to ever more complex categories and relationships - as, for example, textbooks may plausibly present the topics in general medicine. Nor does psychiatric care and treatment have well defined appropriate technical steps or stages, each proceeding sequentially by a necessary causal determination to the desired outcome of cure or remission. Psychiatric practice is not the same order of activity as medical attention for a broken leg, a constitutional condition, a heart-attack, an infectious disease or a cancer.

This might explain why there are so many unsatisfactory books on mental health and ‘the types’ of mental disorder. Everyone has a different opinion about functional mental disorder and its appropriate treatment. Even so, few commentators seem to realise that mental health problems are *fundamentally* different from problems of physical health: they are questions of psychology and interaction - not biological phenomena but *cognitive and normative*.

Any natural science (including general medicine) addresses problems by formulating testable hypotheses to establish fairly indisputable facts; this generates a relatively high degree of consensus about causes and the conceptualisation of the field. Things are quite different with mental health. First of all, regarding the organic mental disorders, there is a demonstrable neural (brain) disease which happens to produce undesirable mental or behavioural effects. As such, a cause for the mental or behavioural dysfunction is traced within the organism, and the problem may or may not be remedied by some or other medical technique. Dementia, for example, may be caused by physical trauma, organic degeneration (aging) or disease (e.g., meningitis). Again, psychosis may be due to substance-abuse, in which the chemistry or structure of the brain is altered by toxins such as alcohol, solvents, cannabis, etc. Organic pathologies are the least puzzling and they make up only a small part of the mental health or psychiatric caseload.

Alongside care and treatment for the organic mental disorders, however, most of the provision for functional mental disorder (mental illness) also has the appearance of regular medicine. Individuals who appear mentally disturbed present for care and treatment and there are traditionally developed medical categories and routines by which the professionals classify and work on each patient. This kind of processing became dominant towards the end of the 19th century, when overall management of the mad was increasingly appropriated by the medical profession, displacing ‘moral management’. By the early years of the 20th century the management of madness had become the monopoly of Medicine and, inexorably, the outlook, vocabulary and formal practices of managing individual irrationality became ‘medicalised’.¹⁷

As we have remarked, no matter how much doctors may wish it, for the functional disorders (the so-called mental illnesses) there is *by definition* no clearly identifiable disease to call forth a scientifically proven medical-technical response. Nor has any study ever demonstrated unequivocally that medical treatment is able to cure a functional mental disorder, or even to ameliorate it more effectively than non-medical therapies or no technical intervention at all. It is difficult to separate out any possibly helpful effects of psychiatric medicine from those of faith or placebo, or from the benefits of care, respite, compassion, reassurance and solidarity. Research has not adequately addressed this issue, but while there is no clear evidence for the efficacy of psychiatry’s medical treatments, there is some for benefit from the social intervention itself. Sympathetic and reassuring care is always likely to reduce a patient’s anxiety and panic, and hence the urgency with which he clings to his unrealistic constructions of reality (his mental disorder).

Moreover, as we also mentioned, if it is simply the case that someone announces peculiar ideas or behaves very strangely, saying that he is ‘sick’ or ‘has a mental illness’ is to employ a confusing metaphor. And if the metaphor is taken literally - which it is, regularly - this commits a category mistake, a confusion of physiological with psychological and cultural dynamics; simultaneously, it makes an aesthetic, moral and political judgement. Arguably, notions and perceptions may be bizarre,

¹⁷ We discuss the theory, practice and success of moral management, its eventual demise, and the emergence of psychiatry out of general medicine, in Chapter 1; see the section: A brief history of the management of madness.

false or upsetting, but not *ill*. Anyway, mental processes or states may only be adduced by private introspection or public expression: it is futile to try to establish the identity of mental events and brain processes by means of neurology.¹⁸ Any condition diagnosed as a mental illness is not a disease or illness but nothing other than worryingly irrational ideation and behaviour. Rather than symptoms of a *disease*, irrational ideas and behaviour are tokens of an individual's profound *unease* - an indication of his being overwhelmed by the intensity of his aberrant emotions and too completely preoccupied by a struggle with his own unbidden and distressing thoughts and feelings. In which case, judgements about mental ill-health are rarely genuinely medical but they are very often quasi-judicial. Inasmuch as psychiatrists have the legal power to curtail an individual's freedom, and are able to do things to him against his will - 'for his own good' - this aspect of mental health provision, as Thomas Szasz pointed out, is chillingly reminiscent of the Papal Inquisition.

Mental illness *is* post-traumatic stress disorder

Meanwhile, in the last thirty years or so it has become widely acknowledged that someone who has a preoccupying and disabling emotional or psychological reaction to surviving any obviously horrific event, even without sustaining a serious physical injury, suffers from post-traumatic stress disorder (PTSD). There is no suggestion that this mental disorder has a biological cause. Instead, it is viewed as a severe and ongoing emotional reaction to an extreme psychological trauma that develops from exposure to one or more terrifying events which caused or threatened grave physical harm and overwhelmed the person's psychological defenses and ability to cope. Stressors may include serious physical injury, being close to a violent death, a threat to the person or someone else's life, or any other serious threat to one's physical or psychological integrity. Anyone diagnosed with PTSD is officially entitled to compassion and counselling, and often to financial compensation.

Post-traumatic stress disorder is recognised as

a severe anxiety disorder with [the] symptoms resulting from a short-lived trauma.... The essential feature is the development of characteristic symptoms following a psychologically traumatic event.... [These] involve re-experiencing the traumatic event, numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric [unease], or cognitive symptoms.

The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps)....

The traumatic event may be experienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is re-experienced.... Diminished responsiveness to the outside world, referred to as 'psychic numbing' or 'emotional anesthesia', usually begins soon after the traumatic event.... After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyper-alertness, exaggerated startle response, and difficulty falling asleep.¹⁹

PTSD is diagnosed for those able rationally to report chronic emotional distress and mental turmoil due to injury or severe psychological shock. According to the Royal College of Psychiatrists,

18 This is demonstrated in Chapters 12 and 13, below.

19 *DSM-III*, op. cit. (n. 103, Ch 1), 236. PTSD was first endorsed by the psychiatric profession in the 1980 edition of this American mental health handbook. As a diagnostic category, PTSD is now considered distinct from Traumatic Stress, which has less intensity and duration, and Combat Stress Reaction, which is also reckoned transitory. See Brunet, A et al (2007) Don't throw out the baby with the bathwater (PTSD is not overdiagnosed). *Canadian Journal of Psychiatry* 52 8 501-503.

typical symptoms include sleep disturbance and nightmares, confused amnesia or persistent vivid recall ('flashbacks') of the event, and perhaps a dulled response to others and the world in general;²⁰ the original trauma is confirmed by reputable witnesses.

A decade or so after PTSD was incorporated into the psychiatric canon, Judith Herman discerned a variant: complex post-traumatic stress disorder (C-PTSD).²¹ This category is not yet adopted by the American Psychiatric Association but it is accepted in the UK: 'Complex PTSD may be diagnosed in adults or children who have repeatedly experienced traumatic events, such as violence, neglect or abuse.'²² C-PTSD is considered more severe where the traumatic events happened early in life, where trauma was caused by a parent or carer, where it was experienced for a long time, where the individual was alone during the trauma, and where there is still contact with the perpetrator. Since it may take years for the signs of C-PTSD to be recognised as such, a child's development, including his behaviour and self-confidence, can change as he gets older; adults may feel separated from others and lose their trust in people. Symptoms of C-PTSD are 'similar to those for PTSD' but may include feelings of shame or guilt, difficulty controlling emotions, periods of lost attention and concentration (dissociation), somatic ill-effects (e.g., headaches, stomach-aches, dizziness or chest pains), difficulties with relationships or being cut off from friends and family, and risky or destructive behaviour (e.g., self-harm, alcohol or substance abuse, and suicidal thoughts).²³

We argue that the root cause of any behaviour diagnosed as a functional mental disorder (mental illness) is unlikely ever to be discovered in a physical lesion, aberration or brain disease. Bearing in mind the above quotation and the other information we give regarding the causes and signs of PTSD/C-PTSD, it seems clear that the first hypothesis should rather be that any individual said to 'have a mental illness' suffers from disabling distress and confusion due to an unacknowledged but profound *psychological* trauma; that the mental disorder is a result of the person's overwhelming anxiety and panic, and is therefore *a type of post-traumatic stress disorder*; that any functional mental disorder (mental illness) is generally triggered by the burden of a current stressor additional to the high level of anxiety engendered by secret or undisclosed cruelty, conflicts or terrors experienced by the individual (usually during childhood); and that when it appears chronic, the mental disorder consists in the person's longer-term imaginative but dysfunctional accommodation to his persistent and overwhelming anxieties.

In other words, due to an excessively traumatic personal history, anyone said to have a mental illness is not ill, in any normal sense of the term, but suffers from specific entrenched emotional and psychological problems. In which case, essentially *the same kind* of compassion and help offered to someone suffering from what is recognised as PTSD or C-PTSD²⁴ ought to be extended equally to anyone diagnosed with a functional mental disorder (mental illness). Apparently, C-PTSD is not yet included in the *DSM* because the great majority of subjects who show signs of the condition are already diagnosed with another well-established psychiatric diagnosis. However, it seems to us that this only underlines the arbitrary nature of the mental health diagnostic system; at the same time it begs the pivotal question of the aetiology of functional mental disorder/mental illness, since by now it is apparent from many decades of research that the root cause of any behaviour or ideation diagnosed as such is unlikely to be discovered in any kind of brain pathology.

It is interesting that neuro-imaging studies demonstrate significant neurobiologic changes with post-traumatic stress disorder, and these are the results, not the causes of the psychological condition. Compared with control subjects, three areas of the brain appear abnormal for PTSD patients: the

20 A full list of symptoms may be found in the leaflet: *Post-traumatic Stress Disorder* (2014) London: Royal College of Psychiatrists.

21 Herman, JL (1992) *Trauma and Recovery: The aftermath of violence - from domestic abuse to political terror*. New York: Basic Books; Herman, J L (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress* 5 3, 377-391.

22 *Complex PTSD* (2015) NHS Choices 6 Sept.

23 *Complex PTSD*, op. cit. (n. 22).

24 See Wilson, JP & Keane, TM (2004) *Assessing Psychological Trauma and PTSD*. New York: Guilford Press.

hippocampus, the amygdala and the medial frontal cortex. The amygdala appears hyper-reactive to trauma-related stimuli. It has been proposed that '[t]he hallmark symptoms of PTSD, including exaggerated startle response and flashbacks, may be related to a failure of higher brain regions (i.e., the hippocampus and the medial frontal cortex) to dampen the exaggerated symptoms of arousal and distress that are mediated through the amygdala in response to reminders of the traumatic event.'²⁵ There is also evidence that exposure to exceptional degrees of stress affects the development of the hippocampus: compared to controls, studies of adults diagnosed with PTSD indicate smaller hippocampal volumes. Studies of children with post-traumatic stress disorder have not replicated the smaller hippocampal findings for adults, so this suggests that a smaller hippocampus may be caused by exceptional stress during neurodevelopment. Although not empirically demonstrated in humans, animal research indicates that the glucocorticoids secreted during stress can be neurotoxic to the hippocampus; a small study (n=15) of maltreated children with post-traumatic symptoms and high cortisol at baseline showed that over the next year to eighteen months the hippocampus did seem to reduce in size.²⁶

Of course, it is not standard practice to scan the brains of everybody who presents with PTSD, C-PTSD or any other kind of mental health condition. But what is it that separates that form of post-traumatic stress disorder which is officially validated - i.e., diagnosed, treated and researched by psychologists and psychiatrists - from the far greater number of instances of seriously distressed and confused responses to emotional or psychological trauma which are known as one or other kind of functional mental disorder (mental illness)? It seems to us that the crucial difference is that a psychologically traumatic event is publicly acknowledged for every diagnosed PTSD or C-PTSD - because there are reputable witnesses - while with functional mental disorder (mental illness) there is no such public recognition. In other words, the diagnosis of a functional mental disorder (mental illness) is routinely employed for all those forms of post-traumatic stress disorder where there is no independent acknowledgement of a traumatic event and it seems that the subject cannot remember, or cannot or will not articulate a memory of a trauma, or is not believed if he does recall a trauma; the psychological trauma goes unrecognised, either by the subject (who has forgotten it, represses the memory or feels unable or too fearful to speak of it) or by any witnesses, or by those officials authorised to assess his mental and emotional condition.

That functional mental disorder (so-called mental illness) is *always* PTSD - and the most common kind - is explored throughout Volume 2. The hypothesis that the root to any functional mental disorder is psychological trauma, usually in childhood, i.e., that it is unrecognised post-traumatic stress disorder - or probably more often complex post-traumatic stress disorder (C-PTSD) - is confirmed by an increasing number of statistical studies during the last twenty years or so. The reader is referred to Chapters 23 and 24 in Volume 2 for a more detailed argument and research evidence.²⁷

In reality, of course, irrational psychological accommodation to overbearing anxiety is by no means unusual. As long as many people share an anxiety, the imaginative accommodation to it often takes an entirely acceptable form as an element of the general culture or ideology. Many points of religious dogma are irrational, and they tend to be the beliefs that are most fiercely defended. But many widely held secular beliefs are also irrational. This book is written precisely because it seems to us that blind faith in the psychiatric medical model and the efficacy of standard mental health

25 Nutt, DJ & Malizia, AL (2004) Structural and functional brain changes in post-traumatic stress disorder. *Journal of Clinical Psychiatry* 65 Supp 11 11-17.

26 Carrion VG, Weems, CF & Reiss, AL (2007) Stress predicts brain changes in children: a pilot longitudinal study on youth stress, posttraumatic stress disorder, and the hippocampus. *Pediatrics* 119 509-516; also Wlassoff, V (2015) How does post traumatic stress disorder change the brain? *Neuroscience & Neurology* 24 Jan.

27 See Chapter 23: The Genesis or Character, especially the sections: The effects of oppressive childrearing, The cycle of childhood oppression, The conditions for the development of mental abnormality, The incidence of child abuse and its association with adult mental disorder: research findings, and The psychotic response to oppression in childhood. Our discussion is summarised in Chapter 24: The Functional Mental Disorders.

treatments figures prominently amongst the various popular but false beliefs about personal and social formations.

Psychiatry makes the elementary cognitive blunder of confusing psychological conditions with organic conditions, and it has done so for a century and more. No doubt it was led to do so because misperceptions such as hallucinations, and very worrying moods and behaviours such as depression and mania, are sometimes the signs of real diseases. With regard to the vast majority of today's presenting cases, however - the functional mental illnesses - psychiatric care is essentially a hybrid of social control and welfare work, an enterprise in which the patient's life is managed for him when he seems too distressed or confused to cope without guidance. And since there is no demonstrable organic cause for most cases of mental disorder, the remedy is rarely medical, even when drugs or other apparently medical techniques are employed. Rather, if psychiatry seems successful at containing individual irrationality and helping patients to return to some semblance of normal daily life, it is mainly due to its powers of persuasion and coercion. This was announced decisively in separate critiques formulated more than fifty years ago by the psychiatrist Thomas Szasz and the sociologist Erving Goffman. Additionally, if there is no such thing as mental *illness*, it follows that psychiatric diagnosis is not a matter of discerning a disease by means of medical science. Instead, it is an attempt to *explain away* the underlying causes of disabling emotional distress and mental disorder; at the same time, it is an act of labelling not necessarily convenient to the distressed person but rather to the doctors and other officials charged with somehow assorting and then 'renormalizing' those delivered to care.²⁸

No doubt the urgency with which psychiatrists believe in their taxonomy of mental disorders (the so-said mental illnesses) is based in the alluring possibility that one day, by means of such a list, they will be able to develop a well-founded and authentic (i.e., predictive) scientific medicine. Even though, after one-hundred-and-fifty years of research, the project of developing evidence-based medical psychiatry still shows no signs of succeeding. Of course, this is not recognised in the beliefs and practices of most mental health professionals, where a diagnosis is supposed to indicate the sort of care and treatment required for that particular *illness*, i.e., for that type of so-said mental illness. In keeping with the psychiatric medical model, professional responsibilities are currently met when the patient is assigned a diagnosis, when provision is made for his basic material needs (safety, food and shelter), and when an attempt is made to combat his purported illness (his mental illness) by the routine application of an allegedly appropriate medical technique - perhaps shock treatment, but most often some kind of psychotropic medication.

Yet it is our contention that a functional mental disorder is engendered only when the individual is overwhelmed by relentless emotional distress and mental turmoil. In the following chapters we will see that the medical model specifically precludes any meaningful exploration of the psychological and social grounds to individual emotional distress and mental disorder. Indeed, on the twin grounds of irrelevance and objectivity, this neglect is *mandated* by the psychiatric medical model: it is already determined that the person 'has an illness' (a so-said mental illness), which is perceived from his worrying irrationality, while the doctor (or any other official) would risk his 'medical objectivity' were he to 'get too involved with the patient' - were he to listen carefully and respond to him as a person rather than recognise and treat the alleged illness. Thereby, a mental health diagnosis serves as a cast-iron excuse for not caring much about the particular person and what he might have to say about anything whatsoever.²⁹

28 See Szasz, TS (1960) op. cit. (n. 12), and Goffman, E (1961/1968) *Asylums: Essays on the social situations of mental patients and other inmates*. Harmondsworth: Penguin, 350-366. Both essays are reprinted in Brown, P (Ed) (1973) *Radical Psychology*. London: Tavistock, 7-45. The arguments of Szasz and Goffman are discussed in the text to notes 8-13 in Chapter 15, below.

29 This observation is corroborated by examples throughout this Volume, and especially in Chapters 4, 5, 13 and 14. In Chapters 13 and 14 we also try to account for the widespread and perennial popularity of mental illness diagnoses rather than psychodynamic accounts. It is true that psychiatry does pay a certain lip-service to concern

In addition, the demand always for a medical diagnosis inspires a pernicious but unacknowledged social-psychological dynamic across the whole of the mental health service. It is well known that members of any social group forge their identities both positively and negatively, as to who they are and who they are not, who is included and who excluded from the group.³⁰ This makes any mental health diagnosis inevitably an act of stigmatisation and exclusion; simultaneously, it performs the ideological and micro-political function of defining as undoubtedly normal, rational, and non-culpable everybody around the site of a mental health crisis who is *not* diagnosed as suffering from an abnormal emotional or mental condition.

As we will see throughout this Volume, the professionals congratulate themselves on providing an enlightened and progressive mental health service, and the public agrees. Yet it seems to us that the attribution of an essential difference - a mental illness - to anyone in the throes of an incapacitating mental disorder, i.e., anyone who seems inconsolably upset, preoccupied and confused - in fact, emotionally and psychologically traumatised - is a matter of the abuse of their human or civil rights as serious as, for example, institutionalised racism or sexism. But unlike racism or sexism, this kind of labelling is not recognised as an issue, let alone an important one. A person only becomes very irrational when he is overwhelmed by the perceived pressures of his difficulties. By the stigmatising, prejudiced and callous attitude it habitually takes towards the patient, however, the conventional mental health response is likely to inflate his anxiety and exacerbate problems that officialdom is supposed to resolve. Adding injury to insult (i.e., the stigmatising mental illness diagnosis), it is also likely that the allegedly medical-scientific treatment for the so-said illness will add to the person's problems by causing painful, disorientating, disabling and sometimes irreversible harm to his nervous system or other vital organs.

First and foremost in the quest for valid knowledge about mental disorder and an appropriate response, then, is the need to recognise the consequences of delegating care and treatment to a branch of medicine. That physicians are required to arbitrate the management of every kind of mental disorder is a source of great confusion. Whereas, by definition, functional mental disorder has no discernible organic cause, just the same every doctor calls it 'mental *illness*'. Neither are doctors able to claim the ability to cure any kind of functional mental disorder; and if they do attest to certain limited successes with the treatment of some mental disorders, they cannot say exactly how they came by them. A psychiatrist is unlikely to allow that his clinical judgements (diagnoses) are not informed by genuine medical science but instead are intrinsically aesthetic, moral and political; and, of course, he is hardly likely to admit that the standard mental health treatments are fundamentally misconceived and that this medicine might act as the alibi for coercive social power. On the contrary, doctors imply that psychiatric medicine is the product of scientific progress, while in practice they refuse to take seriously the evidence that many treatments are often harmful.

There is a fundamental difference between psychiatry and every other branch of medicine. General medicine discovers organic causes and effects, and thereby possible modes of remedy or prevention. Although the doctors call them 'mental illnesses', medicine is unable to provide insight into the functional mental disorders since they are not organic pathologies but undesirable emotional and psychological states. Due to this anomaly, the mental health patient (and each official) finds himself participating in an ongoing bureaucratic enterprise of so-said medical assortment, care and treatment for which, curiously, nobody can account with any great confidence or plausibility.³¹ Psychiatry's best rationale is a desperate hope: it takes responsibility for anyone who 'has a serious

for the patient's sociability - it says he should be encouraged to associate with others - but *in principle* the psychiatric medical model is disinterested in psychology and social-psychology.

30 Anthropologists often remark that tribes or groups outside of the 'civilised' mainstream unselfconsciously view themselves as 'human' and every outsider as 'non-human'; to a less outspoken degree this proclivity has been noted for neighbouring urban communities. See Elias, N & Scotson, JL (1965) *The Established and the Outsiders*. London: Frank Cass & Co.

31 See the experiences reported by some psychiatric workers, in Chapters 9 to 11, and our investigation of psychiatric theory and research in Chapter 12 and its Appendix, below.

mental illness' and, by employing rule-of-thumb but unproven 'medical treatments', tries to 'make the patient better'.

Later in this Volume we will see how the fanatic desire to achieve objectivity and scientific precision drives the psychiatrists to deny the real basis to every functional mental disorder, which is to say, extremely troubled subjectivity. Since anyone diagnosed with such a condition is not ill but only worryingly deviant, every aberrant thing he says or does only serves to confute and confound that 'medical expertise' which, unlike much general medicine, can never achieve a satisfying degree of efficacy. The very existence of every disturbed patient, and the annoying tendency for his malaise to persist or recur or alter in spite of treatment, tends to increase the anxieties and compensating medical fanaticism of the doctors.

On the other hand, by substituting an explicit developmental social-psychological approach for the confusions of the psychiatric medical model, the physician would become simply another member of the welfare team, required to check for the *possibility* of a neurological illness, as well as for assessing general physical health. This would be a vital role, of course, but ancillary to the main project of mediating personal and inter-personal conflicts and offering a degree and kind of psychological, personal and social assistance not provided by other agencies.

As we say, none of the above is to deny that one day it may be discovered that organic processes play a greater or lesser part in the genesis or development of one or other functional mental disorder. For instance, each of us is host to a vast, unique and evolving microbiome, incorporated from the environment into which we are born. This is known as 'the second genome'.

The human gastrointestinal tract alone contains a delicately balanced ecosystem of 100 trillion micro-organisms, nearly ten times the number of cells in the entire human body. These bacteria in our gut, ...collectively called the gut microbiome, play many physiological roles in the body [such as] synthesizing vitamins, developing the immune system, aiding digestion...and managing the stress response.³²

While the body's genes are fixed for life, the constitution of its microbiome is essentially established during the baby's first three months. And although the family (especially the mother) is likely to contribute many of the micro-organisms, each microbiome usually has quite a different character from any hosted by the people around; it is also susceptible to specific and rapid alterations in response to changes in behaviour (e.g., foods ingested) or the environment. This area has recently been opened up to research, and it is known that each set of microorganisms presents a far greater total genome than that of the body itself, and that particular micro-organisms interact crucially to benefit or harm physical health. Furthermore, animal studies indicate that specific constituents of the gut microbiome influence mood and cognition. Although there are not yet many definitive results with human subjects, research seems likely to have important implications for conditions such as autism and Aspergers, but perhaps also for functional mental disorders such as eating disorders, anxiety, depression, bipolar disorder and schizophrenia.

The need for change

The rationale for the established administration of incapacitating emotional distress and mental disorder is announced by the standard psychiatric textbooks. These are compendia of information said to be scientific and presented as a type of medicine that works on organic causes - that works on the brain to remedy or at least 'manage' seriously irrational ideation and behaviour. Central to the founding myth of the psychiatric profession is the notion that every mental disorder is a kind of *illness*, while mental health practice is sustained by the myths of diagnostic precision and medical efficacy. However, in the next few chapters we will see that these claims are not supported by the evidence.³³ In which case, there is no medical-causal logic to legislate that the management of mental disorder *must* devolve to physicians.

32 Microbiome and Mental Health (2018) en.wikiversity.org/wiki/

33 See Chapters 4-8. Of course, we have yet to demonstrate the truth of our contention that regarding the functional mental disorders (which constitute most of the caseload) psychiatry is only *mythically* medical,

What is certain is that mental health officials perform either or both of two quite different social functions: welfare work - the attempt to ameliorate emotional and mental anguish, and cryptopolicing - the attempt to persuade or coerce patients into emotional, cognitive and behavioural conformity. Mental health policy and practice tend to oscillate perpetually between the two modes, and in a confused and confusing manner which only hinders therapy and useful assistance.

In the meantime, psychiatric research is mostly partisan³⁴ and the authorities are in the habit of announcing unfounded beliefs as established facts. Other than nit-picking within their own narrowly defined, allegedly medical-scientific frame of reference, psychiatrists do not welcome criticism: they only ever resist interrogations of the official version of the nature of mental disorder and mental health practice, and not with counter-arguments but often with unconcealed hostility.³⁵ Since the psychiatrists resist criticism, and their beliefs and research projects tend to proceed from bias and blunders in logic and scientific method, inspection of their ideas generally reveals little more than pompous reiterations of 'common sense' intuitions about the brain and the mind. At the same time, the various notions that comprise the psychiatric medical model are decked-out in an abstruse jargon which does not help with care and therapy but surely serves the ideological purpose of falsely affirming the indisputable technical-medical-scientific standing of the professionals. None of this confusion and 'economy with the truth' will be remedied until psychiatry opens itself up to criticism and accountability.

Although it seems to us that the weight of evidence has for many years indicated that therapy should be directed towards understanding functional mental disorder as the individual's attempt to adapt defensively to some or other psychologically traumatic experience, we are not against medicine as such. If he presents with an identifiable organic deficit - a real illness - of course a psychiatric patient may require medical help. A sedative may be recommended if it is obvious that he suffers from excessive agitation or sleeplessness. Perhaps other types of medication may be used judiciously, in a minimal and balanced manner, for the relief of emotional distress.

However, what has become very clear during the last half-century is that it is by no means always helpful to employ psychotropic drugs as the principal and one essential mental health intervention. Psychiatric medications are over-prescribed - especially since it is known that on average they are no better than placebo, no more helpful than other kinds of response, and too often injurious, both physically and mentally. The same is true of shock treatment.³⁶ Physicians appear to believe drug company publicity, but most of the claims for the wonderful efficacy of the various mental health products are simply propaganda: they are biased, extravagant and sometimes derived from falsified research.³⁷ As a result, while there is no evidence that they constitute the optimal method for reinstating emotional and mental well-being, the rate of increase in the number of psychiatric drug prescriptions outstripped population growth every year since the modern psychotropic medications were introduced, in the 1950s. For example, NHS England authorised 64.7million antidepressant prescriptions during 2016; this is more than one script per head, 3.7m more than in 2015, and more than double the 31million dispensed in 2006.³⁸

scientific and helpful to patients. Along with research evidence, further argument is offered throughout this Volume, and by way of a systematic analysis of the most important psychiatric categories and beliefs, conclusively in Chapters 12 to 15, below.

34 Since the 1950s, almost all mental health research has been funded by drug companies; and in Chapter 6 we discuss the evidence of major drug companies deliberately biasing research or failing to declare inconvenient results. See the section: Newer and better drugs?

35 It seems to us that this fanatic resistance to criticism speaks of the depth of the psychiatrists' feelings of insecurity, which is due to the lack of evidence for their wishful beliefs. This 'psychoanalytic' suggestion is expanded in Chapters 13 and 14, below.

36 The evidence for these assertions is presented in Chapters 6 and 7, below.

37 See Chapter 6, below, in the section: Newer and better drugs?

38 Campbell, D (2017) NHS prescribed record number of antidepressants last year. *The Guardian* 29 June. There are no statistics for how many patients are involved, so it is impossible to discern whether more

Drug companies and doctors alike purport to justify the quick and routine prescription of some or other medication for each and every case of functional mental disorder; misleadingly, they say every such disorder is an illness; and so as to support their pronouncements concerning the correspondence between the diagnostic categories and discrete, identifiable mental illnesses, they chatter glibly about 'genetics', 'brain-chemical imbalances' and chemical and physical interventions which they say are scientifically proven and certainly beneficial. In this Volume we will see that there is no evidence for these assertions, and that what the doctors say is essentially a kind of mystification. And all the while the problems which actually confront any mental health patient - seemingly insoluble issues in his or her emotional, psychological, personal or social life - remain largely unaddressed.

We will also see that, however good their intentions, by suppressing the symptoms of mental disorder - which is to say, by suppressing the patient - psychiatrists wield a kind of social power which is totalitarian, sometimes hazardous and essentially unaccountable. This is shameful and has nothing to do with welfare but much to do with subjecting vulnerable, already suffering humanity to further oppressions. More than a century ago Freud inaugurated an alternative perspective in which incapacitating irrationality issues from desperate and ultimately dysfunctional attempts to adapt imaginatively to unspeakable emotional trauma; i.e., functional mental disorder is *psychological* pathology (psychopathology). This idea clearly contests the crude reductionism of orthodox psychiatry which, lacking evidence and argument, nonetheless insists that every serious mental disorder simply *must have* a bio-chemical or genetic cause, and therefore requires medical treatment. Although many thoughtful people are nowadays likely to feel that the psychodynamic hypothesis merits serious consideration, the psychiatric textbooks only nod briefly towards that approach before passing on down a main road which they claim is endorsed by medical science. All the same, if developmental psychology is able to account for functional mental disorder - which we believe it can (and hope to demonstrate in Volume 2) - then the motley bio-chemical and genetic assumptions and medical assurances which are supposed to underpin orthodox mental health routines come together as no more than a monstrous ideological conceit that serves primarily as the alibi for a tawdry practice.

As things stand, the official management of mental disorder prioritises the given proprieties above individual care and therapy. By contrast, a psychotherapeutic approach encourages patients to speak freely and constructively about their troubles so as to help them try to comprehend and face up to them, and thereby recover mental and emotional balance. On the grounds of compassion and practicality, we take up this argument throughout this book, and focus on it in Volume 2. And there is no reason to suppose that person-centred mental healthcare would be a more costly option, in the medium- or long-term. Trying to discover and respond to the psychological and social causes of chronic or recurring emotional distress and mental disorder would surely prove less costly than consigning millions of individuals to years or decades of barely relieved misery, drugging and long-term welfare dependency.

As we indicated earlier in this chapter, the medical-scientific credentials for the mental health services are poor and cannot be explained with any coherence. And yet every psychiatric professional finds legitimacy and is delegated wide-ranging legal powers by reference to Medicine: first of all, a psychiatrist must train as a doctor. However, a major issue with the psychiatric project is that it is not purely a medical authority to which many of us would willingly submit. Psychiatrists are legally empowered to superintend a certain kind of deviant who is usually delivered to them by other parties, and not usually for a criminal offence. Psychiatric officials perform quasi-judicial and quasi-police functions, as well as perhaps facilitating welfare assistance. Anyone subjected to the unaccountable and often apparently arbitrary powers of these officials has limited choices: he can resist, submit or try to escape. Whether or not it protests its humanity, any kind of psychiatry presents its patients with this dilemma. As a result, if any well-meaning psychiatric official tries to 'put the patient first' - to help him feel more secure, to reduce his anxiety and confusion, to get him to 'open up', explore his problems and perhaps become better able to exercise his personal agency - his efforts tend to run up

people are getting help for depression, anxiety, obsessive compulsive disorder or panic attacks, or if doctors are handing out the drugs ever more freely - although the latter is strongly suspected.

against the overriding fact that the same official is legally empowered to restrain and administer hazardous treatments to the patient against his will, and in any half-plausible manner authorised by the psychiatrists concerned. This absolute and often seemingly arbitrary nature of psychiatric power necessarily colours every encounter between any mental health official and any patient: they can never meet as equals but only as a power and a dependent. Of course, there is a propaganda effort and a consensus to persuade everybody that psychiatry is a legitimate and benign power. But as long as it issues from a legal power which once set in motion cannot be evaded, the purely material efficacy of *any* kind of treatment remains questionable. And if a patient does believe in the benefits of psychiatric treatment (rather than only submitting to it because he is forced to do so), placebo or faith becomes at least part of the effect of the therapy, whatever the organic effects.³⁹

Doctors have an obvious interest in refusing to recognise that the concept of mental illness was thoroughly debunked decades ago by critics such as Goffman, Szasz and Laing. After all, how can medical power be justified if mental health interventions are primarily concerned not with real diseases but with more or less disorderly and incapacitating forms of emotional and mental turmoil - with conflicts and confusions that have their main source in private life? No doubt there is more to this anomaly than a vested interest in power and privilege: before he specialises, a psychiatrist trains for years in general medicine, in which he learns that his work must conform to the methods of medical science. And yet, in truth, every individual who presents with a functional mental disorder - that is, nearly every mental health patient - confounds medical science. No matter, the expert has too much cognitive and emotional investment in his years of medical training. Asked to take responsibility for the problem of each presenting individual, doctors face the conundrum of illnesses-which-are-not-really-illnesses, i.e., so-called mental illnesses. Few officials seem able to conceive of the possibility of an obfuscating medical bias. It seems they can only imagine that the medical perspective is *nevertheless* essential for comprehending the undesirable ('ill') conditions of their mental health patients, that even if none are evident there surely *must be* hidden organic causes, and that they (the doctors) are able to provide an appropriate medical response.

In this Volume we will see that adherence to the psychiatric medical model systematically hinders the recovery of those afflicted by a mental disorder. We therefore argue that the near absolute power of the doctors has to be curtailed, for the sake of patients' welfare. Managing mental disorder is always a team effort. If a psychiatric patient does recover, others apart from his doctor are as likely to have helped him - or perhaps more likely. Apart from astute and sympathetic psychiatric workers, other patients or ex-patients and allies often prove helpful. This is why we advocate a more democratic, open and accountable form of the management of mental disorder - one in which the views of every party to a crisis are respected, and each has a chance to take on responsibilities.

Who do we wish to govern the mental health services? Aloof, so-said objective practitioners - psychiatrists and their co-workers - who assume that every mental health patient is *constitutionally* abnormal, and believe in faux-medical treatments? For the last century and more, the doctors have proved themselves little better than closed-minded managers of a callous, bureaucratic-industrial organisation concerned primarily with containing a particular kind of social nuisance.

Or would we prefer teams of professionals - and perhaps volunteers, or elected workers, including ex-patients - who by temperament, experience and training are able to recognise the material, social and psychological problems that trouble those individuals who are driven to distraction, and who have no wish to impose so-said medical treatments but would rather listen to those in their care, who pool their skills, who accept democratic accountability and are able to participate in constructive dialogue, and are willing and able to serve as examples of judicial, emotional and mental balance? This kind of mental health response would require a radical transformation in the perception of the nature and causes of functional mental disorder. Any attempt to reform the mental health services without recognising the true nature and causes of emotional and mental malaise could only deliver marginal improvements around the edges of this central issue.

39 These issues are explored in detail in Chapters 6, 7 and especially 8, below.

A motivated misperception

Someone is said to suffer from a functional mental disorder when there seems to be no organic cause for his obdurate and worrying irrationality. But if there is no organic cause, why say that his condition is nonetheless an illness - a mental illness - and insist on medical treatment? When there are no objective markers and no discernible pathogen, the universal perception of every mental disorder as an illness signifies the triumph of the psychiatric medical model.

Although there is now sufficient statistical evidence to support the hypothesis that functional mental disorder (mental illness) is nothing other than hitherto unrecognised PTSD (or C-PTSD),⁴⁰ and despite the absence of evidence to confirm the official doctrine, we should not expect the accredited experts to willingly admit that incapacitating emotional and psychological malaise is not a medical condition. One hundred years ago the leading lights in the profession were doggedly resistant to clear facts and arguments, and little has changed in the interim⁴¹ - there are still few signs that the psychiatric establishment will let convincing evidence stand in the way of its approved routines. This is illustrated not only by the fanatic opposition of most psychiatrists to psychotherapy throughout the last half of the 20th century, but also by the reluctant response to clear signs of their own malpractice. Modern anti-psychotic medications were introduced during the 1950s, and within a decade or so it had become apparent to every interested party except the psychiatrists that irresponsible prescription of these drugs was causing a global epidemic of the awful and irreversible neurological disease known as tardive dyskinesia (TD). The psychiatric authorities were in denial for years, and only began to take the matter at all seriously during the 1980s.⁴²

What is generally understood by the notion 'mental illness'? In spite of the dominance of the medical model in the field - which is to say, the medical profession's monopoly of the management of anyone who appears worryingly irrational - there seem to be contrasting 'common sense' views of the matter, and often the two views are held by the same person, simultaneously or sequentially. Doctors and mental health officials generally allow that emotional and psychological difficulties may issue from onerous personal and interpersonal problems, but they also maintain that the more serious the mental disorder the more definitely it is caused by a brain-chemical or genetic abnormality, i.e., there really is an organic defect which research will no doubt soon reveal. Among the wider public - most of whom have no vested interest in the medical model - there is often a readier appreciation that madness may be caused by subjecting a person to relentlessly maddening circumstances.

And so, on the one hand, a profusion of technical and reputedly scientific terms is generated so as to discriminate a great variety of so-said illnesses (mental illnesses) and administer an ever-increasing range of medical treatments which are said by the drug houses and the doctors to be undeniably beneficial. On the other hand, and probably without knowing their exact definitions, an untutored public tends to appropriate the technical terms of psychiatry - 'schizophrenia', 'psychopath', 'bipolar', 'anorexia', etc. - but does not necessarily associate a biological cause or a medical remedy with any of them. Moreover, when it permits doctors to suppose that some mental disorders may be caused by a malign context rather than by malign biology, psychiatry's trumpeted 'eclecticism' seems to agree with this 'common sense'. For example, textbooks allow that clinical depression may be traced back to grief from bereavement, while PTSD is specifically defined as a mental disorder resulting from a psychological trauma caused by a horrific event.

This is all very perplexing. Generally - and for no evident reason - the psychiatric medical model will have it one way, but sometimes - for good psychological reasons - the diagnostician is permitted to have it another. By contrast, psychodynamic theory is perfectly clear that any functional mental disorder indicates a psychological trauma. And yet the whole of mental health practice is conducted in terms of the psychiatric medical model, and the routine employment of its diagnostic categories inevitably indicts and stigmatises anyone subjected to an official mental health intervention. That is

40 See note 27, above.

41 See the text to note 13, above.

42 This scandal is discussed in Chapter 6, below, in the Summary: The well-known dangers of psychiatric drugs, (see especially the text to footnotes 78-81).

to say, the use of the language of the medical model cannot help but imply that every mental disorder is indeed an illness caused by deficient biochemistry or a genetic abnormality. By insisting there is an *essential* difference between mental normality and abnormality, rather than a difference of degree which perhaps depends on social context, the medical model implies that anyone who 'has a mental illness' is *intrinsically* alien, less than fully human. Of course, any such stigma impacts negatively on the individual's self-esteem and sense of his own identity.⁴³ Added to which, the distance the medical model puts between someone assigned a mental health diagnosis and every other 'normal' person - i.e., anyone who has not (yet) picked up such a diagnosis - exonerates every intimate or witness from any possible responsibility for the subject's emotional or psychological crisis.

We might suppose that it is years of training in the recognition of real diseases and in administering physical or chemical remedies which persuades doctors, despite the lack of proof, that every serious functional mental disorder must have a hidden organic cause, and that the many different types are surely caused by discrete pathologies. Just the same, since the psychiatric caseload consists mostly of individuals presenting with a functional mental disorder, which is discriminated from a neurological disorder by there being no signs of an organic cause, it is puzzling that every mental health official manages to square this basic fact with a belief in *the actuality* of the mental illnesses *as real illnesses*. The ongoing failure of the professionals to recognise this cognitive dissonance, and their easy tolerance of it, suggests a motivation more powerful than integrity and scientific objectivity. Other interested parties (e.g., members of the family) might also rather wish that the cause of a mental disorder is supposed to be due to a bio-chemical imbalance or even 'genetics', since that would conveniently rule out close official scrutiny of any intimate, painful, and perhaps insensitive, embarrassing, shameful or even cruel and abusive interpersonal dynamics. (These issues are explored in Chapters 13 and 14, below.)

It is not so long since the big old psychiatric hospital on the edge of town was dreaded as the container of dangerous weirdness. In the popular imagination, a psychiatric diagnosis still confirms the failure of the patient as a person, and perhaps an alarming and hopeless incapacity. How should we refer to worrying emotional distress and mental turmoil so that the terms accord with actuality rather than with our perplexed and lurid imaginings? We might observe that anyone overwhelmed by bizarre and troubling thoughts and feelings is 'exceptionally upset, preoccupied and confused', or particularly 'agitated', 'anxious', 'fearful' or 'depressed', etc. If this emotional and mental state seems to continue, to the detriment of his ability to look after himself or to the extent of becoming an intolerable nuisance or danger to others, we might accurately remark that he is 'very irrational', or even that he shows signs of a particular kind of 'mental disorder'. This way of speaking refers to moods, forms of behaviour and states of mind: it simply recognises kinds of emotion, volition and cognition. It does not necessarily imply the existence of an underlying illness, an organic deficit or any other diabolical *essence*.

In the normal run of things, at some time or another each of us is bound to experience or witness high emotion and irrationality. In some contexts we expect extremes of unwanted emotion, confusion and behaviour - for example, when someone suffers a powerful emotional shock: loss of a loved one is often followed by temporarily incapacitating grief. At other times, however, extreme emotion, strange beliefs and outlandish behaviour seem, on the face of it, to have no reasonable cause; or it seems that in difficult circumstances those emotional and irrational states may originally have had good cause, but now they go beyond reasonable or sustainable limits. There then arise questions of the genesis or depth of the condition: why the distress, the anxiety, the depression, the mania or the confusion, and why so alarmingly acute or chronic? Also, for reasons of welfare and the social peace, there are of course questions concerning the management of this kind of aberrant behaviour.

No-one would deny that shocks, stresses, frustrations and oppressions may have troubling somatic, emotional and cognitive effects - pain, anxieties, anger, misperceptions, confusion, panic, and so on. Everyone understands that an unrelieved emotional response to a stressful event may

43 The consequences of stigmatisation are explored in Goffman, E (1963) *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ. Prentice-Hall.

approach the extreme of preoccupying and overwhelming irrationality. Yet there remains the suspicion that someone in the throes of an emotional or psychological crisis is somehow responsible for his behaviour and, perhaps after a certain period of respite, really ought to exert his will so as to recover his emotional and mental balance. At the same time, however, when a person's emotional, mental and behavioural deviance is so preoccupying, disabling and apparently beyond his control, it can also seem to be a kind of sickness. And, in the popular imagination, illness is a matter of bad luck and nobody's fault; further, doctors are able to remedy most illnesses, or at least ameliorate them. Consequently, even though they might generally subscribe to 'common sense' ideas about the social-psychodynamic genesis and ontological status of many dysfunctional mental states, people do not see the inconsistency in referring to them as illnesses - 'mental illnesses'. When someone seems to be suffering from particularly acute or chronic emotional distress and irrationality, the notion of illness (i.e., mental illness) seems to account for the overwhelming intensity and intransigence of the condition, and also to suggest reassuringly that it is well-known by the experts and amenable to medical remedy. But the ambiguities caused by the two conflicting habitual perceptions of mental disorder are pointed up by the fact that whereas there is little or no stigma attached to most real illnesses, there always seems to be a degree of shame or guilt attached to 'being mentally ill'. Moreover, as we have been at pains to argue, to say 'mental illness' is, in effect, to *explain away* the real nature and cause of a functional mental disorder.

Before the rise of Science, emotional excess and bizarre ideation was viewed as 'possession'. This still makes a kind of sense, although of course not possession by demons, gods, magicians or ancestors. Then, and while it was actively promoted by the nascent psychiatric profession, the idea of 'mental illness' seemed to have emerged 'naturally' out of the medical optimism of the Victorian Age. However, not only is it profoundly misleading to confuse functional mental disorder (so-called mental illness) with organic pathology, but the metaphor 'mental illness' unconsciously mutates into *identity*: in most people's eyes, as soon as someone's emotional and mental condition is diagnosed (i.e., said by a doctor to be this or that disorder), it is viewed as definitely an illness. By saying 'mental illness', everyone is encouraged to imagine an organic cause, a medical explanation and a medical remedy. And as a corollary to the fundamental assumption of the medical model - that there must be a hidden organic cause for every serious functional mental disorder - error is generated at every point of mental health theory, research and practice. In so far as they are driven by their blind faith in Medicine, doctors and other psychiatric officials are caught in a contradiction which everyone blandly ignores: dysfunctional emotional and psychological states for which there are no organic causes are dealt with only (or mainly) as if there were. At the same time, the notion of mental illness is the basis for 'a terrifying form of social control'⁴⁴ which, in the name of Medicine, constrains and interferes with the body (brain) in order to restrain or domesticate the person.

As a result, the official management of mental disorder becomes monstrously irrational. Further into the book we will see that denying logic and their own research findings is reason enough for the twitchy, defensive bombast of so many psychiatrists. Fanatic belief in the fantasy of an organic cause for every serious mental disorder permeates the profession and infects most of its research and theory, as much as daily practice. Since mental health professionals influence the lives of millions, this is not just a pedantic quibble, the matter of a slight misunderstanding of what illness really is and what medicine really does. In some respects disabling irrationality might seem like illness, but in practice the perennial official confusion of psychopathology with organic pathology leads to malpractice and the wholesale violation of the rights of vulnerable individuals. Furthermore, this ought to be well known, even if usually each psychiatric patient is socially invisible due to the nature of his incapacity and isolation.

The application of a 'medical' technique to every case of seriously incapacitating emotional and mental turmoil is animated by the unfounded belief that it 'must have' an organic cause. Here we use quote marks ('medical') since in the usual senses of the words 'science' and 'medicine', the so-called

44 Millett, K (1990) *The Loony-Bin Trip*. New York: Simon & Schuster. Kate Millett was a feminist who after becoming famous had a fairly hectic schedule and was twice committed for behaviour diagnosed as bipolar.

medical techniques of psychiatry are not derived from scientific proofs.⁴⁵ Psychiatrists only assert or imply that they are. In reality, the standard psychiatric treatments are only an approximate and more or less heavy-handed interference with bodies (brains) which show no signs of pathology or malfunction - or at least, not until officials begin to work on them with psychotropic medications or electroshock. In any other sphere of medicine, doctors are generally cautious about prescribing a treatment unless its efficacy is already demonstrated or there is a good theoretical reason. When it comes to the so-said mental illnesses, these scruples fly out the clinic window and rule-of-thumb experimentation takes over.

In this chapter we have seen that an examination of the psychiatric medical model reveals that it is ill-defined, confused and lacking in proofs that it can benefit anyone living through an emotional or psychological crisis. As our argument proceeds, we will see that it is in fact the case that mental health theory and practice is not based in the findings of medical science; moreover, most patients seem to experience the official intervention as oppressive and unhelpful, and many find it actually hazardous. In the next few chapters we demonstrate the truth of several propositions: that encounters between psychiatric officials and patients are likely to be insensitive and counter-therapeutic; that mental health diagnosis (which is, of course, part and parcel of the medical model) is not at all objective, on a par with genuine medical science; that while they are often harmful, there is no evidence that any psychiatric medications are able to benefit patients more than non-medical therapies, placebo or no treatment at all; and that while the only certain outcome of shock treatment is brain damage and a short-term lobotomising effect, there is no evidence that it is otherwise more beneficial than placebo-ECT, non-medical therapies or no treatment.

Whereas each of these propositions is attested by various reputable studies, none of this information is divulged by the textbooks or during psychiatric or mental health training. Besides, as we demonstrated earlier in this chapter, the official version of the nature and cause of the psychiatric topic (i.e., mental disorder/mental illness) and the appropriate response (i.e., medical treatment) is self-contradictory at the very point of its formulation. For the facts oblige psychiatrists to recognise a clear distinction between those neurological disorders discovered by medical science - which they call 'organic mental disorders' - and the many more instances of obdurate and worrying irrationality for which there are no discernible organic causes - which they call 'functional mental disorders'. Yet this distinction is immediately blurred by the experts insisting that, even so, every serious functional mental disorder has (or 'must have') an organic cause, in the form of an alleged genetic anomaly or a bio-chemical brain imbalance. If no organic cause is detected, why say that every dysfunctional mental or behavioural condition is all the same an illness - a mental illness - that unquestionably requires medical treatment? There appears to be no other basis for the psychiatric medical model than this outrageous confusion of fact and wish.

None of this would be such a problem were the idiosyncratic medical model engaged as no more than a hypothesis which is yet to be proved. However, it is not regarded in that light. Despite there being not a scrap of evidence for its purchase on reality, and after more than a century of research, the psychiatric medical model is not employed tentatively as a working hypothesis. Instead it is taken for granted and announced by the professionals as unquestionably a true reflection of the nature of functional mental disorder. Meanwhile, there was always another hypothesis concerning the nature, cause and the most helpful response to functional mental disorder, i.e., the psychodynamic model.

45 Since it is not based in sound proofs, and to express our dissent from the notion that psychiatry is just another kind of scientific medicine, we might continue to employ quotation marks around the word 'medicine' when referring to mental health techniques. Likewise, to indicate that it is not proven that every functional mental disorder is just another kind of illness, and is only *said to be* illness, we might always refer to 'mental illness' and the diagnostic categories 'schizophrenia', 'bi-polar depression', etc., etc. But to avoid clumsiness, and with the caveat that we certainly do disagree with the conventional wisdom, from hereon we refrain from putting quotation marks around every questionable term employed by the psychiatric medical model. Also, we will usually refer to mental *disorder*, not mental *illness*, as being an accurate identification of the phenomenon rather than a very confusing metaphor.

The psychiatric authorities have never given this alternative theory any proper recognition; generally, they treat it with utter disdain - before patronising it by inclusion in their 'eclectic toolkit'. The medical profession's antipathy to the psychodynamic perspective is evident from the paucity of research reports in the psychiatric journals and by the way the textbooks continue to reject it without any meaningful discussion, and usually in a manner which fails to conceal a degree of hostility which belies their scientific objectivity.

In the light of this wholesale and scandalous departure from the standards of scientific or any other kind of balance or objectivity, we are forced to conclude that the psychiatric medical model endorses a *motivated misperception* of the nature of functional mental disorder and of the appropriate response. In the following chapters we will see that psychiatry is generally the application of a style of intervention in people's lives which is announced as technical (scientific-medical), and therefore morally and politically neutral, but which in reality is based in wishful thinking, and can only ever result in haphazard, partisan and often reckless rule-of-thumb guesswork. In the official mental health project, and according to the psychiatric medical model, attempts are made to process every individual as if the problem were that of an isolated object (an illness) and not a socially-embedded subject - as if the problem were a diseased brain and not an emotionally distressed and confused person confronted by urgent and apparently intractable personal problems. Since, by definition, functional mental disorder is not illness, it follows that psychiatry can only be comprehended as an ideologically-driven enterprise motivated primarily by the urge to contain and domesticate worrying but ostensibly unaccountable emotional and mental deviance, without disparaging any established social power, and by almost any means.

As our argument proceeds, standard mental health care and treatment is revealed as ritualised and counter-therapeutic. Not only are the assumptions of the psychiatric medical model unfounded, they are vague and misguided, and there is a strict taboo on questioning them. The so-called medical model both generates and depends on the myth of mental illness. Towards the end of this Volume, in Chapters 13 and 14, we explore this myth, together with the psychiatric medical model, as they arise out of broader mythological notions of Science and Medicine. Thomas Szasz, a dissident psychiatrist, identified the administrative consequences of the myth of mental illness as 'the rise of the Therapeutic State' - a medical-despotic impulse which ignores emotional trauma, psychodynamics and the role of oppressive social relations in the genesis of serious personal distress and mental disorder. To understand this urge, we must interrogate the ideology by which it is rationalised. Here we should point out that by 'ideology' we do not mean simply a random collection of ideas, some of which may or may not be true. Rather it is a socially significant system of unevicenced beliefs which, in the service of a social group's material interests, are proclaimed as undoubtedly true; any ruling ideology is generally actualised in an assemblage of approved techniques and social arrangements.⁴⁶

Opponents of the psychiatric medical model often seem to suggest that the idea of mental *illness* is a cynical ploy to benefit doctors and the drug companies. While it is obvious that belief in mental illness serves both interests, later in the book we suggest that deep-seated and unconscious emotional and personal-political motives must surely be the most decisive: that the dominant conception of the nature and cause of incapacitating irrationality - and hence ideas about care and therapy - responds to the fears and wishes of the sane majority; that while psychiatry is indeed a floundering masquerade of scientific medicine, it is best understood as a naive and ill-theorised reflex to everybody's fears of madness and what it may disclose. We argue that there is, in the abstract, a profound dread of the chaos of extreme emotional distress and mental disorder, but amongst intimates to anyone in crisis there is also likely to be additional antipathy to social and psychological investigation since it might possibly discover aspects of their own culpability. In other words, the psychiatric medical model

46 See Marx, K & Engels, F (1846/1970) *The German Ideology* (Ed Arthur, CJ) London: Lawrence & Wishart. Similarly, but at the level of the individual, with regard to the apparently chance mistakes regularly made by anyone in the conduct of his daily life, Freud later spelled out the likely hidden emotional significance or motive for each of many examples, and how each mistake is rationalised by the person concerned; see Freud, S (1914) *The Psychopathology of Everyday Life* (Trans Brill, AA). New York: Macmillan.

perfectly answers to the universal desire for a quick technical fix with no awkward questions asked. Since it lacks scientific proofs, the current medical mental health response is not in fact wholly reasonable and the best that can be done: it only persists as the expression of a universal but unacknowledged neurotic need, and insofar as it ministers to that need. This generalised neurosis and the social formation which answers it - the Mental Health Service - sustain each other in a feedback loop: the neurosis calls forth an allegedly rational social organisation and set of techniques (medications, shock treatment, etc.) for managing the problems which seem to be at hand, while the very existence of the purportedly appropriate and benign social formation and its methods serves to affirm that what everybody feels and imagines about madness is entirely rational, and thereby the neurosis is reinforced. Hence, until it is understood as *responding primarily to the unacknowledged anxieties of the majority*, it is most unlikely that the prevailing management of individual irrationality will be replaced by a response more fitting to the real needs of those in crisis.

Anyone unfortunate enough to seem to suffer from a serious functional mental disorder is made into a psychiatric patient and subjected to almost unaccountable medical power. By taking for granted the medical model, psychiatry indelibly stigmatises and re-victimises every patient. Whatever the officials may imagine they do, it is clear that the first psychiatric interest is not therapy but containing the individual's deviance so as to re-establish the social peace. Consequently, rather than cure or help people, the normal routines tend to make emotional distress and mental disorder chronic; too often the standard treatments cause ill health, organ damage and even death; furthermore, the medical model invites emotional, physical and sexual oppression and abuse of the patients. At the same time, the paranoia of the psychiatrists manifests institutionally and ideologically as the fervour with which so-said medical theories and methods are pursued in the absence of clear evidence for their benefits and to the exclusion of a viable alternative, i.e., psychodynamic theory and therapy; this paranoia appears at the level of everyday transactions whenever anyone but a colleague of equal standing dares question a diagnosis, prognosis or prescription. And if obsessions and compulsions become mental disorders when they are dysfunctional or incapacitating (i.e., become obsessive-compulsive disorder), it could be argued that psychiatric paranoia also issues in a vigorous OCD. This is indicated by the compulsion of the doctors to assign every mental health patient a precise and exclusive diagnosis (but not convincingly for the patient's benefit) and by the obsession with taxonomy. In an attempt to articulate an exact category of mental disorder for every imaginable instance of mental or behavioural deviance, this obsession issues in the urge to forever expand the diagnostic system. Word-magic is the wish to control by naming: no deviant behaviour or ideation must escape the control of the psychiatrists!

Established power likes there to be no question that we live in the best of all possible worlds. The psychiatric medical model obligingly assures everyone that when someone is overwhelmed by distress and confusion, to the point of disabling irrationality, it is not the social relations that are dysfunctional but always the individual who is stricken by illness - mental illness. Rather than providing the most appropriate response to anyone in crisis, psychiatry is first of all an invaluable cornerstone to established power: not only does the mental health apparatus administer psychological casualties in a manner that satisfies the consensus, but its medical ideology vindicates the status quo.

In the following chapters we will see that psychiatry works to contain individual irrationality and, by deploying an ideology which insists that it is objective medical science, to deflect everyone from awareness of the real origins of the individual's malaise. This conflicts with the declared intention of the mental health services, which is to remedy intolerable mental torment and emotional distress by the most reasonable and compassionate means. We do not suggest that ignoring intimate oppressions and dominating the patient are the conscious motives of every psychiatric official. Rather, as an element of the wider society in which medical expertise is pervasively fetishised, it would have been surprising had the official management of irrationality in the modern world not developed as an alienated, pseudo-medical kind of misperception and social control. The psychiatric medical model is not simply mistaken - it is *an unconsciously motivated misperception*.⁴⁷

47 This is argued in detail in Chapter 13, below: The Psychopathology of Psychiatry.

Chapter 4: THE PSYCHIATRIC ENCOUNTER

And I am black, but oh, my soul is white;
 White as an angel is the English child,
 But I am black as if bereaved of light.

William Blake.¹

Here we examine the transcript of a representative series of real encounters between someone diagnosed with schizophrenia, his therapist (a psychiatrist) and his official carer (a psychiatric nurse). This reveals routines which are shockingly misguided and blind to the patient's emotional, psychological and physiological needs. And yet, during the television documentary from which the transcript is taken, the activities of the professionals are commended for typifying 'good practice'.

Power defines reality and rationality

It would be pleasant were mental health care organised primarily to help those suffering from mental disorder in their pursuit of emotional and mental balance and a life of freedom and happiness. Unfortunately, this is not necessarily the case. Of course, the rationale for the enterprise is to re-establish the individual's well-being, but we will see that mental health provision - and especially by the specialist service, psychiatry - is concerned first of all with keeping the peace, and that the normal practices often seriously undermine the advertised intention. In this Volume we explore the ways in which psychiatry is organised to manage troublesome emotional and mental deviance, according to which reasons, and to satisfy which overt or covert interests. We will see that it tends rather to work *by any persuasive or coercive means necessary to adjust patients to that view of reality endorsed by social power.*

Psychiatrists like their discipline to be perceived as an esoteric speciality which demands years of training in medical matters that a lay person - and especially someone with a serious mental disorder - could not possibly understand. Just the same, if we wish to follow the workings of any institution, the view from above and the view from below must both be taken into account: i.e., the convictions of those supposed to manage the events and processes that fall within the organisation's remit, and then again the perceptions of those undergoing that regulation. Although any sort of official understands well enough that the battle is already half-won if he can influence the beliefs of those he has to administer, there are bound to be differences since the two perspectives are based in separate and often opposing interests. Consequently, accounts of the purposes and operations of an organisation may diverge appreciably between those occupying different statuses and roles within it, perhaps to the extent of mutual incomprehension, mistrust and open hostility; obviously, this will affect the functioning of the organisation. That kind of incongruity is more likely for organisations tasked with processing people, and in fact relations between psychiatric officials and their patients are often conflicted and therapeutically unhelpful.

Naturally, the standard textbooks advocate the objectives, assumptions and methods of psychiatry as understood by senior doctors, managers, nurses and ancillary professionals: they only entertain the view from above. And human nature is such that accredited mental health officials tend to be fully convinced of their own splendid expertise; in contrast to everyone else's ignorance and incompetence - and especially, by definition, the essential ignorance and folly of the patients - they feel this is assured by their own allegedly medical-scientific training. Thereby, faced with so many 'difficult' patients, normal practice can easily drift into casual and thoughtless contempt for those in their care,

¹ The little black boy. Blake, W (1789/2005) *Songs of Innocence*. Digireads.com

or even outright abuse. It does not help that by general consensus any psychiatric patient is conceived as a failed person, a useless dependent, and an irritating problem; within the psychiatric organisation he has little standing other than that of someone who requires medical processing but too often unreasonably resists it. He may be 'in care', but as long as he is perceived according to the objectifying medical model, the project of 'treating his illness' (which supposedly inhabits his brain) tends to marginalise every other consideration, no matter how important it may seem to the individual himself. For example, since every psychiatric worker believes in the medical model, anything uncomfortable expressed by a patient may be routinely discounted as irrational and hence an irrelevant nuisance, significant only as yet another symptom of the mental illness. In other words, if a patient suggests a version of events different from the authorised narrative concerning the details of his life or state of mind, or complains about the physical or psychological ill-effects of his treatment, or of deliberate abuse, the medical model encourages every functionary to regard such dissent as nothing more than fantasy, and evidence of the patient's 'lack of insight into his illness'.

By contrast, as our argument develops, we demonstrate that if he is ever to be delivered more effective assistance it is essential to respect the mental health patient's point of view. Hence, not only on the side of humanity but also reason, in this chapter we highlight the jarring disjunction between the views from above and from below, and are persuaded to give credit to the view from below; we also continue to supplement both views with a healthy dose of a view from outside.

It seems to us that the first item on the agenda of organising good psychiatric practice is to recognise, comprehend and remedy bad practice. In its essentials, just like care in general medicine, psychiatric care should be based in the normal decencies of civility, sympathy and assistance. The patient should be treated with respect, made comfortable and encouraged to do what he can for himself; whenever possible, options for therapy should be discussed with him, and he should have a choice. In order to improve their service to the patient, responsible psychiatric officials should monitor his therapy and care. It might seem a rather obvious thing to say, but psychiatry ought to help the person get better rather than leave him distressed and confused. As we will see, though, this is by no means the first concern of every psychiatric official.

Incapacitating emotional distress and mental disorder is, of course, confusing, frightening and exhausting to the person who experiences it. It is also likely to be disturbing to anyone else who is intimately involved. Workers in mental health care may stand at a greater emotional distance from the patient than family and friends, but they might not feel less confused, frightened and threatened by mental disorder were it not for their legal powers and the medical rationalisations and routinised certainties and teamwork of the organisation. A psychiatric official's anxiety in the face of the unpredictable behaviour of the patients may be allayed by his belief in the professional techniques and his own expertise, by the well-defined limits of his responsibilities, by experience and habituation, and by the knowledge that if all else fails there is always legal resort to forcible restraint and treatment.

The immediate and main intention of psychiatric care and treatment is to contain the deviant behaviour which has called down upon the individual the attentions of the authorities. Doctors and psychiatric workers imagine that they begin to remove much of the uncertainty that the patient generates by as soon as possible ascribing to him a reassuringly scientific- and medical-sounding diagnosis. And for each alleged mental illness there is always supposed to be a fair prognosis (prediction of the course of the illness) and an appropriate technical response by which to remedy or at least 'manage' the patient's illness (deviance). In the first instance, treatment is almost invariably a drug. As we argued in the previous chapter, however, the so-said medical model of mental illness is a product of wishful thinking, not of clear evidence. Throughout much of this Volume we will demonstrate that there is no evidence to support many of the crucial psychiatric notions that are said to be scientifically true and therapeutic; they are nothing more than unfounded assertions which, due to powerful emotional and material interests, are only *said to be* undoubtedly true and helpful.²

² In psychoanalysis, a false proposition which an individual insists is true but under analysis is revealed to defend a neurosis is known as a rationalisation; this is close to the concept of 'false consciousness' or 'ideology'

Meanwhile, as soon as he is officially stigmatised by means of a demeaning diagnostic label - as 'having' this or that 'mental illness' - the full humanity of the psychiatric patient disappears.³ It is replaced by the image of a perversely uncooperative recalcitrant in possession of (or possessed by) a defective brain that requires medical treatment due to its having developed (or been invaded by) a peculiar kind of disease which happens not to register physiologically and can only ever be surmised from signs of aberrant behaviour and ideation. As we indicated in Chapters 1 and 3, much as mental health professionals might wish it were true, this idea is only science fiction.

As we proceed with the evidence and argument in this book, we will see that whatever psychiatrists might wish, their diagnoses and prognoses are immediately hazardous to patients since they unleash the prejudices and discriminatory actions which inevitably accompany stigmatisation. Under whatever justification - race, sex, age, law, tradition, so-said science or remedy of a mental disorder - whoever is stigmatised immediately becomes a kind of sub-human whose protests may be casually ignored when he is subjected to the contempt, constraints, humiliations and assaults which unfailingly accompany this kind of discrimination. Naturally, any such oppressive identification is rationalised by the perpetrators as admirable, necessary and even for the good of the stigmatised. Worse than that, if he is sufficiently persuaded, the stigmatised person often assents to everyone's estimation of his essential deficiency, his lack of worth, and his own maltreatment.

In this chapter we will see that all is not well with the state of our stigmatising psychiatry which, by the way, also fiercely resists criticism and accountability. Psychiatrists are legally endowed with great power over the lives of their patients. As long as a psychiatrist can plausibly argue that he 'acts in good faith', he cannot be brought to account for *anything* he does to a patient in the name of care and treatment. Compared to other kinds of legal power, psychiatric authority has particularly far-reaching consequences since, without the normal due process of law, a person may be detained and treated on the word of one psychiatrist (two doctors for longer than 72 hours), while care and treatment is largely ad hoc guesswork and far from what the individual concerned might wish, and yet not subjected to any regular audit. Later in our argument we will also see that the various so-said medical treatments are not based in biological proofs, and that psychiatric personnel are more likely to fail their patients the more blindly they believe that what they do is supported by science. In practice, the lack of accountability means that what the psychiatric experts wrongly imagine they do stands squarely in the way of a clear view of the harm they actually cause.⁴

So as to illustrate these points, we use a transcript of a television documentary in which the public is shown what the narrator calls 'good practice in care and treatment' of a typical patient. Benjamin Gray's article in *Asylum* magazine⁵ uses a technical kind of discourse analysis to highlight nuances of verbal expression which, for easier reading, are here rendered into a more conventional narrative. Otherwise the verbatim report is not altered. Commentary on the transcript is our own.

What appears in the documentary is, by all accounts, entirely routine and a fully approved form of the management of anyone subject to 'Care in the Community'. This is bad news for patients since the care and treatment displayed in this series of psychiatric transactions is peremptory, insensitive, casually indifferent, and physiologically and psychologically harmful. It can only be their unqualified faith in the unfounded medical model that blinds these two psychiatric officials to what must surely appear to any neutral viewer as an abusive and harmful employment of state power.

in Marx's sociology, whereby stubborn belief in the inverse of a demonstrable truth covertly defends or advances a material interest. The concept of ideology - as opposed to knowledge supported by evidence or argued with sound logic - is discussed in more detail at the beginning of Chapter 14, below, in the section: Psychiatry as a component of the political and ideological system; Freud's ideas are discussed in Chapter 21 (Volume 2).

3 Stigma may be defined as 'the phenomenon whereby an individual with an attribute which is deeply discredited by his or her society is rejected as a result of the attribute. Stigma is a process by which the reaction of others spoils normal identity.' Goffman, E (1963) *Stigma: Notes on the management of spoiled identity*. New York: Prentice Hall.

4 This assertion is substantiated by evidence offered in the following chapters.

5 Gray, B (1998) The politics of psychiatry and the voice of the patient. *Asylum* 10 4 15-19. This analysed a transcript of the first episode, on schizophrenia, in the BBC's 1998 series *The Mind*.

More than fifty years ago, the empirical sociology of Erving Goffman showed that patients tended to be profoundly degraded by the normal procedures of psychiatric institutions.⁶ It seems that his critique is forgotten. Perhaps Goffman has fallen off the curriculum because his book is thought to be outdated. Now that the big old asylums are abolished, perhaps psychiatric officials imagine that the grievous systemic abuses which he revealed no longer exist in any manner or form. This documentary acts as an unwitting but stark reminder that what is normal under modern conditions is an equally callous and anti-therapeutic development of the previous organisation of psychiatric power. It may be convenient to the professionals, but it utterly fails to serve the interests of vulnerable patients.

The film is announced as a document of 'good practice'. This is the phrase of the hour, trotted out in the commentary and by both officials. To anyone who does not wear the blinkers of psychiatric ideology, however, on display is shabby and routinised carelessness, appallingly wanton inattention to the needs and wishes of the patient.

After his initial hospitalisation, this individual lives 'in the community' and appears to get no care or treatment other than the 'medication' (drugging) that, as a matter of course, is handed out to almost every psychiatric patient - along with the usual mortification of the self perpetrated by case-hardened officials. All the same, while clearly not genuinely listening to him or taking what he says seriously, both professionals summon up the appearance of a certain perfunctory and superficial concern and sympathy. Since the patient has no option but to submit to whatever they demand of him, perhaps this display of 'humane feelings' is as much to persuade themselves of their own elevated, professional, 'medically objective' intentions as to persuade the patient not to resist. In this particular case, the patient is not only subjected to psychiatric prejudice - whereby he is denied a voice and has to submit to injurious medication - but also, since he does not acquiesce willingly and happens to be black, he is forced to endure the officials' sniggering racism.

Gray's article features the lines by William Blake which appear at the top of this chapter. In the last verse of the poem the little black boy wishes he could be like the little white boy, and then he would be loved. This expresses the power of ideology in malforming a child's conception of himself: if everyone has a stigmatising view of him and acts towards him with that in mind, how is the child to form any other idea? The lines do not mean that what they express is what Blake believes - far from it - but that the little black boy growing up in a white and racist culture believes it, and this belief works a dreadful havoc on his sense of self-worth. Bigotry performs simultaneously the functions of denigrating 'them' and flattering and vindicating 'us': if black equals all that is bad, then white must equal all that is good.

The analogy with psychiatric stigmatisation is clear enough. If anyone who 'has a serious mental illness' is conceived as more or less hopelessly sick, unreasonable and therefore of no account - at least for the duration of the alleged illness - then anyone deemed 'normal' must be in good mental health, rational and worthy; and whatever means the agents of the consensus employ when they manage and 'treat' those said to have a mental illness, without a doubt they must be acting in a reasonable and admirable manner. Blake's poem concerns the terrible humiliating and self-effacing effects of ideology on those the majority deems different and inferior. It seems that this issue is still very much alive - not only with regard to racism but also in terms of that psychiatric stigmatisation and maltreatment which smugly congratulates itself on being good practice.

(Mis-)diagnosis and denying the patient

The narrator for the documentary tells us that the patient, referred to as John Baptist, has said he believes he is descended from the British royal family. We are informed that he also believes his sister was cannibalised, that his hair is blue, and that he has white skin - despite the fact that he is a Ghanaian immigrant with black hair. However, during the film we do not hear the patient voice any delusions, and perhaps more unsettling to a non-partisan viewer is his treatment by the experts. They

⁶ See Goffman, E, op. cit. (n. 28, Ch 3).

are recommended for performing ‘good psychiatric practice’, mainly at that most modern and supposedly progressive site of mental health care - ‘in the community’.

The documentary follows John Baptist’s encounters with the psychiatrist, who decides his fate, and the psychiatric nurse responsible for bringing care and treatment to him at his home. It then shows the two officials meeting together with the patient, in what they call ‘a final consultation’.

When he meets the psychiatrist, the patient says: ‘I-I’m not coming here [pause] okay, to be given drugs that I don’t need, [pause] yeah, to be injected in my private parts, ...kept under files... I came out of this hospital hardly able to brush my *teeth*, [pause] hardly able to *eat*, hardly able to stand... Now, what sort of medicine is that?’

The psychiatrist tries to interrupt: ‘Can I ask you?..’

The patient continues: ‘H-hold on. You keep me here by force... Wh-wh-what sort of, um, m-medical practionion is that?’

The patient tries to continue, as the doctor says: ‘L-let me [pause] take it one by one, okay?’ He takes a breath. ‘You’ve been admitted under Section Two⁷... It’s a compulsory order: it means you have to stay in hospital...’

The patient talks over the doctor: ‘You answer my question, that’s what I want.’

The doctor sticks to the formalities, the form of words that the law decrees must be told to each patient who is compulsorily detained and treated. He says: ‘I-I’m doing that, all right? Now it’s up to four weeks...’

The patient talks over the top of the doctor: ‘No, no, no, no. Listen, listen...listen. [Pause] If I come under your treatment...am I supposed to leave better or worse?’

The doctor says: ‘I hope you leave much better.’

The patient says: ‘It’s not *I hope*. [Pause] Um, it’s talking about what you did in the past. [Pause] Yes?’

The doctor says: ‘I don’t know about the past...’

The patient cuts in: ‘You *DON’T* know. Listen, listen... You don’t know about the past.’

Here we have a patient trying to complain about the serious effects of being drugged - what psychiatry calls medication but what a neutral witness might view as poisoning. The patient is understandably worried about what the doctor will do to him. He wants him to acknowledge that the drugs previously forced on him had disabling, disorientating and painful physical effects - or presumably, at least to investigate the possibility. The psychiatrist is not interested. Instead, he slyly side-steps the issue by pretending that he does not know what the patient is talking about and that, therefore, this is just crazy talk. He only wants to inform the patient of the legal position.⁸

But the doctor ought to have information about the patient’s past. When a patient has been under psychiatric authority before, there should be records and the doctor should be able to refer to them. Additionally, if the patient wishes to discuss the ill-effects of the drugs previously administered - which should be recorded - he should be allowed to do so. In which case, either the doctor (or the psychiatric organisation) is inefficient to the point of negligence, or the doctor prevaricates. Neither negligence nor prevarication is likely to help reduce the confusion of someone said to be already disturbed.

This meeting could have been an opportunity for genuine dialogue, for each side to put his case and listen to the other. The doctor, who calls the shots, does not take that chance. Gray quotes RD Laing’s observation:

The role of the patient tends to become defined as a non-agent, as a non-responsible object, to be treated accordingly.⁹

7 Talk of ‘sections’ or ‘sectioning’ refers to compulsory detention and treatment under a section of a Mental Health Act. Section 2 of the 1983 Act is for new patients or those who have not recently been hospitalised.

8 And on this point the routine psychiatric discourse is counter-intuitive and confusing. However, we can be sure about its rhetorical intent: since ‘admission’ normally implies the person wishes to enter the place in question, ‘compulsory admission’ is a euphemism for ‘detention’.

9 Gray, B, op. cit. (n. 5), 19.

To deal cavalierly with the individual, as if he were nothing more than an object, an illness to be worked on, is the prejudice of a total power which justifies itself as Medical.

The doctor continues: 'M-my [long pause] *judgement*, I'll be *frank*, was...that the stories that you told me, I thought were... [he draws a breath] ...in *large* part, your imagination getting the better of you. Now, *I know you don't agree with me...*'

The patient responds: 'What's your proof?... How do you get that information?'

The doctor says: 'The only way I make that [pause] diagnosis is on [pause] people's thoughts [pause] and feelings.'

The patient asks: 'Wh-whose [pause] thoughts?'

The doctor speaks softly: 'The person I'm talking to.'

The patient replies: 'What's my thought and feelings?...'

The doctor talks over this: 'Well, I haven't made the diagnosis, by the way. Y-you keep using it, I haven't used it *yet*...but I might come to that decision.'

Inconclusive turns at speaking are here omitted, and then the patient says: '*What* you should do as a conscientious doctor is to spend time and find out... [he draws breath] ...and stop saying that I-I'm having delusions.'

On the face of it, the patient seems to have a point. We are not presented with any evidence that the doctor has made a medical investigation of the patient's complaints of drug poisoning from a previous psychiatric intervention, or that he has any intention of doing so. On the contrary, he seems to dismiss the patient's complaints as 'imaginings'. Nor is there any evidence that the doctor has discovered and investigated any presenting delusions. The patient thinks that the doctor should listen to him before coming to any conclusions. No wonder he is upset, and a wonder he is not more so. Yet a seasoned patient knows the score, of course. He knows that if he were to display too much emotion he would simply open himself to the likelihood of an even worse diagnosis and greater psychiatric duress in the form of longer detention and more frighteningly painful and disorientating compulsory drugging.

Meanwhile, the doctor appears to operate under the routine assumption that anybody who is committed to psychiatric care *must be mad* - as a sort of absolute condition¹⁰ - and that therefore anything and everything that the patient says which is inconvenient to psychiatric power *must be* a symptom of his madness and need not be taken seriously, except as such. In this he is fully supported by the circular logic of both the psychiatric medical model and common sense - 'what everybody knows' - that, *by definition*, a psychiatrist embodies rationality and his patients nothing but some or other kind of troublesome and perhaps dangerous irrationality. This socially approved dogma catches every patient in a Kafkaesque nightmare where he is damned (said to be mentally ill) if he cannot or will not conform to an official's demands, and damned (said to be mentally ill) if he offers no resistance and accedes to the psychiatric diagnosis. All he can do is try to live through the nightmare as best he can, offer as little as possible resistance to his powerful tormentors, and hope they will soon release him.

Even if this patient were to express fantasies in amongst what might well be justified complaints of toxic harm from psychiatric drugging, the psychiatrist should listen to him, if he really wishes to help, for

[p]hantasy...is always experiential and meaningful and, if the person is not dissociated from it, relational in a valid way..¹¹

It may be awkwardly expressed, but this is a point of view that a truly humane form of psychiatry would at least consider. Psychiatry has the power arbitrarily to deem worthless *anything whatsoever* that a patient says which it does not wish to hear or believe: this is known as 'lack of insight', and registered as evidence for the persistence of the alleged mental illness. As a consequence, those doctors who subscribe to the medical model - which is to say the great majority - are able to discount anything in the patient's speech and behaviour which they find disagreeable as *nothing but* an

10 And the more serious the diagnosis, the more the condition is considered inherent and permanent.

11 Gray, B, op. cit. (n. 5), 19.

irrational symptom which only has value insofar as it is a sign which may help the psychiatrist to confirm a diagnosis. In this particular case, the psychiatrist has already decided that the patient is ruled by his wild imagination. He is not about to listen to him, let alone discuss what he says or investigate his complaints. He simply takes the patient's attempts to argue with him as further evidence for the illness, thereby justifying his right as a psychiatrist to deal with him as he sees fit.

Another disturbing twist to this encounter is the psychiatrist's attempted deceit that it is not he (the psychiatrist) who makes the diagnosis of schizophrenia, but the patient himself. As if somebody taken against his will by psychiatry is not aware that he will be assigned a diagnosis and, in this case, that the label 'schizophrenic' was undoubtedly pinned on him in a previous psychiatric encounter. The doctor's unsavoury verbal acrobatic is an attempt to divest himself of the responsibility and load it onto the patient, as if: 'Not only is he mad, but he admits it and defines himself as such.' The psychiatrist would then conveniently feel absolved from the responsibility of deciding the nature of the patient's malaise, when in reality the diagnosis (and the treatment that follows from it) is his own unilateral decision.

After this exchange, the patient leaves the room and the doctor sits back and complacently confides in us, the television audience. This bureaucrat of the mental health system is not only entirely unembarrassed but, on the contrary, is proud to express a curious and confused notion of the diagnostic category of schizophrenia and its application:

'Schizophrenia's a very *complex* disorder which is characterised by...*strange*, [pause] bizarre beliefs - which we call delusions - strange experiences, called hallucinations... hearing voices talking about you. [Pause] He's never talked about hearing voices... [takes a breath] ...and he's never given evidence of what's called... [pause] ...thought disorder, but I've no doubt that this is [pause] a schizophrenic illness.'

The good doctor has no doubts that this is a schizophrenic illness, *even though he admits that the symptoms are absent*. This is the kind of routine but dreadful medical-scientific gaffe of which psychiatry is so unaware that it is quite unashamed and, in fact, is pleased to parade to a television audience. Why should we believe this doctor's - what - hunch? Ah, because he is an expert. We can be sure he is an expert because he patronisingly tells us about what (clever, expert) psychiatric doctors 'call' delusions and hallucinations. As if we, the poor stupid public, had not already given to psychiatry, from out of the common language, the concepts 'delusion' and 'hallucination'!

The doctor makes no bones about not carrying out a diagnosis - in any normal medical sense of the word - in line with any procedures or guidelines. By reference to the standards of general medicine, this absence of an adequate diagnosis makes the doctor's behaviour both absolutely unscientific and absolutely unethical. Apparently, however, this is of no consequence to 'good psychiatric practice'. Moreover, we can be fairly sure that the psychiatrist 'has no doubts that this is a schizophrenic illness' because in fact he *does* have records of a previous diagnosis, and that whoever brought the patient to psychiatry on this occasion reported him for what they considered some sort of mentally disturbed behaviour. As far as psychiatry is concerned, once a diagnostic label is decided it will almost invariably be supposed to fit thereafter. It is therefore most likely that the doctor does attribute to this patient a previous diagnosis. In which case, it is most likely that the doctor is brazen in his attempt to deceive the patient.

Lying is a strange basis upon which to build trust. Will this lie make the patient feel less insecure, less confused and more inclined to confide in the doctor? If the object of the exercise is to help the patient become less confused and hence perhaps both feel and get better - rather than bamboozle and control him - such an approach is self-defeating. And yet *withholding information and deceit towards the patients is employed routinely within psychiatry, and is sometimes recommended to nursing staff as often appropriate*. As well as seeming convenient to the administration of a notoriously awkward 'clientele', the habitual use of 'harmless' deceptions towards patients is encouraged by the medical model. No doctor would expect an ordinary member of the public to be able to offer any useful understanding of the biology and medicine of his own illness. The psychiatric patient is supposed to be ill, and the illness which generates his troublesome irrationality is something which must be managed or remedied as quickly and efficiently as possible. Why, therefore, when the main symptom

of his sickness is his very irrationality, should the psychiatrist even begin to engage with a patient as a reasonable fellow human being, or listen to him for longer than it takes to diagnose the type of mental illness with which he is afflicted? Doctors are busy people. According to psychiatric theory, what a patient thinks is usually a time-wasting nuisance and very often a manifestation of the illness itself. What matter a few little white lies for the sake of the efficient delivery of psychiatric help?¹²

This is why, even though it determines whether and how to continue the psychiatric intervention, and whether to medicate and with which drug, and even though it is made *in full awareness of the absence of any evidence for the ascribed mental illness*, this particular doctor's off-hand, so-said diagnosis is not in fact exceptional. One study reported a random sample of a large number of diagnostic consultations at a typical North of England psychiatric unit, in which actual evidence (symptoms) of pathological behaviour was offered to support the continuance of psychiatric intervention (drugging) *in only 53% of the cases*.¹³

What strange branch of medical science is this, which half the time asserts the presence of an illness in the absence of any symptoms? Even so, could it be that psychiatrists' intuitions are often correct? Perhaps they *do* often see patients with all sorts of disabling and dangerous mental disorders which somehow abate at moments of psychiatric interrogation. In which case, what strange kinds of illnesses are these which appear or disappear randomly, or depending on the patient's whim or his circumstances? And what strange kind of medical science is it that routinely refuses to recognise this fact?

Along with the failure of research to discover the biological correlate or basis to a single kind of functional mental disorder, a central issue for psychiatry is this puzzling nature of the so-said mental illnesses: their tendency to manifest or abate, apparently depending on the patient's will or his circumstances; this, together with the general unwillingness of the professionals either to recognise or confess such a regular phenomenon. We hope to solve these puzzles towards the end of this Volume. At the moment we will say that, in fundamental distinction from the real illnesses of general medicine, the presence or absence of the symptoms of a functional mental disorder *always* bear some relation to the situation in which the individual finds himself. While 'the situation' includes the patient's body and mind, it also includes most significantly *his relationships, as he sees them*, to his own body and mind, and to everything and everyone around him. For example, perhaps there is something about the nature of psychiatric interrogation that often causes a functional mental disorder suddenly to abate (*or* to become florid). Perhaps this is something to do with the great power that a psychiatrist has to determine a patient's fate.

In the meantime, it is clear that anyone who is under psychiatric scrutiny would be well advised to avoid the staff and reveal as little as possible about himself, if he can help it, since it is apparent that official recognition of a so-said mental illness depends not only on the clear presence of symptoms but *just as much* on the whim of any doctor who is determined to make a diagnosis.

Organised callousness and the ill-effects of enforced drugging

Next we see John Baptist back 'in the community', in a bed-sit. He is still 'under a section', however, which is to say, compelled to submit to psychiatric authority. A community psychiatric nurse (CPN) visits to give him a depot injection. The patient complains that he suffers from the effects of the prescribed drug. Though, of course, why should anyone believe that this is anything serious? After all, the patient 'has schizophrenia': he is mad.

Expressing concern, the nurse says: 'Your mouth is shaking away.' He tuts and smacks his lips to demonstrate.

The patient responds: 'Uh-hum.'

12 Lin Bigwood reports that during her long and varied psychiatric nursing career she regularly witnessed lying to patients, and sometimes it was explicit managerial policy; she also witnessed academics recommending to trainee nurse tutors the tactic of lying to patients. See Chapter 10, below: Working as a Psychiatric Nurse.

13 Summers, S & Kehoe, RF (1996) Is psychiatric treatment evidence-based? *The Lancet* 10 Feb.

In a monotone, the psychiatric worker says: 'I really feel for you. [Long pause] Would you *take* one now? [referring to a pill he offers, presumably a psychotropic drug]... It's tough. [Pause] I'll get them for you.'

The patient looks unhappy. His lips tremble and he seems close to tears. He whispers: 'Okay.'

The psychiatric worker says: 'Mmmm.'

Since the first scene, it is clear that the legal power of psychiatry and the drugging have combined to repress the patient into miserable silence. The nurse recognises that the patient seems to suffer from the uncomfortable-looking effects of medication. These are supposed to be only side-effects to the psychiatrically intended effect of remedying or 'managing' the schizophrenic illness. As the medical formularies explicitly caution, however, they are in fact the well-known and not unexpected *detrimental effects* of the drugs. The psychiatric nurse is obviously not interested enough in these ill-effects to record or report them, let alone not to administer the offending drug. He is there for his own reasons: to get compliance for another shot of 'medicine' that will last another two weeks, and to belabour the definition of the patient's problem - that is, according to the psychiatric experts.

The nurse continues: 'Now, most of the clients I work with, [pause] because we feel they have a mental illness, they *are* entitled to a bus pass. [Longer pause] But you would have to sign something... Would that be all right?'

The patient says: 'Yeah.' [Pause]

The nurse says: 'Yeah. [Pause] It says that "I am permanently and substantially disabled"..... It's difficult, innit?'

The patient agrees: 'Yeah.' Reluctantly, he signs.

Here the psychiatric worker carefully denies any categorical diagnosis, and at the same time manoeuvres the patient into ratifying a prognosis - which necessarily presumes a diagnosis. This is expressed by the nurse saying that 'we *feel* [that our clients] have a mental illness' (our emphasis), rather than 'we *know*' and will stand responsible for the knowledge that they have a mental illness. He then holds out the carrot of a free bus pass if only the patient will sign a paper to the effect that he accepts the prognosis/diagnosis with which he will forever after be saddled.

Another key term in this speech which throws off official responsibility for the plight of the patient, as well as the need to listen to him carefully, is the use of the 'politically correct' euphemism: 'client'. Since 'client' denotes free entry into a contract, in the context of psychiatry this is a wretched misnomer. In any genuinely unforced manner, very few candidates are permitted to choose whether or not to become a psychiatric patient. At the moment of crisis, the individual is routinely offered the bogus choice of entering care 'voluntarily' by self-committal or, if he refuses, being 'sectioned' anyway - which is to say, compelled. In other words, it is not usually the person in crisis who freely employs psychiatry, but on the contrary, in accordance with the Mental Health Acts¹⁴, it is psychiatry which gathers in almost every patient under 'contracts' (legal instruments) largely of its own design and suited to its own purposes. Substituting the term 'client' for 'patient' is now in general use throughout the pre-emptively defensive psychiatric discourse: to say 'client' is to imply that the person subjected to psychiatry *is happy to employ* such a reasonable medical power. Sometimes, if someone takes himself to a doctor or is genuinely glad to get psychiatric help, it might make some sense to call him 'a client'. But that is not usually the case, and in this instance, since we know that the patient objects to his treatment, referring to him as 'client' is a motivated kind of double-speak. This can only confirm to him that those who hold him in their power are able to define reality and to deal with him in any perverse and dishonest manner they wish.

This is not to suggest that society does not sanction and fully approve the psychiatric view of diagnosis, or more generally, the standard methods of processing mental health patients (known as 'care' and 'treating' or 'managing the illness'). Nor is it to deny that some individuals might sometimes be glad of a psychiatric intervention. Yet to refer to the psychiatric subject as 'a client' who 'has a mental illness' for which no symptoms need be adduced, is to engage in a shameless public relations exercise rather than to recognise what the person might actually wish, who he

14 I.e., *The Mental Health Act* (1983), op. cit. (n. 70, Ch 1) and subsequent legislation.

employs, and what really are the problems that caused him to be delivered into the hands of psychiatry in the first place. It would be wonderful if psychiatry were ever to reach the point where its subjects did routinely become clients - where they could choose to go for help, or where they freely accepted it because they could decide what forms of help should be employed. At the moment we are far from that point, and it would take monumental changes in mental health legislation and official attitudes to reach it. Like previous legislation, the 2007 Mental Health Act refers to the psychiatric subject as 'patient', and although it is true that to assert their independence and self-respect many patients - especially those normally able to cope well enough 'in the community' - now prefer to be known as 'service users', this also glosses the fact that legally they remain under official surveillance and regulation.

In this instance, as regards agreeing to a prognosis/diagnosis in order to get a bus pass, since the patient is obviously not a rich man, and has been landed with a stigmatising label and the drugging anyway, one can imagine that he thinks: 'Why not sign?'

Coercion and humiliation at the psychiatric inquisition

In the last scene of the documentary we witness a kind of summarising meeting, referred to as 'the final consultation' - as if this is the last psychiatry will see of this particular patient. Present are the doctor, the patient and the psychiatric worker assigned to check and drug him.

The psychiatrist asks: 'So you feel [pause] now that y-you weren't b-born white, but that sometime in the past there'd been somebody white in your... [he takes a breath] ...ancestors?'

The patient cuts in: 'Yes, yes.' ...[pause]...

The doctor goes on: 'So you feel that when you were born you did have black hair and... [pauses and whispers] ...black skin.'

The patient says: 'Yeah.'

The interview continues in like vein, with the patient monosyllabic and accepting whatever the doctor says. Then the doctor, winding up, draws a deep breath and says: 'Would you be prepared to see me again after the section finished, or am I completely out of your life, then?'

There is a pause before the patient mutters: 'Completely out.'

The psychiatrist says: 'I'm out. ...[pause]... into outer darkness.'

The nurse laughs.

This exchange indicates that the patient is now almost completely subdued. In spite of being unable to resist asserting his independence just a little - by refusing to admit the value of the psychiatric intervention - generally he responds minimally, just enough to get by. John Baptist is not in a position to object when, as a response to being rejected, the doctor makes a racist comment. To object would risk the judgement that he 'over-reacts to a harmless joke', which could precipitate a detrimental re-evaluation of his case. For, at this point of the proceedings, John Baptist is still in the clutches of psychiatry. Equals may josh each other, but psychiatric power is no laughing matter. This is not care; conscious or not, it is a cruel jibe at the expense of a defenceless victim.

More than that, considering that he has the power to determine the fate of this patient, the doctor's ill-considered 'joke' is an example of racism more sickening than the bigotry expressed by the proverbial but generally powerless man in the street. At first, the psychiatrist is embarrassed when he talks about the patient's colour. He pauses and whispers the tabooed topic: 'black skin'. Then, when the patient spurns him, he makes a tasteless pun at his expense. To top it off, this 'joke' concerns the very issue which apparently so troubles the patient - the colour of his skin, i.e., racial prejudice, discrimination and oppression. Nervous or not, by laughing - and not then apologising - the nurse shows his complicity. Rather than genuinely caring and therapeutic, this 'consultation' ends with two insensitive functionaries abusing their legal powers by taunting a vulnerable patient.

In this documentary, and in celebration of 'good practice', we are presented with a travesty of care and a whole gamut of indecency and bullying: harmful drugging, refusing to entertain a patient's reasonable complaints, 'diagnosing an illness' in the absence of symptoms, lying to the patient,

ridiculing and attempting to humiliate him. Altogether, this illustrates the fundamentally unscientific, un-medical, arbitrary, unimaginative and heartless nature of routine psychiatry.

This response to a particular patient - apparently typical and 'good practice' - is probably also a good indication of how defensive and vulnerable psychiatric workers feel about the job that they do. They may feel they perform a thankless task of medical help and social welfare in the face of a relentless stream of fairly hopeless human misery. The work is often difficult, of course, and one can have a certain sympathy for psychiatric workers. However, this sympathy evaporates when they act as callous functionaries who refuse to reflect on what they do, and could so easily do so much more for a 'clientele' which is always more or less desperate for signs of human solidarity.

No psychiatric patient needs to be ignored, neglected and ridiculed; neither does he require officials to practice on him their harmful treatments and public relations deceptions. Instead, he needs genuine sympathy, care, understanding and material help. The kind of 'good practice' revealed by this documentary is likely only to cause patients psychological and physical harm.

An alternative perspective

There are no indications that psychiatry helped to improve the mental condition of this particular patient, or in any way reduced his misery. On the contrary, the psychiatrist and the nurse seem to add to his pains and, for good measure, they gratuitously insult him. It is likely that the patient would soon relapse and once again be back under close psychiatric care.¹⁵ The two officials might have used another approach had they not imagined that they helped simply by drugging him.

On camera, this patient showed no signs of a mental disorder, but various signs of good sense. In which case, we can easily imagine a form of care and treatment that his carers could have taken and which might have proved more therapeutic.

For instance, the first thing we hear is that the patient is confused about his colour, his ancestry, and the fate of his sister (who he thinks has somehow been lost to a stereotypically 'primitive African' fate); apparently, he also identifies with John the Baptist. Throughout all the 'good psychiatric practice' that he receives, why are none of these issues addressed by those supposed to help him? Rather than assume that it is appropriate to discount whatever he says that they do not wish to hear - as nothing but irrelevant babbling and delusion, the incomprehensible signs of the illness - why does no-one listen to the patient and reflect on what he says? The conventional psychiatric attitude is that a schizophrenic such as John Baptist jabbars a lot of nonsense, and to indulge him is not beneficial since any hint that that his delusions deserve serious consideration only makes the illness worse by encouraging his irrationality; on the other hand, medication helps by inhibiting the expression of his unreasonable beliefs and behaviour.

All the same, psychiatry's reliance on drugs is based on medical prejudice. Research has yet to establish that any kind of standard mental health treatment is particularly efficacious. At the same time, a number of studies indicate that listening to the patient so as to explore his problems - that is, counselling or psychotherapy - is *at least as therapeutic as any drug*, and without any of the damaging side-effects.¹⁶ In which case, why does almost every psychiatrist still insist on running through the routines of the standard 'good practices' depicted in this film? A patient is at the mercy of psychiatric power. Why do doctors and other mental health officials imagine that systematically disparaging him, causing him pain and distress, attempting to deceive him, and dismissing out of hand his feelings, experiences and beliefs, can possibly contribute to the recovery of his reason, self-esteem and peace of mind? By the same token, unapologetic attempts to simply sedate allegedly psychotic patients by means of harmful drugs must surely increase their fears of manipulation and isolation, and contribute to their alienation.

Except when the nurse comments on the drug-induced dyskinesia (and does nothing about it), in the documentary there is not even the hint of an attempt by either official to empathise with the

15 More than three-quarters of admissions to psychiatric facilities are re-admissions. See Bird, L, op. cit. (n. 21, Ch 1), 16.

16 See the evidence cited in Chapters 6 and 7, below.

patient so as to try to see things from his point of view. This sort of psychiatry - regular psychiatry - misconceives its project as essentially technical (medical) work on a malfunctioning object, the brain. It is not within the remit of the medical model to listen and respond to mental health patients as if their 'bizarre' beliefs might possibly bear some relation to their lives - perhaps to some or other unutterably awful experiences. Given the duress to which they are subjected by psychiatry, patients often get by with surprising composure and clarity. As it is, during the ritual which doctors say is the diagnosis of the illness (the mental illness), and during the enforcement of so-said care and treatment (usually restricting the patient's freedom and compelling him to submit to drugging or electroshock), anything whatsoever that a patient says may be conceived by a psychiatric official as trivial or meaningless chatter. Moreover, if he complains or expresses any kind of dissent, that is likely to be seen as another sign of the mental illness; in the eyes of psychiatry, unless he agrees with the official view of things, what the patient says is surely nothing to do with, or to throw light upon, the nature of any of his experiences (including his mental condition).

Mental health professionals stubbornly refuse to allow that there is a difference between a malfunctioning brain and one that works well enough but produces deviant thoughts and behaviour. And yet functional mental disorder is not reducible to brain disorder: that is why psychiatry is distinct from neurology.¹⁷ And while some individuals with mental disorders caused by real brain diseases are consigned to psychiatric care, the great majority of psychiatric patients are afflicted by mental disorders that are *purely psychological*. This particular patient was said to have 'a schizophrenic illness', which is not a neurological condition. In spite of this elementary logic, the kind of psychiatry illustrated by this television program - which is to say, nearly all psychiatry - thoroughly confuses psychology with physiology. In the process, it succeeds in confusing everybody about the real nature and most appropriate response to functional mental disorder.

Unwittingly, this documentary confirms our contention that blind faith in the medical model and unaccountable psychiatric power combine to stand in the way of a humane response to the patients. As a matter of televised fact, this patient - John Baptist - appears reasonable, whereas his psychiatric minders do not. Since there was nothing to prevent the two officials from taking seriously and dealing properly with the patient's complaints about the ill-effects of drugging, as any healthcare professional should have, their official powers seem to render them stupid, arrogant, neglectful and insensitive to the point of cruelty. Unquestioning pursuit of the tired old psychiatric routines seems to have inured these supposedly fine professionals to any fellow-feeling; psychiatric dogma, bigotry and callousness unite to prevent them from taking just a little time to empathise and help with the patient's physiological, emotional, psychological and social problems.

Leaving aside the questions we have already raised - most importantly, dereliction of duty with respect to a patient's complaints about the ill-effects of drugging - on the face of it, this patient's reported beliefs point to issues which might have been addressed by anyone who would acknowledge that they could indeed be significant.

Apparently, the patient had intimated various confusions. By the sound of them, they were most likely engendered by emigrating to live as a poor black person in a predominantly white and racist society. He expressed grief-driven beliefs about his sister's fate, probably heightened by confused shame about his colour (see the extract from Blake's poem at the top of this chapter), and quite likely by taunts about cannibalism that he would undoubtedly have heard. Denigration and alienation issued as a profound wish to be recognised, valued, included; this was expressed in the jumbled notions that he was white and a member of the British royal family,¹⁸ and by his self-perception as a powerful prophet in direct contact with God and foretelling a saviour, but who was fated to have his own head cut off.

17 In Chapters 12 and 13 below, we consider in detail the evidence and arguments around the correlation of brain-states and psychological states.

18 The patient is driven to deny his colour. The delusion that he has blue hair might be explained by the colour 'seeming black, but not *being* black'; also, royalty are said to have blue blood.

Here is a man who suffers from medically-induced pain, most likely also from much experience of prejudice, powerlessness and feelings of low self-esteem, and who probably became overwhelmed and confused under the combined impacts of loss, discrimination and the indignities and injustices regularly experienced by being black, African and poor. By way of compensation, and apart from saying he is a white royal, he identifies with an archetypal figure - a biblical hero who worked directly with God for truth and justice, and who hoped for a saviour but was beheaded by his enemies. If we take this last detail as a metaphor for the chronic and accumulating lobotomy effects of the psychotropic drugs routinely administered to any diagnosed schizophrenic, and given a history of encounters with psychiatry, this latter-day John is not deluded but *knows* that his doctor is determined to 'chop off his head'.

This cursory interpretation of the signification of one patient's 'schizophrenic symptoms' (delusions) is not offered as a definitive truth. Obviously, it is a speculation made at a distance. Nevertheless, it is the sort of hypothesis that in this case - and routinely - psychiatry fails to make or will ever consider. Yet it is because it refuses to listen to the patient, and to imagine what his delusions might signify - to consider their metaphoric or symbolic nature - that psychiatry cannot even begin to help him with the real problems and preoccupying anxieties which overwhelm the balance of his mind.

Of course, it is likely that more details of the case and of this patient's beliefs or delusions would reveal a more complicated picture requiring a more subtle analysis. Like this psychiatrist, however, most of his colleagues would also refuse to entertain the possibility that any patient's 'bizarre' ideas and behaviour are at all interesting except as symptoms - meaningless babble, signifying only that the person 'has a mental illness'. Furthermore, if they take exception to them - which in 'good practice' they do, as witnessed by this documentary - they are able to insist that a patient's fully rational ideas and behaviour are *also* symptoms of his illness. When, in this manner, psychiatric officials are in league to deny the patient's significance, their oppressions only add to his problems. Especially when there is no attempt to carry out any kind of psychological and social analysis, medicating psychiatry simply adds to the number of anxieties which already afflict the patient.

It might be objected that the case of John Baptist is no more than anecdotal evidence - only an unfortunate exception to the normally reasonable and compassionate workings of psychiatry. But that patient's experience was not unusual: the psychiatric advisors to the documentary recommended the officials' dealings with him as a wonderful display of 'good practice'. Again, it might be imagined that in the meantime psychiatry has reformed, and what was then considered 'good practice' is now substantially changed for the better. But this is not the case: the same unfounded medical model remains the unquestioned reference-point for care and treatment, and there is no evidence that there have been significant changes in psychiatric practice since this film was made.

As we shall see throughout this Volume, if the object is to alleviate personal misery, it is by no means certain that psychiatry is helpful to many patients. Neither does it address the problem of that substantial sub-population of individuals who suffer year after year from chronic emotional distress and mental disorder. Mental health provision based on the medical model is a false economy. Over the years, patients who are forever relapsing demand a great deal of attention from the psychiatric and social services. The *systematic* lack of thoughtful care and appropriate treatment is rationalised by the medical model and the exigencies of case-loads: 'There are too many patients. We can't spend a lot of time with them all'. Be that as it may, in order to reduce the number of cases and the burdensome long-term human and financial costs, why not in the first place listen carefully and analytically to each patient, and with genuine sympathy and empathy try to help each to reduce his misapprehensions, re-establish his mental equilibrium, and get his life back together?

We are told in this documentary that the patient John Baptist harbours certain delusions. And yet throughout the film there is no sign of them and he seems entirely reasonable: it is the psychiatrist and the nurse who are breathtakingly irrational and irresponsible. Perhaps there were reasons for the patient feeling the way he did, and even for expressing himself by means of the delusions that apparently he had once announced. 'Good practice' psychiatry would never know. It takes no interest in a patient's version of events, or in his emotional and mental pains. It is not even interested in his

physical pain: since it is reported by a psychiatric patient, who is defined by his irrationality, it may be casually discounted as a fabrication or delusion. Nonetheless, this patient was clear enough about his experiences of the ill-effects of the drugs he was forced to endure - '*side-effects*' that are actually listed and cautioned in the standard drug formularies. Compared to general medicine, which is at least prepared to listen and respond to patients' complaints about how they feel, psychiatry is positively hazardous.

In short, psychiatry took no interest in this patient, except to silence him. At the same time this was rationalised by declaring an interest in his illness - his so-said mental illness.

How is it that in every modern society there is officially organised disregard for the humanity and well-being of those who suffer from emotional or psychological oppression? How do the perpetrators of the faux medicine of the mental health service contrive to remain entirely reputable? Even when they have the best of intentions, it is the ill-conceived and unevicenced medical model which, as a matter of routine, rationalises and permits psychiatrists, nurses and other functionaries to oppress their patients; or rather, we should say, the medical model *positively inspires* the oppression of every mental health patient. And how is it that mental health officials, and the wider public which employs them, cannot see this, even when it stares them in the face?

We hope these questions will be answered as we pursue our argument during the course of this Volume. Briefly, we will see that psychiatry is a particular institutional embodiment of the general but largely unacknowledged character of the *oppressive social relations*. The historical development of alienated psychiatric care and treatment is discussed in Chapter 14, below; we will see that the deluded and arguably *psychotic* behaviour of the psychiatric experts is, in the statistical sense, *entirely normal*. It therefore seems to us that the present organisation of the management of mental disorder must be both an expression and part-fulfilment of an unrecognised but universal neurotic need. And while the social formation of psychiatry is sustained under the impetus of that general neurosis, in turn this social formation serves to reinforce and sustain the neurosis. It seems to us that *psychiatry functions not so much to assist the afflicted by remedying their unbearable emotional distress and mental turmoil as to protect the emotional and material interests of everybody else*.

The two officials who dealt with the patient John Baptist surely must have imagined that this documentary testified to their fine intentions and exemplary psychiatric skills. Despite all their 'good practice', however, did either of them really care about him?

The legal repression of John Baptist by medical power, resulting in dyskinesia, physical pain, lethargy, cowed silence and abject misery, is an all too typical result of 'good psychiatric practice'. Towards the end of the film this patient eloquently expresses his oppression by psychiatry when he is left alone and talks to the camera:

'My body seems a blur. You know, sometimes you feel your body twisting. [pause] You know what I mean? Twisting painfully. As though somebody were pressing you, pushing you against yourself.'

Chapter 5: DIAGNOSIS

Simplification is usually part of a manoeuvre in some struggle for power. Simplifications are self-serving; most political leaders simplify... Walter Benjamin wrote 'The state of emergency in which we live is not the exception but the rule.' ...Within this concept of history we have to come to see that every simplification, every label, serves only the interest of those who wield power; the more extensive their power, the greater their need for simplifications. And, by contrast, the interests of those who suffer under, or struggle against this blind power, are served...by the recognition and acceptance of diversity, differences and complexities.

John Berger¹

This chapter includes a synopsis of psychiatry's taxonomy of the functional mental disorders - the so-called mental illnesses. But first we comment on the peculiarity that a mental health diagnosis is not decided by the normal rules of medical science, and that consequently it can never shake off the suspicion of being an arbitrary and motivated judgement.

The peculiar nature of mental health diagnosis

Psychiatric medicine differs from general medicine in a number of surprising ways. First of all, and by definition, none of the diagnostic categories of mental disorder derive from the discovery by medical science of an actual illness. If someone thinks or behaves with worrying irrationality, and an organic cause is evident, we know that he suffers from a medical condition - a particular neurological or brain disease. As distinct from real (neurological) illness, however, when there is no organic cause for his worryingly irrational ideas and behaviour, someone is said to suffer from a functional mental disorder. Confusingly, it is not generally referred to as such; instead, it is known as a mental illness.

Bizarrely, psychiatric reasoning contrives to both acknowledge and yet ignore the distinction between organic and functional disorders. The dogma which rules psychiatric practice - the so-called medical model - continues with the same logical blunder it has been making for a hundred years: it takes a figure of speech - 'mental illness' - as reference to a biological process, to *actual* illness. The notion of 'mental illness' is not a product of science, and nor does it have any scientific utility: there is no evidence to support it and it cannot generate an explanation for anyone's irrational ideas or behaviour. The same applies to all the sub-categories of psychiatric diagnosis: none of the listed mental disorders has an identifiable organic cause; each is no more than a *scientific-sounding* tag given to what appears to be a cluster of worryingly deviant behaviours or compulsions, and irrational perceptions, ideas and attitudes, of a distinct type that distressed individuals regularly present.

Meanwhile, research blunders on unreflectively, trying to bring precision to ideas which in their normal everyday use were only ever rule-of-thumb, and could never have any other reasonable employment. For, in the absence of organic pathology, there is no evidence to suggest that anyone is ever *essentially* depressed or psychotic, paranoid, anorexic, OCD, or whatever - that he 'has a depressive illness', 'has psychosis', or 'has OCD', etc., etc. When the psychiatrists refuse to imagine that stress and psychological trauma might be sufficient to cause a person to become worryingly depressed or psychotic, etc., they commit the logical error of *misplaced concreteness*: they mistake a certain kind of undesirable behaviour - someone's troublesome irrationality - for a different order of

¹ Berger, J (2007) *Hold Everything Dear: Dispatches on survival and resistance*. London: Verso, 127.

events, i.e., for a tangible object or process - an illness. In the face of overwhelming evidence to the contrary, psychiatry will never allow that its categorical tags *might not* indicate distinct emotional or mental entities, each with its own discrete organic cause.²

Unlike diagnosis in general medicine, which detects real pathophysiological events, the various categories of mental disorder/mental illness are *imaginative constructs*. They are part of a *medical fantasy* which has conjured up an ever-expanding taxonomy of what are imagined to be many different syndromes (or clusters) of inter-related irrational kinds of belief, attitudes and behaviour.

The confusion of functional mental disorders with organic conditions was established during the first years of the 20th century by the psychiatrists asserting that, despite there yet being no discernible organic process or cause, the diagnostic category 'schizophrenia' signified a disease: within the profession it was agreed that certain forms of psychotic behaviour may be grouped together as one *alleged* disease. This was nothing more than a wishful conjecture.³ The purported discovery of an increasing variety of so-said mental illnesses began to accelerate after this decision. Because there are so many different ways of thinking and behaving irrationally, thereafter the putative medical science of psychiatry was bound to come up with a growing number of diagnostic categories - and until very recently there always seemed to be new ones to 'discover'.

Consequent to the distinction between organic illness (neurological or brain pathology) and the *imaginatively constructed* so-said mental illnesses, psychiatric medicine is conceived and carried out quite differently from general medicine, and in many ways at odds with it.

- As we have indicated, when someone is diagnosed with a mental illness this is because there are no signs of actual illness, of a neurological or brain disease. 'Mental illness' is a confusing misnomer. Really, it may only be accurate to say that a person suffers from a 'functional mental disorder' - that is, not from any discernible illness but from an apparent inability to function adequately due to a disabling *psychological* condition. Most mental health patients suffer from emotional and psychological malaise, not organic pathology.
- Although general medicine does have certain legal powers to isolate people with dangerous contagious illnesses, psychiatry is medically unique in that its practice is *based in* the legal possibility of compelling anyone diagnosed with a serious mental disorder to submit to care and treatment. *Any* psychiatric diagnosis therefore has immediate implications for civil liberties.
- In general medicine, diagnosis - and hence prognosis and choice of treatment - follows from interpreting symptoms (often by using bio-chemical tests) which usually more or less *clearly indicate* one organic pathology rather than another. Prescription is then in accordance with an *indication* for a specific diagnosis. By contrast, mental health procedure routinely inverts this logic: diagnosis and prescription accord with *contra-indications*, i.e., according to whichever treatments *do not* seem to work for the particular patient. This means that often the doctor experiments on a patient with this or that treatment (usually a drug) and *then* closes in on a specific diagnosis when it seems that one treatment which is advertised as specific to a certain kind of mental illness produces a beneficial effect, when others do not. Medical experimentation on the patient population (and with poorly informed consent, or compulsion) is an integral part of the mental health project. On the face of it, this practice offends natural justice, common morality and the medical ethic: First, do no harm.

There is no theoretically coherent and scientifically substantiated basis to *any* conventional mental health diagnosis (or treatment); it is always essentially 'trial-and-error', based only on speculative or anecdotally confirmed beliefs about 'which treatment sometimes seems to work', and therefore what the specific condition 'must be'.

- Whereas there are generally clear and indisputable symptoms or bio-chemical tests for the real illnesses discerned by general medicine, it has been known for decades that statistically there

2 This point is further explored in the section: The myth of the medical science of psychiatry, in Chapter 13, below.

3 The political process by which this diagnostic category came to be adopted by the psychiatric profession is described in the section: The invention of schizophrenia, in Chapter 14, below.

is only poor agreement between any two doctors about the category of mental illness to which any one patient should be assigned.⁴ Furthermore, patients often have the diagnostically dismaying tendency, in their ideas, attitudes and behaviour, to drift or suddenly jump from one category of mental illness to another. But if there is no reliable diagnosis for any given patient, how are we supposed to have faith in the various specific treatments doctors nonetheless prescribe? There is bound to be this kind of confusion, however, since mental health's diagnostic categories do not identify real illnesses; as we say, they are nothing more than imaginative constructs based on judgements about the different kinds of psychological malaise that people seem to present.

- As we saw in Chapter 4, above,⁵ it is also bizarre that doctors *very often* make a mental health diagnosis when the symptoms for that diagnosis are absent. In general medicine, absence of symptoms of course indicates that the person *does not have* a suspected illness. Apparently, for some undisclosed reason, this is far from always the case with psychiatry.
- The overall result of this medically eccentric diagnostic system is that in practice, *and in the name of 'good practice'*, psychiatry is also peculiar in that if a patient complains about the ill-effects of treatment, *very often* this is either ignored or construed as further evidence for the presence of the illness, and therefore for increasing the potency of the treatment. The reasoning is that the patient either exaggerates or lies about the ill-effects - which is viewed as a sign of his continuing mental illness, and therefore of his need for more treatment - or that his reports of ill-effects are perhaps to an extent true but do not outweigh the benefits of the treatment. After all, according to the medical model a person is only a psychiatric patient because he is intrinsically unreasonable.

In the meantime, most of us entertain the complaisant belief that we live in a wonderful scientific age when advances in chemistry have produced a full range of cures for all the mental illnesses, or at least good enough palliatives. Mental health professionals certainly seem to believe it. Psychiatry's diagnostic typology is supposed to make distinctions that allow doctors to discern the separate natures of the various kinds of mental disorder, so that each patient may benefit from a specific technical response. And everyone imagines that by their miraculous alchemical research and development, the pharmaceutical houses are always able to devise wonderful new and improved concoctions which are just the job for managing all known mental illnesses as well as suddenly discovered new ones.

In point of fact, all this apparent progress is only sustained by the drug companies pouring money into lobbying and bribing influential psychiatrists and politicians, and aiming public relations exercises, advertising, promotions and more bribes at every other doctor, nurse and mental healthcare manager. The upshot is that during the forty years to 1994 the number of types of mental illness increased nearly fourfold, and every different so-said mental illness seemed to call forth its own specific so-said remedy. More accurately, in a devious twist which serves best to benefit the drugs companies, it transpires that at least during the last thirty years or so it has been just as likely that the production of each new drug has called forth the invention of its own specific new diagnostic category.⁶ Psychiatric drugs are a significant part of the total pharmaceutical product, and sustained growth in the sales and profits of the drugs companies during the last sixty years made this one of the world's most profitable industrial sectors.

In the next few chapters we will see that the assumptions that underpin the whole of modern psychiatry are not supported by sound science: its techniques and practices are not based in reliable

4 Doering, CR (1934) Reliability of observation of psychiatric and related characteristics. *American Journal of Orthopsychiatry* 4 249-257; Ash, P (1949) The reliability of psychiatric diagnoses. *Journal of Abnormal and Social Psychology* 272-276; Grove, WM et al (1981) Reliability studies of psychiatric diagnosis: Theory and practice. *Archives of General Psychiatry* 38 4 408-413; Matuszak, J & Piasecki, M (2012) Inter-rater reliability in psychiatric diagnosis. *Psychiatric Times* 29 10 5 Oct. This anomaly is discussed in the text to footnotes 33 to 38, below.

5 See the text to footnote 13 in Chapter 4.

6 See the argument in the text to footnote 23, below.

research evidence. Doctors cannot even regularly agree about which type of so-said mental illness it is that any particular patient suffers from. Nor can medical psychiatry claim to cure any kind of functional mental disorder, or even provide greater relief from the pain of emotional distress and mental turmoil than non-medical techniques. Nor is it certain that the latest types of medication are more effective and have less harmful side-effects than the older ones. Moreover, as we just pointed out, neither is it true that so many new mental illnesses have been *discovered* in recent years - rather, the multitude of purported mental illnesses has simply been *devised* from the wishful imaginings of psychiatrists, and most commonly those funded by drug companies interested first of all in expanding their markets.

Psychiatry takes an interest in emotional distress and mental disorder only when it reaches a certain critical point for the person, or an overt degree of intolerable social nuisance. We remind the reader that in this book we are not concerned with the organic mental disorders, i.e., actual, identifiable neurological diseases; there are textbooks which give useful information about them.⁷ We should also mention that it is possible for doctors to presume the presence of a psychiatric disorder when there is none, and often simply due to confusions triggered by specific organic problems a person has with his hearing, eyesight or memory. This is especially the case with respect to dementias in the elderly, where there is currently some controversy about the attribution of the diagnosis of (organic) Alzheimer's disease to every dementia in old age. Some authorities reckon that probably half of all such diagnoses are wrong; the problem, of course, is that the presence or absence of cortical atrophy is not easily assessed until post mortem.

Otherwise, in the absence of any signs of an organic disease - which is the case with the great majority of those who become mental health patients - psychiatry speaks of 'the functional mental illnesses'. To characterise as 'functional' a more or less severe emotional or mental disorder - a disorder of functioning alone - is to recognise the absence of any discernible organic cause. It is therefore confusing, in the same breath, to call such a disorder 'an illness'. Since there is no evidence of an actual disease but only apparently something worryingly wrong with the patient's beliefs and behaviour, it is incorrect to say that he 'has an illness'; it is only safe to say that he presents with 'a mental disorder'.⁸ In which case, attempts to investigate and remedy most mental or behavioural disorders might more fruitfully focus first of all on processes of the person and his social relations rather than on any particular part of his organism (e.g., his brain). If there is no discernible organic cause - no real illness - a doctor succumbs to dogma if he only looks for a medical cause and cure, while he is illogical, ignorant or dishonest if he claims the undoubted efficacy of medical treatments.

However, with regard to its fundamental concepts and beliefs, the psychiatric medical model dispenses with logic and evidence. According to psychiatry's characterisation of 'functional mental illness', absence of evidence for an organic cause is simultaneously acknowledged and disregarded: a mental disorder is recognised *only* by the person's abnormal behaviour and ideas (and not by any signs of organic disease), *and yet* it is assumed that the malfunction signifies illness. The general agreement that functional mental disorder is nevertheless a kind of *illness* immediately sidelines those emotional, psychological and social problems which actually lie at the root of any such malaise.⁹ Today, and ever since the inception of psychiatry, when someone is diagnosed as 'having a mental illness' this is understood by the orthodox mainstream not as his becoming confused and overwhelmed by serious problems in his life; instead, by sheer misfortune, the individual is supposed to have 'contracted' or 'developed' a disease within his brain - a disease with a curiously undetectable nature and cause. Meanwhile, absence of evidence does not prevent doctors from subscribing to a belief that has held sway for the last fifty years: the notion of chemical imbalance.

7 For example, Thompson, T & Mathais, P (Eds) (1998) *Lyttle's Mental Health & Disorder*. Oxford: Balliere Tindall, which is also full of good nursing advice.

8 Although even that may be dubious since it is not unusual for psychiatrists to diagnose a mental disorder in the absence of any signs of abnormal behaviour or ideation. See text to footnote 13 in Chapter 4, above.

9 That functional mental disorders may be sufficiently explained by reference to social-psychological processes is demonstrated throughout Volume 2.

This asserts that there is a critical deficit in the brains of the mentally ill. Nowadays, if a patient is diagnosed with clinical depression, doctors generally assume the truth of the serotonin deficit hypothesis; if he is deemed psychotic, the dopamine theory.¹⁰

Psychiatry is not primarily interested in making practical interventions in the problematic lives of distressed and confused individuals. When mental disorder is viewed as illness, this indicates only (or mainly) a medical response. Psychiatry *wishes* that it could find organic causes for the functional mental disorders which it names and describes, and this wish issues magically in the near universal agreement that there *must be* organic causes. In spite of this, more than a hundred years of psychiatric research has failed to locate a single organic disease, genetic aberration or chemical abnormality as a cause of any so-said mental illness (functional mental disorder). If psychiatric research ever did find such a cause, that would make the mental disorder the result of a real illness: it would make it an organic mental disorder, i.e., another neurological or brain disease.

This point of dogma within the mental health consensus - that every serious mental disorder *must have* an organic cause - is a kind of science fiction born of wishful thinking. More than this, it masks the unsavoury truth about the agenda of psychiatry and its pseudo-medical interventions. Considering that it underpins and rationalises the standard techniques and routines of psychiatric diagnosis and treatment, all of this muddled theory and practice is to the main advantage not of mental health patients but of the drugs companies and the complacent monopoly exercised by the medical profession over the management of those emotional or cognitive deviants who find themselves consigned to its authority.

The diagnostic categories

As this book pursues its argument, we demonstrate that the belief that functional mental disorders are illnesses is always misleading and fundamentally unhelpful; often it is harmful to patients - too often disastrously so.¹¹ No matter how false and fantastic a belief, there can be far-reaching real consequences whenever a powerful group subscribes to it. Naturally, psychiatry's medical fantasy is couched in terms which have the look of science. Like the authentic science of biology, it begins with a kind of taxonomy. Doctors refer to this scheme so as to organise what they suppose is appropriate care and therapy. The essentials of this taxonomy emerged from the everyday, pre-professional discourse of common sense, and they might once have had a certain value. As it is, the system of diagnostic categories is by now preposterously overblown, and it is generally used to support the notion that each supposedly discrete 'illness' - each so-said mental illness - 'must have' its own genetic or biochemical cause and its own specific medical remedy.

Doctors broadly distinguish:

- Cognitive disorders, which affect learning, memory, perception and problem solving; they include amnesia, dementia and delirium.
- Anxiety disorders, characterised by feelings of anxiety and fear - where anxiety is excessive, preoccupying and apparently unreasonable worrying about future events and fear is a reaction to current events. These conditions may cause physical symptoms such as accelerated heart-rate, palpitations and trembling. The various types are named for their symptoms and patients' expressed feelings; the most commonly diagnosed are generalised anxiety disorder, phobias (including agoraphobia), social anxiety disorder, separation anxiety disorder, and panic disorder.
- Mood disorders, diagnosed where the main feature is deterioration of the individual's emotional equilibrium. Mood may be elevated, depressed or oscillating; i.e., where there seems to be mania or hypomania, a major depressive disorder (MDD, aka clinical depression, unipolar depression or major depression), or bipolar disorder (formerly known as manic-depression).

10 E.g., Schloss, P & Williams, DC (1998) The serotonin transporter: A primary target for antidepressant drugs. *Journal of Psychopharmacology* 12 2 115-121, and Seeman, P, et al (1975) Brain receptors for anti-psychotic drugs and dopamine: Direct binding assays. *Proceedings of the National Academy of Science* 72 11 4376-4380.

11 The reader who wishes to see the argument of these matters is referred to Chapters 12 to 15, below.

- Psychosis, referring to an abnormal mental condition involving ‘loss of contact with reality’. Someone undergoing a psychosis may manifest personality changes and thought disorders; depending on the severity, there may be unusual or bizarre behaviour, difficulties with social interaction, and impairments in carrying out the normal activities of daily life.¹²

Unless the cause is demonstrably organic, e.g., a brain trauma or Alzheimer’s, conventional psychiatry offers no persuasive causal theory for any of these disorders.

In practice, doctors distinguish mildly incapacitating from severe kinds of mental disorder (or as they call it: mental illness). This conforms to the distinction between neurosis and psychosis, established towards the end of the 19th century. ‘Neurosis’ derives from the Greek: neuron = nerve; it denotes pathology of the nerves = ‘nervous illness’. Sometimes a person might feel or appear emotionally or mentally quite disturbed, but his condition does not seem to present an imminent danger either to himself or to those around him, and he does not abdicate responsibility for his own behaviour. If he is so worried by the development that he goes to a doctor, nowadays he it is likely to be diagnosed with anxiety or depression, or perhaps obsessive-compulsion disorder (OCD). The neurotic is plagued by irrational symptoms but otherwise remains sufficiently rational: he believes he has a mental health problem, he seeks and accepts help from professionals, despite his problems he remains broadly in touch with consensual reality, and he is able to pass as essentially ‘sane’.

The term ‘psychosis’ is from ‘psukhe’ = breath, life or soul; it denotes incapacitating mental derangement so severe as to pose a threat to the welfare of the individual or those around him. Clinical psychosis is defined by signs of the person’s inability to apprehend or interpret consensual reality, or there is evidence of his inability or refusal to play the roles expected of him (without giving any culturally acceptable reasons); this is accompanied by ‘failure of insight’, as manifest by the person refusing to accept that he is unwell and in need of care and treatment. Due to his more pervasive irrationality, a psychotic is more completely incapacitated than a neurotic. Typically, he undergoes a symbolic transformation and formulates and tries to live by ideas about himself and the world which are at odds with any viable consensus. The law requires psychiatry to take responsibility for the supervision of anyone who appears psychotic.

As we mentioned, cognitive disorders are distinguished from mood disorders. The latter are recognised as less clearly irrational, more diffuse, more purely emotional, and less active inclinations of the person which nevertheless tend to separate him from social life. Clinically, ‘mood’ is a state of feeling or inclination, an affective condition¹³ or an undesirable attitude towards life in general that persists beyond any immediately obvious cause. When someone’s mood is ‘poor’, a particular negative emotion is present ‘in a condition of sub-excitation’ and may be evoked ‘too readily’. Depression, mania and bi-polar disorder (manic-depression) are known as the major affective disorders since they appear specifically rooted in an emotional disorder, and can be severe to the point of psychosis.

Others who find themselves consigned to psychiatry are said to have a behavioural or personality disorder (PD), or a borderline personality disorder (BPD).¹⁴ These patients usually seem sufficiently rational or ‘in touch with reality’, but they are perceived as generally intending to cause mischief and reluctant or unable to accept full responsibility for their deviance. This category includes persons who cause alarm and nuisance by persistently loud and outrageous behaviour, or are habitual but

12 These groupings are specified in *The Diagnostic and Statistical Manual of Mental Disorders, Text Revision: DSM-IV-TR* (2000) New York: The American Psychiatric Association.

13 In psychopathological discourse, ‘affect’ is feeling or emotion attached to an idea.

14 A diagnosis of personality disorder (PD) is nowadays almost invariably qualified as ‘borderline’: borderline personality disorder (BPD). Why has ‘full-blown’ PD fallen by the way in recent years? Does this indicate that these days few people have a personality which is very clearly disordered, but many are still ‘on the edge’ of outright PD? Or that psychiatrists’ skills are so improved that they can now better distinguish ‘full-blown’ from ‘borderline’? Or is it perhaps that the doctors do not wish to commit themselves, and might evade full responsibility for making the diagnosis by its qualification: ‘maybe disordered, maybe not; maybe a mental illness, maybe not’? BPD officially entered the diagnostic lexicon in 1980, in *DSM-III*, op. cit. (n. 103, Ch 1). See Proctor, G & Shaw, C (2004) Borderline personality disorder under the microscope. *Asylum* 14 3 6-7.

unsuccessful petty criminals, sexual deviants or addicts, or they self-harm or try to commit suicide. It is mainly women who attract such a diagnosis.

By unwitting word-magic, every psychiatric diagnosis translates what in everyday life would be an adjectival trait - a description - into an undoubted noun - a 'thing' with a proper name: 'an illness'. Instead of someone 'being depressed' - perhaps due to the contingent circumstances of her life - it is said that she '*has a depressive illness*'; instead of talking of a disorderly person or her disorderly behaviour, it is said that she '*has a behavioural disorder*' or '*has a personality disorder*'. This implies that the disorder is rooted in some kind of disease which happens to have descended upon the unfortunate person from out of the blue, or developed within her as some hitherto unsuspected part of her constitutional or genetic make-up. In this manner, a behavioural attribute magically becomes the essential condition of the person: her illness, her mental illness. This linguistic sleight-of-hand performs a crucial ideological function in the psychiatric discourse. It suggests that *because she has an illness which manifests as irrationality*, the patient is intrinsically unable to respond reasonably - either to the deviant ideation and behaviour which calls the diagnosis down on her, or towards other aspects of her life. The *only* appropriate action, therefore, is to *make the individual submit absolutely* to that specialised medical authority which will work on the disease or constitutional quirk which supposedly caused the failure of her reasonable executive agency. And yet, as we have seen, a person who exhibits a functional mental disorder *is not in fact ill* - otherwise she would be taken to a general hospital to receive genuine medical assistance.

Except perhaps to those psychiatrists who believe in the medical model and have to make snap decisions on a daily basis, it should be obvious that the diagnostic criteria by which an opinion is decided - as to whether or not someone 'has' this or that mental illness - are bound to be problematic, and are likely to be charged with unacknowledged aesthetic, normative and political assumptions and judgements advanced by a variety of interested and motivated parties.

The diagnostic types are distinguished by the forms of behaviour displayed by those who suffer from the apparent conditions. Among the less worrying kinds of mental disorder (the neuroses), a major category is depression. Until recently doctors used to distinguish 'reactive' from 'endogenous depression': those for which a psychological or emotional cause seems obvious and 'reasonable', and those for which there is apparently no good reason. This is now unfashionable and the distinction is generally blurred, or the belief that *serious* depression has an organic basis continues by calling it a major depressive disorder (MDD), i.e., especially where the depression seems to require a psychiatric response rather than only GP treatment. MDD is 'a mood disorder distinguished by...one or more major depressive episodes'; it is diagnosed when someone experiences

five or more of the following nine symptoms for at least two consecutive weeks (at least one of the symptoms is depressed mood or loss of interest or pleasure [anhedonia]): depressed mood; marked reduction of interest or pleasure in all, or almost all, activities most of the day, nearly every day; changes in appetite that result in weight losses or gains unrelated to dieting; insomnia or oversleeping nearly every day; psychomotor agitation or retardation nearly every day; loss of energy or increased fatigue; feelings of worthlessness or inappropriate guilt; difficulty thinking, concentrating, or making decisions; and recurrent thoughts of death or suicide, or attempts at suicide. The symptoms produce significant distress or impairment in social, occupational, or other areas of functioning, and the episode is not accounted for by the physiological effects of a substance or by another medical condition. The occurrence of one major depressive episode typically leads to the diagnosis of major depressive disorder except under a few circumstances, such as having had a manic or hypomanic episode in the past. A cause or trigger for major depression may not be identified in all individuals. However, genetic predisposition and/or disturbances in levels of the neurotransmitters serotonin, dopamine, and norepinephrine are believed to be the underlying metabolic abnormalities in most cases.¹⁵

15 *Major Depressive Disorder* (2017) www.mdguidelines.com/depression-major Note the end of this quotation, where it is assumed that if no 'trigger' is identified, all the same there simply must be an organic cause.

The above quotation may serve as an example of how the presence of various symptoms are said to relate as the constituents of a diagnostic category. Another major category is anxiety. Psychiatrists recognise various types: free-floating or generalised anxiety, perhaps occurring as fear, tension or panic attacks; or anxiety focused on unreasonable fears about one's health - hypochondria; or that manifesting as a phobia - an overwhelming but unrealistic fear of specific objects or situations; or anxiety as obsession-compulsion - an irresistible preoccupation with some unreasonable belief and a compulsion to perform a particular kind of repetitive behaviour (a ritual) to assuage the fear. Also recognised is neurasthenia - unaccountable lethargy and fatigue; depersonalisation - feelings of emptiness or loss of identity; and derealisation - an acute feeling that the world is unreal. Cases are rarer these days, but there is also conversion hysteria - claimed or apparent presence of physical symptoms such as pain, deafness, blindness or paralysis, in the absence of any recognisable physical cause, and perhaps accompanied by seemingly baseless affect or indifference; and dissociative hysteria - the apparent separation of part or parts of the person from a consciously controlled whole, manifest in behaviour such as sleepwalking, trance states, and dual or multiple personalities. If someone is seriously incapacitated by any of the beliefs or behaviours in this list, he is considered to suffer from a psychosis.

Psychiatry also distinguishes paranoia,¹⁶ which involves delusions of persecution and grandeur; these days paranoia is usually subsumed under the diagnosis of schizophrenia. Psychiatrists used to employ Bleuler's differentiation of schizophrenia into four main sub-types: simple - absence of florid delusions or hallucinations, but a marked withdrawal from social life and a tendency to fantasy and apathy; catatonic - manifesting (or alternating) as withdrawal to the point of stupor or mania; hebephrenic - regressive, infantile 'silliness'; and paranoid. These days the undifferentiated category 'schizophrenia' seems to be applied to any psychosis not considered a kind of depression or bi-polar disorder: it is a catch-all category for psychosis which onsets in adolescence or early adulthood, and which is generally marked by hallucinations or delusions.

As we mentioned, there is also the residual, broad category of the apparently less irrational personality or behavioural disorders. The two types are not clearly differentiated in theory or in practice - really they make up one category. While considered neither clinically neurotic nor psychotic (because otherwise, in themselves, not more than temporarily incapacitating), self-harm and attempted suicide are nevertheless thought to be symptoms of a personality or behavioural disorder. Nowadays, chronic and disabling alcohol or substance addictions are also considered mental health conditions. The general category of personality disorder (PD or BPD) also includes naïve individuals who are a habitual a nuisance, as well as those who are preoccupied or driven by bizarre, inappropriate, alarming or dangerous sexual urges (mostly pertaining to paedophilia). Homosexuality (but not lesbianism!) used to be listed as a mental disorder and was often subjected to compulsory psychiatric treatment, but not since de-criminalisation (in England in 1967). The eating disorders, anorexia and bulimia, were added to the personality disorders in the last twenty years or so, even though there seems no reason for not regarding them as kinds of obsession-compulsion.¹⁷ Psychopathy and sociopathy seem to be interchangeable diagnoses applied to those asocial or anti-social individuals who do not seem particularly irrational and do not seem to fit any other diagnostic category but end up as psychiatric patients because they seem a danger or serious nuisance to others.

Autism is disconnected, schizophrenic-like behaviour which is recognised in infancy by a child's failure to develop normally. The symptoms are an absence or worrying impairment of social interaction, communication and development of the imagination; i.e., it manifests as self-isolation, restricted interests and obsessively repetitive behaviour. There is dispute as to whether autism is always organic or may be functional. Although organic cause has yet to be shown for most cases, at the moment the consensus runs to it being the result of some genetic or constitutional peculiarity (e.g., a birth defect) since in many cases there is a clear correlation of one or other kind of genetic or birth abnormality with such behaviour.

¹⁶ From Greek: *paranoos* = distracted; hence: *paranoia* = distracted with (or by) fear.

¹⁷ They are often reported by sufferers as the only way in which they can express and identify themselves.

By definition, a functional mental disorder (so-said mental illness) has no apparent neurological cause. Consequently, the diagnostic categories of the medical model are fairly arbitrary and it may well be that when many adult psychiatric patients are diagnosed with this or that mental illness - such as OCD, sociopathy or personality disorder - their problem is really an unrecognised degree of autism or Asperger's, and that the underlying condition is constitutional. Paediatricians now recognise degrees of autism - 'the autistic spectrum' - but many educationalists and psychiatrists still employ the traditional categories.¹⁸ As a result, if problems are recognised during childhood they may simply be said to be 'learning difficulties' or 'special needs'; and when the adult goes on to fail to live up to social expectations, due to the same autistic disability, this is misdiagnosed as one or other kind of mental illness. (Various issues around the autistic spectrum disorders are discussed in more detail at the beginning of Chapter 16, Volume 2.)

Apart from the mental or affective disorders cited above, many physical diseases are the result of psychosomatic processes. When it seems clear that they are based in a neurotic disturbance, amongst many other conditions, these include psoriasis, eczema, asthma, stomach ulcers and heart problems. Obesity is very often the physical result of an emotional condition.¹⁹ and now has profound effects on the general health of a high proportion of the population: an estimated 40% of the UK population now jeopardise their health by carrying significantly too much weight, and at least one-quarter are clinically obese (i.e., at least one-third above a healthy height-weight ratio).²⁰ Obesity doubles the chances for a person to develop diabetes, and that disease has recently become an epidemic set to overtake heart disease as the single biggest drain on the total health budget. For all that, psychosomatic illness is only interesting to mental health officials when it takes the form of the illness-mimicking signs of conversion hysteria: psychosomatic processes are not considered mental health problems unless the resulting organic diseases are also accompanied by overt behavioural symptoms indicating a listed mental disorder. Neither do allied professionals in primary healthcare systematically suspect and deal with the likely psychosomatic basis to a great many cases of the physical illnesses which present in general practice. Presumably this lack of interest is because the official general theory of mental pathology is proposed by psychiatrists, and their interest is almost exclusively in the application of medicine to *non-medical* personal crises usually involving very evidently irrational beliefs and behaviour.

With the general discriminations in mind, psychiatric theorists and researchers are forever qualifying and sub-dividing the taxonomy of so-said mental illnesses into types, sub-types and sub-types of sub-types (etc.), according to particular apparently discrete modes of deviant behaviour and ideation. This is interesting, to an extent, as a series of snapshots of the great variety of dysfunctional responses to overwhelming anxiety. However, the ever-lengthening list of diagnostic categories is used by doctors as if it were genuinely a medical-scientific differentiation of real illnesses - as if the medical model were not merely a conjecture but is definitively proven. Inevitably, this 'medical-scientific' conceit ignores or plays down the development of a particular trajectory of mental or behavioural dysfunction as it arises out of the traumas and stresses unique to the biography of each

18 Asperger syndrome (AS) or Asperger disorder (AD) differs from other autism spectrum disorders (ASDs) by being 'high functioning' - showing a normal degree of linguistic and cognitive development. In 2013, the diagnosis was removed from *The Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* and replaced by the diagnosis of autism spectrum disorders, on a severity scale.

19 'Gluttony is an emotional escape, a sign that something is eating us.' de Vries, P (1956/1968) *Comfort Me With Apples*. New York: Little Brown, Ch 15. As already suggested (in Chapter 1, above) there is evidence that over-eating and obesity is often unconsciously used as comfort from, and defence against, physical, sexual or emotional abuse, or other psychological traumas; see Anda, RF & Felitti, VJ, op. cit. (n. 48, Ch 1), whose study is discussed in the text to footnotes 134-136 in Chapter 23 (Volume 2), and to footnote 24 in Chapter 24, below.

20 During 2011 the proportion of adults in England with a healthy body mass index (BMI) fell to just 34% for men, and 39% for women. There has recently been a marked increase in clinical obesity rates: in 1993 13% of men and 16% of women were obese, but by 2011 this had risen to 24% for men and 26% for women. During 2011-12, 9.5% of children attending reception class (aged 4-5 years) were obese. See Latest obesity stats for England are alarming (2013) *NHS Choices*. www.nhs.uk/news/2013/02February.

presenting individual. Of course, diagnosis is used mainly so as to prescribe for patients from an ever-expanding range of allegedly efficacious medications.

The most influential mental health reference book is *The Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by The American Psychiatric Association (APA). Unfortunately, no matter how good any particular doctor's intentions may be, over the years it has become clear that *DSM* does not so much serve the best interests of the patients as those of the medical professionals and the drug companies.

There have been lists of diagnoses since the infancy of psychiatry, in the 19th century. In 1917, together with the USA's National Commission on Mental Hygiene, a committee of what is now known as the APA developed a national guide: *The Statistical Manual for the Use of Institutions for the Insane*. This proposed twenty-two diagnostic categories. Over the years the categories were revised and increased several times by the APA, which also provided the psychiatric subsection of the USA's national medical guide: *The Standard Classified Nomenclature of Disease* (known as *The Standard*). In 1952, the first *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* offered 106 types of mental disorder. Until recently, each revision of the manual increased the number. By 1994 (*DSM-IV*), there were apparently 374 different kinds of mental disorder, although in 2000 (*DSM-IV-TR*) this was reduced to 365.²¹ The most recent edition is *DSM-5*, published in 2013, in which there were only minor changes from *DSM-IV-TR*.²²

An insider to the APA's *DSM* committees disclosed that by the late-1980s the types of behaviour to be included as separate kinds of mental illness had come to depend wholly on political lobbying and bribery; by then, almost every prestigious psychiatrist and university research department had been co-opted by a pharmaceuticals corporation. This had led to open disregard of research findings, and new diagnostic categories were instead devised solely to suit the powerful commercial interests; naturally, the drug companies took little or no cognisance of the interests of those with mental health problems. Under the pseudo-scientific and pseudo-medical legitimisation of *DSM*, pathological mental or behavioural reactions to any and all kinds of emotional or psychological trauma are glossed by a medical definition, e.g., by means of such diagnoses as obsessive-compulsion, phobia, panic disorder or generalised anxiety disorder. In a relentless drive to medicalise *every possible* emotional, cognitive or behavioural problem, there is now literally *no* human behaviour which cannot be defined by a psychiatrist as 'illness'. This was made clear when *DSM-IV* introduced the catch-all diagnostic category Immature Personality Disorder: *no* empirical diagnostic criteria are specified for this disorder, and the decision as to whether a person should be assigned the diagnosis is left *entirely* to the discretion of the interrogating psychiatrist.²³

In the UK, medical professionals are directed to employ WHO's *International Classification of Diseases (ICD)*, which includes a section on mental disorders.²⁴ British psychiatrists may not be so driven to employ every finely nuanced category of *DSM*, but they certainly agree with their American counterparts concerning all the most popular diagnostic distinctions; and since the USA is the world leader in mental health theory and research, *DSM* is known as 'The Psychiatric Bible'. As distinct from Europe or most other developed areas of the world, the USA eschewed socialised healthcare, and consequently diagnosis in that country is driven by the demands of the private medical insurance

21 *The Diagnostic and Statistical Manual of Mental Disorders: DSM-I* (1952) New York: The American Psychiatric Association; *The Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* (1994) New York: The American Psychiatric Association. There were minor revisions for *DSM-IV-TR*, op. cit. (n. 12).

22 *DSM-5*, op. cit. (n. 103, Ch 1). Although a few mental disorders had ostensibly been deleted, these were mainly only name changes. See *DSM-5* (2013) en.wikipedia.org/wiki/DSM-5 16 June, which comments: 'In most respects *DSM-5* is not greatly changed from *DSM-IV-TR*. Notable innovations include dropping Asperger syndrome as a distinct classification; loss of subtype classifications for variant forms of schizophrenia; dropping the "bereavement exclusion" for depressive disorders; a revised treatment and naming of gender identity disorder to Gender Dysphoria; and a new Gambling Disorder.'

23 See Caplan, PJ, op. cit. (n. 101, Ch 1); in its entirety, but specifically 76-77.

24 *ICD-10*, op. cit. (n. 104, Ch 1). *ICD* is regularly amended, and *ICD-11* is being prepared for publication in 2018.

companies. Along with everybody's belief in the medical model, that particular political-economic fact has determined that in the USA it is necessary to find a definite diagnosis for anyone who presents to a doctor with *any* kind of problem which may be construed as a mental illness (including emotional or behavioural problems), and however trivial or fleeting the problem may seem. If no specific diagnosis can be made then, effectively, there is no illness; if no illness is determined, then there can be no treatment; and if no treatment, then the insurance company will not pay out. Doctors in the USA therefore require the number of categories of mental illness to expand to the point of enumerating any kind of troublingly aberrant behaviour or ideation that can possibly be imagined; they are positively encouraged to gloss every personal or interpersonal conflict as 'mental illness', and are discouraged from making a psychological or social diagnosis or prescribing anything other than a medical remedy.²⁵ This has had a great effect on the expansion of the number of diagnostic categories in *DSM*. The absence of the insurance imperative outside of the USA means that doctors elsewhere are perhaps not so constrained to diagnose every presenting emotional or psychological state or condition as definitely an instance of one or other specific mental illness. Nevertheless, given the natural tendency of medically trained professionals to embrace the medical model, with the notion of its progressively improving precision, they are also likely to defer to the authority of *DSM* as a standard manual which is regularly updated and supposedly scientific. Over the years the influence of manuals, and especially *DSM*, has increased such that in the UK today it is most likely that anyone who goes to a doctor because, for example, he feels depressed, is automatically said to 'have depression' and is prescribed an anti-depressant; or a particularly troublesome child is said to 'have ADHD' and be prescribed Ritalin, etc., etc.

The push to medicalise every problem of living is rhetorical and scientifically bogus. It is driven by the groundless assumptions and wishes of whoever happens to have an interest and possesses sufficient economic or political clout. Ever-increasing medicalisation accommodates the economic, political and emotional interests of the psychiatrists,²⁶ while the drug companies underwrite their professional associations, and stand to make ever greater profits. In *DSM* there is often now barely the pretence of science. The major concerns of the central organisations of psychiatry are public relations, lobbying, power plays and political negotiations, increasing the market for psychiatrists (i.e. persuading everybody that almost any distressed or troubling person suffers from a mental illness), and fudging research so as to protect members against malpractice suits. Unashamedly and without protest from his colleagues, in 1986 the APA's president-elect announced that his first aim was not the interests of the patients but maximisation of members' salaries; to which end he advised doctors never to practice relatively poorly-paid psychotherapy but always to maximise the flow of patients through their clinics by making quick diagnoses and prescribing drugs.²⁷

The dubious nature of mental health diagnosis is illustrated by that mental illness which is said to inflict an ever-increasing number of hapless children - attention deficit disorder (ADD), or what is now generally known as attention deficit hyperactivity disorder (ADHD). As we have seen, whenever a new mental illness is said to have been discovered, the recognition, definition and naming of the condition magically morphs into its own 'explanation'. This is magical thinking: ADHD is supposed to 'cause' a child to be a nuisance. This behavioural disorder first surfaced in 1968 as 'a hyperkinetic reaction of childhood'; the symptoms were short attention span, hyperactivity and restlessness. By 1970 *DSM* was calling it 'attention deficit disorder' (ADD), with the sub-species 'hyperactive ADD' and 'inattentive ADD'. In 1994 (*DSM-IV*) it was renamed ADHD, and there were three sub-types: 'ADHD, primarily inattentive'; 'ADHD, primarily hyper-active/impulsive'; and 'ADHD combined type'. By the turn of this century (*DSM-IV-TR*), almost anything 'naughty' that a child might do was

25 In the USA, basic medical insurance will provide cover for psychotropic drugs but not for psychotherapy. This is on the grounds of expense, and due to the belief that psychotropic medicines achieve quick results.

26 The emotional or neurotic component of these interests is mentioned in footnote 34 to Chapter 3 above; it is further explored in Chapter 13 below, especially in the section: Psychophobia and the wish to view emotional distress and irrationality as illness.

27 See Caplan, PJ, op. cit. (n. 101, Ch 1), 234; also Breggin, PR, op. cit. (n. 107, Ch 1), 344-370.

a symptom of the purported mental disorder - such as fidget, answer an adult's question before it is finished, or dislike homework.²⁸ Each *DSM* revision defines more kinds of unwanted behaviour as 'symptoms'. In the USA in 1987 half a million children were diagnosed with ADHD, and by 2001 this had mushroomed to six million; most were boys. This is not to suggest that some or even many children do not habitually engage in behaviour which is troublesome to others (especially adults), and perhaps also to themselves. It is simply that we cannot specify one simple cause (e.g., a genetic or other organic aberration), that we ought to consider the biographic context and possible social and psychological factors,²⁹ that naming a certain 'syndrome' of behaviour as a type of disease (mental illness) does not begin to explain or remedy it, and that giving millions of children dangerous medications is perhaps not the optimal response.

Of course, the pernicious habit of making every particularly irritating child into a psychiatric case is not limited to the USA. In response to a newspaper article, a critic in the UK nicely summarises the objections to psychiatric diagnosis in general and ADHD in particular:

Whenever the media writes on the subject of disruptive, inattentive or boisterous children who have been labelled ADHD (Attention Deficit Hyperactivity Disorder), there seems to be an assumption the reader accepts the psychiatric label is real, and that 'experts' can treat it. This could not be further from the truth.

While there is no question that children and adolescents can be argumentative and impulsive, and that some can be more active than others, psychiatry has packaged up these and other behaviour characteristics and categorised them as the so-called mental illness ADHD.

If you strip away all of the psychiatric rhetoric, the reality...is children and adolescents are being chemically restrained for displaying behaviour that is considered to be an illness because a psychiatrist says so. As for the idea of a 'chemical imbalance of the brain' as the reason given for drugging young minds, forget it. It's hype and slick marketing. While psychiatrists spout their claims, they have never found a test or submitted evidence to support the existence of such an imbalance. They can't measure a balance in the brain, so they wouldn't know if an imbalance had been resolved, even if there was one.

A significant factor in the whole charade, however, is money. Last year [2012] in England alone the cost of ADHD drugs was over £52m. Add the cost of ADHD drugs [in the rest of the UK] and [during the last ten years] the figure comes to over £409m. That's extremely good business, but bad medicine.

It is important that we question ideas, especially those that are based on opinions rather than science. It goes without saying that psychiatric drugs will chemically restrain a person, but they don't cure anything. Psychiatry does not have any science or cures.

While life is full of problems that can sometimes be overwhelming, it is important to know that psychiatry, its diagnoses and its drugs are the wrong way to go. The emphasis must be on workable medical testing and treatments.³⁰

This quotation recognises that diagnosis of a mental illness is not a procedure based in medical science but only ever a judgment made by a doctor about a person's psychological condition. Since the so-called mental illnesses are not real (organic) diseases,³¹ the 'symptoms' that the psychiatrist

28 *DSM-IV*, op. cit. (n. 21); for the full list, see *DSM-IV-TR*, op. cit. (n. 21).

29 For example, it is well known that ADDH correlates significantly with abnormal levels of cortisol, or even in the mother before she gives birth, and that these factors also correlate with heightened levels of stress.

30 Daniels, B (2013) Psychiatry does not have a cure. *Bristol Post* 19 July. Daniels is national spokesperson for the anti-psychiatry pressure group: Citizens' Commission on Human Rights International (CCHRInt). On the basis that 'my enemy's enemy is my friend', in 1969 Thomas Szasz worked with the controversial Church of Scientology to establish and develop CCHR as a nonprofit campaigning organization to publicise the view that mental illness is not a medical condition, and that the use of psychiatric medication is fraudulent and harmful. The mission of CCHR is 'to eradicate abuses committed under the guise of mental health and enact patient and consumer protections'. *About CCHR*. www.cchr.org/about-us/ July 2013.

31 In particular, see Chapters 12 and 13, below.

discovers are only ever the signs of a kind of deviance (e.g., perhaps irrationality) and not the signs of a disease (perhaps affecting the brain). We have already argued that it is confusing to say that someone who shows no signs of an organic disease nevertheless ‘has a mental illness’; it may only be legitimate to say that the person shows signs of functional mental disorder.³²

There is no theoretically coherent and scientifically substantiated basis to mental health diagnosis. Based only on conjecture and whichever chemical or physical treatment ‘sometimes seems to work’, any such diagnosis is only a ‘rule-of-thumb’ guesstimate. In practice, moreover, psychiatric diagnosis is *very often* retrospective. What happens is that an overwrought person is delivered to psychiatry and a particular drug is administered to manage his behaviour. If that drug does not elicit the patient’s compliance, then another is tried. If or when a particular drug appears to ‘work’ with that particular patient, the psychiatrist then ‘reads back’ to whichever type of mental illness the drug is supposed to manage. In this manner the doctor ‘discovers’ which mental illness the patient ‘must’ therefore have. Imagine if general hospitals were to organise Accident & Emergency units along these lines: a person is brought in having collapsed in the street, and instead of running routine scans or blood tests, etc., this or that drug is tried on him before it is finally decided that he responds to a specific drug and therefore suffers from diabetes and not, perhaps, a heart condition!

The problem of reliability

In the previous section we pointed out that a peculiarity of mental health diagnosis is that whereas there are normally clear symptoms and reliable bio-chemical or other tests for the real illnesses discerned by general medicine, and therefore doctors can usually agree about the nature and cause of any particular malaise, studies show that there is not a high degree of agreement among psychiatrists about the kind of mental illness presented by any given patient. This was recognised as long ago as 1934, and since choice of treatment must surely depend on the diagnosis for each case, it might seem surprising that there has not been much research on this issue in the meantime. What there is does little to increase confidence in mental health diagnoses. A study published in 1949 found that between two psychiatrists there was agreement on a specific diagnosis for a number of patients *in only 20% of the cases*; the level of agreement was even poorer between three psychiatrists. With regard to the major categories - that is, as to whether an individual was ‘normal’ or presented broadly with mental deficiency, neurosis, psychosis or psychopathy - agreements between three psychiatrists managed to achieve 45.7%. By 1981, a survey of the research reported that the situation seemed to have improved, but agreement between two or more psychiatrists about the specific diagnosis for any patient was still no better than the toss of a coin.³³ Furthermore, it appears that patients often have the diagnostically confusing tendency in their behaviour to drift or suddenly jump from one category of mental illness to another.³⁴

However, during the first half of the 20th century many clinicians were not very interested in deciding a particular diagnosis for each patient. Naming the condition was not always necessary for therapy since psychiatrists either employed a kind of psychoanalysis or, especially in America, the social-psychiatry of Adolf Meyer, which also focussed on the patient’s biography and social context. But then, after mid-century, pushed by the World Health Organization and the American Psychiatric Association, the number of psychiatric categories began to multiply. In 1948, the sixth revision of WHO’s *International Classification of Diseases (ICD-6)* included a section on mental disorders. Over the years this section was always elaborated. And, as we mentioned, by 1952 the APA’s Committee on Nomenclature and Statistics had developed its *Diagnostic and Statistical Manual for Mental Disorders (DSM)*, a publication which until this century increased the number of different mental illnesses with every revision.

32 See the sections in Chapter 3, above: The confusion of the psychiatric medical model, and The psychiatric medical model is unproven, unhelpful and harmful.

33 See Doering, CR, op. cit. (n. 4), Ash, P, op. cit. (n. 4), and Grove, WM et al, op. cit. (n.4).

34 Davey, B (1991) Some thoughts on psychosis. *Asylum* 5 1 25-29. Brian Davey was once a patient; at different times he was diagnosed manic-depressive and schizophrenic.

As the medical model moved towards complete dominance, increased emphasis was put on the use of a medical vocabulary and making a precise mental illness diagnosis. The rationale is that psychiatric classification and nomenclature facilitates communications among clinicians about clinical features, etiology, the course of the illness, and appropriate treatments. As diagnostic criteria for the various mental disorders were made more detailed and specific, structured interviews were developed to measure the symptoms comprising each psychiatric disorder. These include: Schedules for Clinical Assessment in Neuropsychiatry (SCAN), Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Diagnostic Interview for Genetic Studies (DIGS), and Mini-International Neuropsychiatric Interview (MINI).³⁵

All the same, a recent review of the research finds that despite these and other efforts to improve reliability (e.g., in training), the level of agreement on diagnosis still falls well below that of general medicine. Studies between 1950 and 1980 found improved levels of reliability, but still not enough to give great confidence in any specific diagnosis. One study involved 426 in-patients diagnosed independently by a pair of psychiatrists: agreement with respect to specific diagnostic sub-types occurred with only half of the cases. In another, 91 cases diagnosed by ten experienced psychiatrists resulted overall in a 57% likelihood of a second opinion agreeing with the first. Two further studies found 54% agreement between two clinicians for a specific diagnosis with 153 out-patients, and 63% agreement on 90 out-patients examined independently at an interval of three days.³⁶

Some psychiatrists recognise that diagnostic unreliability is a serious problem. It had been hoped that better manuals and textbooks and improved training would resolve the issue, especially by providing much more detailed, explicit and specific criteria for each kind of mental disorder, and by more exhaustive standardised questionnaires or interview schedules. This was offered as a main reason for the extensive revisions included in *DSM-III*, published in 1980. After this, studies of the reliability of psychiatric diagnosis expanded, and research designs became more sophisticated. Overall, the reliability of psychiatric diagnosis does seem to have improved somewhat since *DSM-III*, presumably by the increased use of structured interviews, more stringent diagnostic criteria and better research designs. Nonetheless,

[a]lthough the diagnostic criteria of psychiatric disorders were developed along with many structured interviews, unreliability of psychiatric diagnosis remains a serious problem.³⁷

For example, one recent study did demonstrate a kappa of 0.83 for a choice of four common psychiatric diagnoses. (A kappa calculation is considered more robust than percent agreement since it provides for agreements occurring by chance.) On the other hand, there is also research which shows a strong discordance among the diagnoses of psychotic disorders. One recent study documented 66-76% inter-rater reliability, i.e., discordance of 24-34%; another resulted in a very low kappa (0.22) for the diagnosis of schizoaffective disorder.³⁸

As well as this serious shortcoming, recent evidence indicates that anyone diagnosed with a mental illness also runs a significantly higher risk of developing a serious *real* illness. It is clear that 'diagnostic overshadowing' is prevalent: physical ill-health is masked by the mental health diagnosis and the doctor's focus on treating the mental disorder. Patients diagnosed with bi-polar disorder or schizophrenia show higher rates of hypertension and breast cancer, while diagnosed schizophrenics run twice the average risk for developing bowel cancer. Compared with the norm, people with diagnosed mental health problems have higher rates of obesity, heart disease, respiratory disease and stroke; they are likely to die younger, twice as likely to contract coronary heart disease or have a stroke before the age of fifty-five, and are less likely to survive five more years if they do. At the same time, they are less likely to be given certain standard physiological tests and treatments (including cholesterol tests and a statins prescription for heart disease). It is true that mental health patients are more likely to smoke (possibly due to the inactivity, boredom and stress in their lives),

35 See Aboraya, A, et al (2006) The reliability of psychiatric diagnosis revisited. *Psychiatry* 3 1 41-50.

36 Aboraya, A, et al, op. cit. (n. 35); references to these studies are provided in that article.

37 Aboraya, A, et al, op. cit. (n. 35).

38 Matuszak, J & Piasecki, M, op. cit. (n. 4); see their article for references to the studies mentioned.

but the official report providing these statistics³⁹ fails to consider any possible connection between the well-known toxicity of mental health medications and the higher incidence of real illnesses amongst those subjected to them.

Finally in this section, we draw attention to events which should have thoroughly debunked the alleged medical-scientific status of psychiatric diagnosis once and for all. In Chapter 4 we saw that it is not unusual to assign a mental illness diagnosis to someone *even in the absence of any symptoms of the so-said illness*; this occurred in 47% of a large sample of diagnoses prior to re-prescription.⁴⁰ Apart from this evidence, however, there is good reason to believe that any psychiatric diagnosis is *always* likely to be arbitrary. In 1973 this was famously exposed by a study constructed on the premise that if sane people are not detected as such in psychiatric facilities, then the main determinant of any mental health judgement is not the presence or absence of a mental disorder but the way in which the situation and the people within it are defined.

In Rosenhan's famous experiment, eight sane people separately sought admittance to 12 different psychiatric hospitals. When he presented himself, the only unusual thing that each subject was to do or say during his initial interview was admit hearing an unfamiliar voice say the words 'empty', 'hollow' and 'thud'. According to the textbooks and manuals, this is a symptom of psychosis: it is understood to indicate an obsession with the meaninglessness of life. The diaries kept by each subject indicated that they had all been admitted with surprising ease. At first, these pseudo-insane subjects felt uneasy on the wards, but they soon found that they could act as their normal selves. They spent an average of 19 days on admission wards (ranging from 7 to 52 days) before being considered fit for release. At that point, however, all but one of the subjects was diagnosed not as sane but 'schizophrenic in remission' - one was diagnosed with manic-depression (bipolar disorder). Some visitors and patients had detected the sanity of the pseudo-patients during their time on the wards (e.g., 35 out of 118 patients polled), but not one doctor or member of staff had guessed it. What's more, these pseudo-insane subjects told unexceptional life histories, such as being closer to mother than father in early childhood, and the reverse during adolescence; and yet the case-notes showed the staff discovering significance in this information, and distorting it so as to fit in with their preconceptions about the dynamics of schizophrenia. On their part, the subjects took notes to record events on the ward, but at first made efforts to hide their note-taking, fearing that it would cause the staff to see that they were not really insane. Yet it soon became clear that this was unnecessary since note-taking was viewed by the officials as a symptom of mental illness. Any other sort of behaviour might also be interpreted as abnormal, of course: walking about was considered a sign of nervousness and called 'pacing', when really it was a product of inactivity and boredom; in response to manhandling by staff, a patient might lash out, but the staff would blame his behaviour on his reacting to a recent visit from a relative or friend; the patients had so little going on in their life that many would start to queue outside the refectory half an hour before any food was served, and a psychiatrist said that this behaviour demonstrated 'the oral-acquisitive nature of their syndromes'.⁴¹

The publication of Rosenhan's study caused uproar and panic within the psychiatric profession. Two fellow professionals then added to the furore with a paper demonstrating that the *DSM* of the time (*DSM-II*) was not reliable for diagnosis: different practitioners seldom agreed when diagnosing patients with similar problems. In a review of previous studies of eighteen major diagnostic categories, the authors concluded that

...there are no diagnostic categories for which reliability is uniformly high. Reliability appears to be only satisfactory for three categories: mental deficiency, organic brain syndrome (but not its subtypes), and alcoholism. The level of reliability is no better than fair for psychosis and schizophrenia, and it is poor for the remaining categories.⁴²

39 *Equal Treatment: Closing the gap* (2006) Disability Rights Commission. London: HMSO.

40 Summers, A & Kehoe, RF, op. cit. (n. 13, Ch 4).

41 Rosenhan, DL (1973) On being sane in insane places. *Science* 179 250-258.

42 Spitzer, RL & Fleiss, JL (1974). A re-analysis of the reliability of psychiatric diagnosis. *British Journal of Psychiatry*. 125 4 341-347.

Together, these findings so upset the leaders of the psychiatric profession that they established committees tasked with expunging ambiguities, psychobabble and subjectivity; the committees were charged with tightening-up the diagnostic criteria by devising strict rules for the duration and frequency of symptoms. In response to the critique posed by anti-psychiatry and these two shocking revelations, the developers of *DSM-III* (published in 1980) used extensive field trials to gather data, and reworked the diagnostic system by dropping all interest in psychodynamics so as to focus strictly on *discernible behaviours*. Their field studies revealed surprisingly high levels of reported anxiety, depression and mental disorder, so they tweaked the system by defining many new mental disorders such as panic disorder and obsessive compulsive disorder (OCD). They claimed that their radical makeover would prove reliable, and might be employed not just by doctors but by anybody who used a standard protocol.

However, in 1994 it was pointed out that

Twenty years after the reliability problem became the central focus of *DSM-III*, there is still not a single multi-site study showing that *DSM* (any version) is routinely used with high reliability by regular mental health clinicians. Nor is there any credible evidence that any version of the manual has greatly increased its reliability beyond the previous version. There are important methodological problems that limit the generalisability of most reliability studies. Each reliability study is constrained by the training and supervision of the interviewers, their motivation and commitment to diagnostic accuracy, their prior skill, the homogeneity of the clinical setting in regard to patient-mix and base rates, and the methodological rigor achieved by the investigator...⁴³

In other words, the profession's response to the demonstrable failure of the psychiatric diagnostic system was itself largely a failure - it simply helped to push the diagnostic taxonomy towards the greater complexity of *DSM-III*. In turn, this probably led to a greater number of suspects being given a mental illness diagnosis because they exhibited one or two 'symptoms' of the ever-lengthening list of types of undesirable behaviour. The principal author of *DSM-III* now feels that its main effect was indeed to medicalise every negative human feeling that anyone ever took to his local doctor, thereby making mental health diagnosis more perfectly suited to persuading the population to take an ever-increasing amount of psychotropic medications, and conform to every perceived social expectation.⁴⁴

Later we provide more detail to show that the medicalisation of problems of living is a pernicious invasion of the freedoms of those who suffer from emotional distress and mental disorder - which is to say, those who have already had to suffer and succumbed to trauma, anxiety and oppressive levels of stress. Whatever psychiatric officials might imagine they do, it seems clear enough that, in effect - and as enjoined by mental health law - their priority is to enforce the compliance of patients, usually by means of drugging. As we describe in subsequent chapters, shock treatment and forms of threat and punishment known as behavioural therapy are also employed in this project, and lately a kind of cajoling or motivational persuasion known as cognitive behavioural therapy (CBT). And if a person who appears to be 'in crisis' refuses to acquiesce to care and treatment, a psychiatrist is able to exert his coercive power either directly by 'sectioning', or indirectly by the threat of it.

As we develop the argument of this book, we will see that not only are none of the functional mental disorders genuine illnesses but psychiatry's diagnostic categories are a confusing hindrance to the remedy of emotional or psychological malaise. *A mental health diagnosis does nothing to explain or solve the person's problems*. On the other hand, the diagnostic system splendidly fulfils certain ideological, political and commercial purposes. A doctor's diagnosis serves to persuade everyone that problems of micro-social conflict, emotion and psychological disorder are *only* or *mainly* due to the unfortunate individual's mysterious illness. In this manner, psychiatry's diagnostic categories provide

43 Kirk, SA & Kutchins, H (1994) The myth of the reliability of *DSM*. *Journal of Mind and Behavior* 15 1-2.

44 Spitzer, RL (2007) Interview in *The Trap: What happened to our dream of freedom (Part 1)* (Dir Curtis, A) BBC 2.

both an alibi for misdirected and oppressive social action and an almost limitless field for the employment of mental health workers and the making of pharmaceutical profits.⁴⁵

Prejudice upon prejudice: the arbitrary nature of psychiatric diagnosis

Professional opinion about the presence or absence of a functional mental disorder is formed not by reference to organic signs - since by definition there are none - but only with regard to behavioural signs. Besides this medical peculiarity, in Chapter 4 we noted the equally strange fact that it is not unusual for a psychiatric diagnosis to be made *in the absence of symptoms* and only according to the doctor's *intuition* or due to his patient's *reputation*.⁴⁶ This leaves mental health diagnosis wide open to the bias of prejudice or a covert agenda.

Seeing that psychiatry is supposed to remedy the plight of its patients - who regularly suffer from stigmatisation, prejudice and discrimination (along with all their other problems) - one might imagine that workers in the field would be aware and sympathetic to these issues. Unfortunately, mental health officials are not necessarily less self-serving, insensitive or bigoted than anyone else. The prejudicial and oppressive nature of psychiatric diagnosis is indicated by what appear to be signs of *systematic* misogyny and racism. There have always been more women than men in the psychiatric population, and in comparison with men there are unaccountable disproportions in the kinds of diagnoses and the types and intensities of treatment: women are twice as likely to be diagnosed with depression and twice as likely to be given shock treatment. These anomalies are barely researched. Are they because women are more prone to emotional distress and mental disorder (and to specific types of disorder), and hence inevitably more often become psychiatric patients? Or could it be that deviant females are more likely to be subjected to prejudice, and are therefore more easily consigned to psychiatry by decision-makers such as parents, husbands and agents of the state, including (mostly male) psychiatrists? Psychiatric officials ought to be adequately trained to recognise prejudice, whether their own or others', but it seems they are not.

Light may be cast on such questions by exploring possible reasons for these anomalies. In 1991, when women made up only 4% of the prison population, they were 20% of the inmates of the Special Hospitals (a total of about 350 women); among them, the rate of criminal offending was much lower than that for the male inmates, and 38% had not been convicted of a crime (9% of the men). One woman had been sentenced to prison on a minor drugs charge but was soon transferred to a Special Hospital where she then spent fifteen years. When she was forty-nine she reported:

It took them two minutes to label me an aggressive psychopath, and it's taking me the rest of my life to get rid of that label.

If I asked too many questions they locked me up in seclusion. Every time I asked staff if I was ever going to get out, they'd titter; every time I asked why we didn't have the same facilities as the men, they'd titter.

Once you're labelled a nut-case how are you supposed to behave? Once they put you inside a Special Hospital you can't be normal. If I had a headache they said it was my mind. If I laughed they said it was because I was high. If I was lucky, I saw my psychiatrist twice a year.

I know women in Special Hospitals who'd do anything for a kind word from the staff. I didn't need that kind word. I wasn't ill. I shouldn't have been there, and I resented the fact that I was. I will never agree to that label of aggressive psychopath or that I was mad. Yes,

45 By 2006, American sales of atypical anti-psychotics were running at \$10.5b per annum, and rising; this type of drug alone had generated over \$100b sales since 1990. See A typical story (2006) *What Doctors Don't Tell You* 17 11 17. The issues raised in the text to this footnote are addressed in detail in Chapters 12 and 13, below. In Chapter 20 (Volume 2), we further elucidate the meaning of the taxonomy of mental disorders, in the section: The response to intolerable anxiety.

46 See especially the text and citation to footnote 13 in Chapter 4.

I was a bad little bugger, but I was not mad. Women in ‘Specials’ are forgotten; they don’t know their rights. I was lucky, I got out.⁴⁷

Why should women be so prone to being ‘specialised’? The Women in Special Hospitals Support Group (WISH) believes this is a particularly vivid reflection of the prejudices of psychiatrists and judges concerning appropriately feminine attitudes and behaviour, and their belief that women have less self-control and are more in need of care: female criminality is relatively uncommon, and so it is viewed as psychologically abnormal. Women found guilty of a crime have 50% more chance than men of being diagnosed ‘psychopathic’. WISH also found that more than half the women in one Special Hospital reported sexual abuse during childhood. The hospital’s managers were unaware of this fact, even though by 1990 it was well-documented that the consequences of childhood sexual abuse are characteristically those listed as the signs for borderline personality disorder (BPD), and the symptoms for BPD are the same as those for psychopathy: self-harm, ‘inappropriate’ or uncontrolled anger, impulsive activity, extreme mood disturbance, unstable interpersonal relationships.⁴⁸

We surely do not need to rehearse the evidence for generalised racial prejudice and discrimination before suggesting that similar attitudes and behaviour are likely to influence psychiatric diagnosis, care and treatment. Certain racial or ethnic types have long been disproportionately represented in the psychiatric population. Researchers tend to focus on the stresses engendered in the wider society, and offer reasons for over-representation such as prejudice, poverty, social isolation or dislocation, and culture-shock. However, it is likely that over-representation in the psychiatric population is also due to discrimination at the point of entry; as well as lack of training or insight concerning the latent prejudices of doctors and other psychiatric officials, as we already mentioned, discrimination is also due to insensitivity, incomprehension, prejudice and fear on the part of those authorities who make initial contact with individuals who then become psychiatric candidates. For example, Section 136 of the 1983 Mental Health Act permits the police to detain someone ‘in a place of safety’ for up to 72 hours if they consider him mentally disordered and a danger. Research shows that Afro-Caribbeans have been subjected to Section 136 two-and-a-half times as often as whites, and for young black males the disproportion is far greater. In forensic psychiatry, the referral rate for migrants and Afro-Caribbeans is *twenty-nine times* that for their white peers. The exact statistics are hard to come by, but it is clear that members of this category are much less likely to be bailed and far more likely to be subjected to compulsory psychiatric treatment; they figure disproportionately in high-security facilities, and are on average committed to them for much less serious offences than whites.⁴⁹ Once made into a psychiatric patient, there is no noticeable relief from racism for someone who is not white. Again, this was highlighted by the situation in the Special Hospitals. The 1992 Report on Ashworth Special Hospital found that many of the staff had participated in the endemic bullying, taunting, abuse, and regular assaults of black inmates; many paraded their racism by wearing fascist party badges to work; at least 15% of the inmates were black, but out of 800 members of staff, only three (less than 0.4%) were not white.⁵⁰

Meanwhile, in 1988 it was estimated that anyone British-born but with West Indian parents was nine times as likely as a white person to be diagnosed with schizophrenia; and young British-born blacks were *twenty-five times* as likely as young whites to get a psychiatric referral by court order. In 1989 The Mental Health Act Commission found that young Afro-Caribbeans were twenty-five times as likely as young whites to criminal commitment under Part III of the Mental Health Act, and seventeen times as likely to civil commitment under Part II. A little later, a consultant psychiatrist estimated that Afro-Caribbeans were between five and ten times as likely as their white peers to be diagnosed with schizophrenia, and were much more likely to be given higher doses of medication;

47 Lloyd, A (1991) Altered states. *The Guardian* 25 July; Eaton, M (1997) Women in special hospitals *CJM* 29 Autumn. www.crimeandjustice.org.uk/18-19. There seems to have been no published audit since then.

48 Lloyd, A, op. cit. (n. 47). The Special Hospitals are now called High-Security Psychiatric Hospitals.

49 See the research cited in Pilgrim, D & Rogers, A, op. cit. (n. 35, Ch 1), 50-51.

50 *Committee of Inquiry into Complaints about Ashworth Hospital (Blom-Cooper Inquiry)* (1992) London: Department of Health. In England, Regional Secure Units have now replaced all but three Special Hospitals.

and while only 15-20% of all white patients were admitted to a mental facility compulsorily, for blacks the proportion was 60-70%.⁵¹ In 1992 it was estimated that young black men born in the West Indies were twenty-five times more likely than young white men to be 'sectioned', and UK-born black youths five times as likely - that is to say, forcibly removed to psychiatric incarceration.⁵²

We may imagine that both females and non-whites are subjected to greater than average stress due to being more likely to experience problems of dependence, denigration, discrimination, poverty, unemployment, threats, assaults, and so on; and hence that they might indeed succumb in disproportionate numbers to emotional distress and mental disorder. On the issue of race, we are able to cite The Mental Health Foundation which commissioned a meta-study on race and mental illness.⁵³ Unsurprisingly, this found a high correlation between the incidence of mental health problems and unemployment, poverty and racism.⁵⁴ The authors summarised fifteen studies over the preceding twelve years which indicated that, holding constant age and income, schizophrenia is diagnosed three to six times as often for Afro-Caribbeans as for whites. Some studies, though, found up to eighteen times the rate; young Afro-Caribbean men had particularly high rates.⁵⁵ It is simply not credible that young Afro-Caribbean men are actually *so much* more prone to develop a serious psychosis. Since there is no evidence for any biological cause (genetic or otherwise), this disproportion must surely be due to a combination of higher degrees of stress and deviance *as well as* significant prejudice on the part of uncomprehending, fearful or malicious white officials (police, social workers and doctors), which issues as a punitive use of diagnostic and admission procedures, and excessive medication.

Undoubtedly, some of the disproportionate representation of ethnic minorities in the psychiatric population is due to the greater stresses to which they are subjected on a daily basis - poverty, marginalisation and cultural disorientation, as well as endemic racism. Other stresses are more specific. For example, most probably due to the peculiar demands of family and marriage to which they are subjected within their communities, suicide rates for young Asian-born women are more than double the national rate, and for UK-born, 60% higher.⁵⁶ Yet it is also a fact that after contact with the police and social services, compared to whites, Afro-Caribbeans were far less likely to be referred to a GP but much more likely to be detained by the police or taken to a psychiatric facility; they were then far more likely to be compulsorily detained (whether as offenders or non-offenders), much less likely to receive early diagnosis and treatment, and far more likely to be detained in locked wards, secure units or high-security hospitals; they were also much less likely to receive non-medical treatments such as psychotherapy or counselling, or to draw an alternative to institutionalised care; and they were more likely to be given more potent medication, more likely to be detained longer and to face greater difficulties in moving back into the community, and far more likely to relapse and be put back into psychiatric care. This reflected their over-representation at all levels of the police and judicial systems - from stop-and-search to being given custody rather than bail, to being assessed with a mental illness and then subjected to compulsory psychiatric treatment, being charged rather than cautioned, being given a custodial sentence, and getting a longer sentence.⁵⁷ At the same time, in 1989, the last time anyone seems to have counted, there were only two Afro-Caribbean consultants in the whole of UK psychiatry.⁵⁸

51 See Burl, J (1988) Racism and psychiatry. *Asylum* 2 3 18-20; Francis, E (1988) Racism and psychiatry: A reply. *Asylum* 2 4 23-24; Brindle, D (1989) Racial stereotyping blamed for discrepancies in mental detention. *The Guardian* 17 April; Brindle, D (1991) Psychiatrist accuses hospitals of race bias. *The Guardian* 11 Nov.

52 *The Orville Black Community Campaign* (1993) London: Afro-Caribbean Mental Health Association.

53 Raleigh, VS & Almond, C (1995) *Mental Health in Black and Minority Ethnic People: The fundamental facts*. Newport, Gwent: The Mental Health Foundation.

54 Raleigh, VS & Almond, C, op. cit. (n. 53), 15.

55 Raleigh, VS & Almond, C, op. cit. (n. 53), 17.

56 Raleigh, VS & Almond, C, op. cit. (n. 53), 31.

57 Raleigh, VS & Almond, C, op. cit. (n. 53), 33-34.

58 Francis, E, op. cit. (n. 51).

Summary

When we hear the word ‘diagnosis’, we assume this means an assessment based in well-founded medical science. However, a mental health diagnosis does not identify an actual illness, and it tends to be stigmatising and oppressive in its consequences for the individual concerned - much more so if he is made into a psychiatric patient. A mental health diagnosis does not help us to understand anything about the cause of the disorder, and nor does it particularly help with prognosis or decisions about the most appropriate therapeutic response. This is because it is not based in genuine medical science. At best, a diagnosis simply registers that the person exhibits a particular kind of problematic behaviour (or set of behaviours), and this identification may help with managing possible risks.

If there is no discernible disease - no neurological illness or apparent constitutional cause (e.g., autistic spectrum) - then it is neither scientific nor reasonable to insist, all the same, that a mental disorder somehow ‘must be’ an error or deficiency in the person’s brain, a matter of some peculiarly elusive illness. Rather, it is more reasonable to entertain the hypothesis that the mental disorder is the subject’s unwished-for deviance, i.e., that it is due to an aberrant and dysfunctional psychological development. Faced with someone who seems to be incapacitated by his own irrational thoughts and compulsions but is clearly not physically ill, *psychological* assessment is unavoidable. In fact it is the only useful product of a diagnostic interview.

The regular confusion of psychology with physiology has far-reaching unhelpful effects. As we pursue our argument into Volume 2, it will become clear that any apparently *medical* diagnosis of a person’s irrationality, as allegedly a *sufficient explanation* of his confusion and distress, is a thoroughly misleading gloss of his particular mental and behavioural deviance and his own unique psychological and personal plight. It therefore seems obvious that where there is no organic anomaly to cause a mental disorder it would be better for the individual if everyone were to entertain the hypothesis that what is called his ‘mental illness’ is in fact a hitherto unacknowledged post-traumatic stress disorder: whatever the particular manifestation of the disorder (whatever the mental health diagnosis), the indispensable first step to recovery is to investigate the possibility that it is based in psychological trauma.⁵⁹

Psychiatric diagnosis is supposed to be based in medical science. This is a deceit: where there is said to be mental illness, by definition there may be worryingly abnormal ideas and behaviour but no evidence for actual disease. Unexamined belief in the existence of mental illnesses and blind faith in medicine makes the official response oppressive and anti-therapeutic, since a categorical diagnosis automatically prioritises a medical response to the problem at hand; at the same time, to say that someone ‘has a mental illness’ is to deny or derogate the significance of his psychological, material and social problems - and *the person* slips from view. Care and therapy then becomes an exercise in surveillance and chemical or electrical treatment, and the main concern is the patient’s conformity to official expectations. If he begins to conform, he is said to be ‘recovering’, or at least ‘the illness’ is said to be ‘successfully managed’; if he fails to conform - if the original symptoms seem to remain, or if he complains, dissents or wishes to discuss anything the officials find contentious, or if he disobeys them in any manner - then ‘the illness’ is said to persist. Other than recognising it as ‘a symptom of his illness’ if they find it inconvenient, once someone in crisis is given a psychiatric diagnosis it is normal for officials to recognise little or no significance in anything he suggests or does of his own volition, however reasonable it may seem to someone who is not a mental health worker. After all, mental illness is recognised by worrying irrationality, and a positive diagnosis confirms that, due to his ‘illness’, the individual is *essentially* capricious.

How can this be therapeutic? Official theory, policy and practice resist the idea that functional mental disorder is the result of psychological trauma. And yet the conventional method of pseudo-medical diagnosis and treatment is clearly untenable: there is no illness, in the normal sense of the word - no such thing as mental illness, the organic nature and cause of which is peculiarly opaque to medical science. Rather, in every individual who presents to the mental health or psychiatric services there is a unique configuration of incapacitating anguish and confusion.

⁵⁹ This view is argued in detail during the course of the second Volume.

Chapter 6: DRUGS

More than words could ever have done, taking those pills indoctrinated me with the notion that I was a defective person whose only claim to uniqueness consisted of a bio-chemical defect, probably genetic in origin... What I had been taking did not 'cure' anything but was merely a chemical lobotomy or strait-jacket whose sole virtue stemmed from the fact that it tranquillised the people around me, and thus kept them from locking me up.

John Modrow.¹

We review the various kinds of mental health medication and briefly describe how they were developed. There is no evidence that they are significantly more effective than placebo, psychotherapy or no treatment at all. In addition, there is no psychotropic medication which does not regularly cause patients discomfort, pain and organic harm; they are also very often addictive, and too often the way some are used results in fatalities.

Rather than purely technical procedures that undeniably benefit those suffering from a mental disorder, it seems that psychiatric diagnosis and drugging together comprise a ritual of social control and identity formation. In a modern rite of passage, anyone who becomes very worryingly irrational when overwhelmed by a personal crisis is forced to abandon much of his old identity and take on the new one of a singular kind of stigmatised and supervised sub-person: psychiatric patient. As such he loses important civil rights and faces prejudice and discrimination; legally, he may be forcibly administered toxic chemicals or electroshock so as to 'manage' a kind of illness for which, curiously, there are no organic signs.

The types of psychiatric drugs

As a matter of 'common sense', where there is diagnosis of an illness (a mental illness) doctors confidently prescribe a medical treatment. Yet, as we demonstrate throughout this first Volume, the consensus around this enterprise is not supported by logic, plausible theory or science. Again, in line with the medical model, it is 'obvious' - but not supported by the evidence - that the response should normally take the form of some kind of medication or physical work on the brain.

The main intention of this Volume is to show that although the professionals maintain that it is just another kind of scientific medicine, mental health theory and practice is very different from every other kind of medicine. In Chapter 4, for example, we witnessed a patient being bullied by psychiatric officials who saw nothing wrong with ignoring anything he said which conflicted with their own agenda. Specifically, they ignored both the fears and beliefs which they believed indicated that he 'had a mental illness' (fears for his sister, fantasies about his own skin colour, etc.) and other fears which seemed perfectly realistic (that psychiatry would continue to disregard and harm him, i.e., keep forcing painful and disabling medications on him). Instead of the epitome of scientific reason, psychiatry appeared like some demented, uncontrollable machine that once set in motion could not be brought to a halt. Apart from various other humiliations which the patient was powerless to avoid, it was particularly striking that the psychiatrist and the nurse ignored the patient's complaints about the ill-effects of his medication, and compelled him to keep taking it.

We examined that case because it is probably typical, and indeed it was celebrated in the documentary as a fine example of 'good practice'. Unwittingly, however, the film graphically demonstrated the twin main pillars of modern psychiatry: cold-hearted compulsion and drugging.

¹ Modrow, J, op. cit. (n. 35, Ch 2), 146 and 148. As we saw in Chapter 2, Modrow was diagnosed with schizophrenia at the age of sixteen.

This indicates that the priority is to suppress the patient's symptoms - in that specific case, by suppressing the patient. If mental health officials are questioned about it, the general absence of treatment options which might help patients without risking physiological or psychological harm is rationalised by the great busyness of over-worked staff who only wish they had more time to give. Of course, this fails to register the possibility that they might be rather less busy in the medium- and long-term were they to try engaging in a different kind of practice, such as one that led to some other place than interminable drugging and sometimes electroshock.

As we indicated in Chapters 1 and 3, mental illness is conceived as a kind of essential and more or less unremitting condition. Furthermore, by dint of his being irrational, the psychiatric patient is supposed to be unable to provide any information of any possible therapeutic interest. Hence, whatever a patient might have to say about his bad experience of the drugs used on him, and despite the absence of clear evidence for their efficacy, nearly every doctor appears to believe that psychiatric drugs do indeed help to remedy mental illness. There is also always the hope that organic causes will soon be found and antidotes concocted.

Still, the high hopes that accompanied the introduction of the modern psychiatric drugs have more recently somewhat abated. Fifty or sixty years on, most doctors advocate the utility of the current crop of drugs not so much as outright cures but more for the relief or 'management' of symptoms. In this chapter we examine both the stronger and the more qualified beliefs, and we find that in neither case is the evidence ever better than questionable.

Instead, what has become obvious during the last forty or fifty years is that too often the drugs cause chronic dependency (addiction), as well as other kinds of harm such as disabling and irreversible deterioration of the nervous system, obesity and liver damage; in addition, psychiatric patients regularly die as a result of excessive sedation. This all seems an unusual application of medicine. In the practice of general medicine, drugs with such strong ill-effects (called 'side effects') are either not routinely employed or the patient is given a clear and free choice.

Psychiatry and the drug companies are usually careful to put this knowledge to one side, however, and both parties claim that the latest drugs on offer will surely prove better than the old ones. As a result, today it is generally taken for granted that it is helpful to treat almost any kind of mental disorder by means of one or a combination of the following categories of drugs.

- Anti-depressants: these are known (for their chemical form) as the tricyclics, for example, amitriptyline and imipramine, or the monoamine-oxidase inhibitors (MAOIs), such as phenelzine and isocarboxazid. The latest kinds of anti-depressants to be developed were the selective serotonin re-uptake inhibitors (SSRIs), of which fluoxetine (Prozac) and paroxetine (Seroxat) are the most popular and best known.
- Anti-psychotics: the major tranquillisers or neuroleptics, used to quieten gross disturbances. These include the phenothiazines, e.g., chlorpromazine, and the butyrophenones, e.g., haloperidol. Unfortunately, these drugs often and almost immediately produce symptoms 'similar' to an actual disease of the nervous system, i.e., they harm the nervous system. In the 1990s hopes focussed on the new but more expensive atypical anti-psychotics, e.g. clozapine, olanzapine, risperidone and aripiprazole.
- Anxiolytics: the so-called minor tranquillisers, used to alleviate anxiety. These are the benzodiazepines, such as diazepam and lorazepam.
- Mood Stabilisers: the most common is lithium carbonate, which needs regular monitoring due to its physical dangers. Anti-convulsants, used to control epilepsy, are also employed as mood stabilisers, e.g., sodium valproate.
- Sedative-hypnotics ('sleeping pills' and sedatives): very addictive barbiturates used to be employed but they are now largely displaced by types of supposedly safer benzodiazepines. Nitrazepam (Mogadon) was the first in the field, then drugs such as the less effective (shorter acting) temazepam were more favoured, and now the most popular is zopiclone.
- Anti-parkinsonians: mainly used to counter the ill-effects of an anti-psychotic.

By implication, and for the purposes of medication, the great number of psychiatric diagnostic categories is effectively reduced to four essential types: depression, psychosis, anxiety and mania. For each of these conditions, if only the dose is big enough (says the medical model), there is always an appropriate medicine. Or again, according to the essential types of medical response, we might realistically reduce the number of categories of psychiatric disorder to just two: serious or florid forms of euphoria or mania, and serious forms of depression. In the first instance, an anti-psychotic ('downer') is employed so as to block the chemicals naturally occurring in the brain, thereby changing brain chemistry and electrics to elicit the required degree of sedation; in the second, an anti-depressant ('upper') encourages the release of certain brain chemicals (e.g. serotonin), thereby acting as a euphoric.

It should be noted that the effects of a mental disorder and the effects of the purported remedy very often overlap. A patient who is thought to suffer from depression and who also cannot sleep is usually given an anti-depressant 'upper' to raise his mood, and also a hypnotic 'downer' so as to get him to sleep. When one drug or combination of drugs does not seem to work, it is routine for doctors to try another. It is certainly not publicised, but this 'mix-and-match', rule-of-thumb practice of psychiatric medication amounts to ongoing experimentation on the patients. A mixture of drugs *might* result in greatly increased potency; equally, the drugs may act against each other; or they may combine to make a toxin that could damage a vital organ, such as the liver. Drug formularies warn against giving too many different drugs at the same time - known as polypharmacy - and doctors should be aware of the common contra-indications. And yet, in the absence of the desired response, it is common practice to 'mix-and-match'. If pressed about this blind experimentation, doctors plead that they can do nothing else when a patient needs help and all the other medical avenues have been explored.

A large-scale survey found that 91% of a sample of psychiatric patients had at some time been prescribed some sort of medication for their psychological problems. Nearly 70% had been given anti-depressants, 60% major tranquillisers, nearly 50% minor tranquillisers, and nearly 40% mood stabilisers. Also, 28% had been given electro-convulsive therapy (ECT). Confusion and ambivalence seem to reign amongst the recipients of psychiatric medicine. In this sample, the most helpful treatment, reported by 30%, was - *no treatment at all*. Many psychiatric patients do tend to expect and demand some kind of tangible treatment, however: 33% also reported no treatment as the most damaging medical response. The second most helpful treatment, but only reported as such by less than one-third of those prescribed it, was an anti-depressant. Despite widespread worries about side-effects and long-term ill-effects, two-thirds of those who had been given anti-depressants did feel that they had sometimes been helpful. The other kinds of drugs were experienced as rather less useful: fewer than 30% felt that the other types had proved particularly helpful. Many patients were anxious about the strong and deleterious effects of the major tranquillisers, although half of those with experience of them found they helped at least some of the time. Generally, across the range of drugs, it appeared that about one-half of the patients felt some benefit, at least sometimes; but about one-quarter reported no help at all, and many reported more or less fearful harm.²

Psychiatric patients are generally given little if any real choice of treatment, and today they are as worried as they ever were about the painful and unwanted effects and long-term consequences of medication. Formularies advise a maximum dose for any drug, but there are *no* legal safety limits, despite regular deaths from overdose; there is also knowledge of the high risks of addiction or damage to the nervous system from all of the commonly used drugs.³ It seems to us that these dangers are compounded by the fact that psychiatry imposes an absolute separation between the

2 Faulkner, A (1997) *Knowing Our Own Minds: A survey of how people in emotional distress take control of their lives*. Newport, Gwent: The Mental Health Foundation, 29-36. Responses were similar to the survey reported in Rogers, A, Pilgrim, D & Lacey, R (1993) *Experiencing Psychiatry: Users' views of services*. London: MIND.

3 Cobb, A (1996) *MIND's Yellow Card Scheme Reporting the Adverse Effects of Psychiatric Drugs: First report*. London: MIND.

expert who is supposed to know best and the patient whose discomfort, pain or organic harm is regularly counted a price worth paying for reducing his psychiatric symptoms. After all, doctors might argue, isn't there often a lot of discomfort and pain associated with many of the treatments used in *general medicine*?

Drug treatment was not always an unquestioned routine in the management of irrationality. Physical restraint was normal well into the 19th century, but the visible horrors of its abusive use sparked a humanitarian response which in time nearly brought about its abolition. However, this reforming impulse was not sustained. Towards the end of the 19th century, restraint re-emerged in the form of *internal control* by drugging. Being internal and visible only in signs of the person at close quarters, drugs became the preferred method for controlling inmates. Because some drugs had proved their value by curbing patients' unruliness, others were then used to 'raise the mood' of the melancholic. In the meantime, a century of research, chemical cooking and experimentation on patients has delivered less objectionable drugs - less noxious, less overtly toxic, and allegedly less addictive. Nowadays a significant part of the pharmaceuticals industry serves psychiatry. Or perhaps, in the light of the profligate use of psychotropic drugs, without clear evidence for their efficacy and despite the evident dangers, we may legitimately invert this proposition: psychiatry and the wider mental health system serves the pharmaceuticals companies.

Just the same, who could object to the judicious use of drugs? Exactly what constitutes care or good judgement is of course a matter of debate in which clear arguments and the evidence of research findings should not be ignored. But there is no meaningful debate. Reasonable argument has been stifled by those psychiatric authorities who should be encouraging it for the sake of scientific enquiry and the welfare of the patients. This is deplorable. Worse is the routine over-administration of drugs, in the face of clear evidence of the dangers. It could be said that doctors are addicted to drugging, and that the habitual prescription of drugs supposed to relieve symptom hardens psychiatric workers to their work. 'Care' takes on the odour of a kind of social control which either depletes the patient, body and soul, or induces in him a false euphoria. The power psychiatry holds over the patients is almost total, and it should really be subjected to constant and scrupulous criticism. However, this is not welcomed by the authorities. On the contrary, both the guardians of psychiatric orthodoxy and the drug companies which now seem to call most of the shots have more than once been caught out deliberately fudging the facts, cheating on research findings, and stifling criticism.⁴ In both the UK and the USA, it has also come to light that many doctors involved in drugs research have been threatened, intimidated, sacked or silenced by threats of legal action for questioning what the drugs companies wish to have made public. This has probably happened to hundreds of doctors involved in hundreds of trials.⁵

Naturally, most of the general public, most GPs and most psychiatrists would deny this picture of a general and unrestricted drugging free-for-all, using medications sometimes approved only because the research was rigged or the drug companies and regulatory agencies were 'economical with the truth' about the evidence for their efficacy and safety. What can you do when somebody is in the throes of a mental illness, or simply needs help to sleep or to relieve his depression or anxieties? Psychiatry is the service of last resort, and everyone supposes that the doctors do their best. It is taken for granted that a psychiatrist is bound to prescribe drugs for his patients in order to cure or alleviate the medical problem of their mental illnesses. This is 'common sense'. As our argument proceeds,

4 See Breggin, PR, op. cit. (n. 107, Ch 1), 77-80 and 82-85 for scandalous evidence of the distortions, cover-ups and denial of research findings in relation to the world-wide plague of irreversible tardive dyskinesia caused to millions by routine anti-psychotic drugging, perpetrated for decades by the pharmaceutical companies and those occupying the highest positions in American psychiatry.

5 Dying for drugs (2003) *Channel 4* 27 April. The makers of the program interviewed researchers and quoted the fears of a *Lancet* editorial. Yet this degree of corruption is not unusual in the defence of ideology and the pursuit of personal ambitions and profits. An investigation of scientific journals across many fields estimated that 40% of all the articles were either plagiarised, contained made-up results or were wholly recycled under a different name. Boseley, S (1999) Fraudbusters needed to curb dud research. *The Guardian* 9 Sept.

though, it is this 'sense' which we intend to question. In the meantime, how did we arrive at today's pervasive use of psychiatric drugs? And anyway, how good are the drugs - or how bad?

The development of the psychiatric drugs

Psychotropic drugs are supposed to bring the person back into emotional and mental balance by altering his mood or mental processes.

In a pre-history of psychotropic drug use which stretches back into the mists of the past, the benefits of naturally occurring plants or easily prepared potions have been tried and tested the world over. There are many common natural drugs, including peyote, agaric, psilocybin, opium, alcohol, coca, cannabis, coffee, tea and tobacco. In recent times, self-administration of the more potent drugs (except for alcohol) has been prohibited in most societies. Yet what is the widespread and excessive (i.e., incapacitating or harmful) consumption of alcohol or non-prescription and illegal drugs if not very often a response to feelings of oppression? People have always 'self-medicated' so as to abate or obliterate their unwanted feelings or induce euphoria.

Systematic discovery of psychoactive drugs was part of the new science of chemistry which developed during the industrial revolution. By the 1850s it was common to use ether, nitrous oxide and chloroform as medication or anaesthetic. Steady advances in chemicals manufacturing increased the number of pharmacological agents used throughout medicine. Potassium bromide, and then chloral hydrate and paraldehyde were each widely adopted to subdue psychiatric symptoms - in other words, to subdue patients. However, those drugs proved dangerously toxic. Barbiturates were synthesised towards the end of the 19th century; they found widespread use after 1900, but proved dangerously addictive. Between the two World Wars, the amphetamines were synthesised and used as anti-depressants, but they also proved highly addictive and fell out of psychiatric use when the next generation of drugs came onto the market.

The trouble with psychiatric drugs until the 1950s was that it was not at all clear that the benefits out-weighed the high costs of organic harm and addiction. This did not prevent their use, but it did spur further chemical research. The period between the World Wars was marked by the optimism of the spectacular cure of the disease of syphilis, which had previously filled about a quarter of all psychiatric beds with patients suffering from General Paralysis of the Insane (GPI).⁶ This breakthrough encouraged the development of psychiatric interventions which looked like standard medicine, such as attempts to develop narcosis and coma therapy for chronic patients (either by a barbiturate or by insulin, respectively), and the invention of lobotomy and electro-convulsive therapy. After a generation of use, those medical interventions also failed to prove themselves unambiguously successful, and since they are such crude and irremediable assaults on the brain, they were also increasingly criticised for the dangers involved.

All the same, by the late-1940s it had become apparent that the melancholic were more likely to recover than in the past, and that some psychotic patients might be safely returned to the community. This seems to have been due to a combination of factors: the number of GPI patients had naturally started to decline, a generally more benign atmosphere had begun to prevail in the mental hospitals, material and social conditions in the outside world were less chronically awful than before, and there was now a welfare 'safety net' which caught many people who might otherwise have fallen into despair. By the end of the Second World War, both the doctors and the general public were in a more optimistic and liberal frame of mind, and many people began to believe that incarceration in the big old asylums might not be so therapeutically useful.

During the 1950s, when the number of psychiatric patients in the UK was already in decline, new psychotropic drugs were developed and marketed. Apart from the cure for syphilis/GPI, the success of previous medical interventions had been debatable, but psychiatrists still anticipated the next advance and perhaps another definite cure. The first of the new drugs were the major tranquilisers. The main types were the phenothiazine family, but there were also thioxanthenes, butyphenones and

⁶ Although it has since been suggested that many of those diagnosed with syphilitic GPI might actually have suffered from a chronic functional mental disorder.

reserpine alkaloids. Doctors hoped for tranquillisation without complete sedation. These new drugs were not devised by way of anything known about brain-chemistry, or due to any particular causal theory of neural or brain function, but simply by serendipity or trial-and-error experimentation. Chlorpromazine (Largactil) was the first on the market, in 1952. Many other phenothiazines were synthesised and used to alleviate psychotic symptoms, especially the delusions, hallucinations and disturbing behaviour of patients diagnosed with schizophrenia.

Today it is generally recognised that tranquillisation might help to manage a patient, but it does not cure him. After a decade or more of their use, it also became clear that many patients suffered from terrible ‘side effects’. After years of denial, in the 1980s the psychiatric establishment finally admitted that irreversible tardive dyskinesia (TD) and many other side-effects were a serious risk to almost any patient given a major tranquilliser. This did not stop the use of these drugs but only inaugurated an era of supposedly more careful use. In the 1970s lithium, monitored for its toxicity, found a certain favour for the treatment of both mania and depression; it is still routinely used for bipolar disorder. Long-acting subcutaneous or intramuscular injections of tranquillisers (known as depot injections) were also developed to counter the problem of persuading chronically disturbed or reluctant patients to keep taking their medication, e.g., fluphenazine (Modecate), flupentixol (Depixol), and later risperidone (Risperdal). Tablets and ‘depots’ are now the usual basis for controlling the drug input of diagnosed psychotics or intractable patients released for ‘care in the community’.

The benefits of the MAOI and tricyclic anti-depressants were also found by chance or deliberate trial-and-error. Imipramine was the first tricyclic, and along with amitriptyline, it was for many years the most commonly used. These drugs were introduced at the end of the 1950s. MAOIs have a euphoric effect; they are also dangerously toxic, and were largely replaced by the tricyclics. Nowadays the SSRIs have mainly supplanted the tricyclics.

In reality, the so-called Minor Tranquillisers are minor neither in effect nor use. Otherwise known as anxiolytics, they are relaxants or sedatives. The first successful versions were the benzodiazepines, which were marketed in 1960; the most popular are diazepam (Valium) and lorazepam. In view of their appearing safer, more effective, less addictive and less harmful to the liver, they replaced the barbiturates. Their highly addictive properties soon became apparent, however, and nowadays they are supposed to be prescribed more cautiously.

The most popular types of drug now used in psychiatry are:

- Anti-psychotics: the atypical anti-psychotics, such as olanzapine and risperidone, or clozapine (for those ‘unresponsive to, or intolerant of, conventional anti-psychotic drugs’). The older type of major tranquillisers or neuroleptics, such as chlorpromazine and haloperidol, are now used less frequently. In acute or forensic units, clopixol acuphase is given by deep intramuscular injection; it is regularly administered for ‘the short-term management of acute psychosis, mania or exacerbations of chronic psychosis’.
- Anti-manic or mood stabilising medications: such as lithium carbonate or the anti-convulsants, carbamazepine and sodium valproate.
- Anti-depressants: SSRIs, such as fluoxetine (Prozac), paroxetine (Seroxat) and citalopram, and (less frequently nowadays) tricyclics such as dosulepine and amitriptyline.
- Anxiolytics: the benzodiazepines, such as diazepam and lorazepam.
- Sleeping tablets: benzodiazepines, such as temazepam, and now non-benzodiazepine drugs such as zopiclone.

No drug has been shown to cure a deep-seated mental disorder. Each of them is likely to produce significant undesirable somatic or psychological effects.⁷

⁷ Naturally, the development of psychiatric drugs is a matter of pride for the drugs industry. For example, see Allderidge, P & Lader, M (nd, circa 1980) *The SK & F History of British Psychiatry, 1700 to the Present*. London: Smith, Kline & French.

The efficacy and the dangers of psychiatric drugs

Theories to support the use of the psychiatric drugs often arrive *after* the introduction of the drugs concerned, and in relation to the benefits that, by chance, they seem to provide. For example, the idea supporting the anti-psychotics is that someone diagnosed with schizophrenia has nerve-cell receptors hypersensitive to certain neurotransmitters: his receptors fire too readily, and this particular type of chemical reduces the hypersensitivity. Another unconfirmed psychiatric theory is supposed to account for severe depression: some people happen to suffer a decrease in the receptivity of their neurotransmitters, and specific drugs re-stimulate those cells.

In Chapter 12 we discuss the lack of evidence or argument with regard to the neurochemistry proposed for schizophrenia. In relation to conventional ideas about the neurochemistry of depression, there are in fact no markers of *organic* depression amongst the clinically depressed. On the contrary, depressed people show signs of heightened arousal: in clinical depression, the adrenal glands become hyperactive and produce excessive cortisol, the body's main hormonal response to stress.⁸ Besides, natural processes are rarely simple and unilinear, and especially in such a complex organism as the human body; neurotransmitters and hormone production are always in feedback with each other and with emotional and psychological processes such that there is no easy way to determine cause and effect. And drugs intended to act on the brain also intervene significantly in many other dynamics of the whole organism.

For these reasons, simplistic notions about direct brain-chemical causes for the functional mental disorders do not make scientific sense. Moreover, each psychiatric drug always carries some risks to the whole neurological-hormonal system. In the 1950s and 1960s the MAOI inhibitors were most often used to treat anxiety, phobias and depression, but it was discovered that they interact with many common foods to cause dangerously high blood pressure, and that interactions with other medications were also problematic.⁹ The most modern drugs are hardly less hazardous. For instance, the selective serotonin re-uptake inhibitors (SSRIs, such as Prozac and Seroxat) superseded the tricyclics for the treatment of depression because they are less sedating and have fewer antimuscarinic and cardiotoxic effects. Unfortunately, common SSRI side-effects include gastro-intestinal problems such as nausea, vomiting, dyspepsia, abdominal pain, diarrhoea and constipation; also reported are anorexia with weight loss *as well as* increased appetite and weight-gain, hyper-sensitivity reactions such as rashes (which may be signs of an impending and serious systemic reaction), urticaria, angioedema, anaphylaxis, arthralgia, myalgia and photo-sensitivity; other side-effects include dry mouth, nervousness, anxiety, headache, insomnia, tremor, dizziness, asthenia, hallucinations, drowsiness, convulsions, galactorrhoea, sexual dysfunction, urinary retention, sweating, hypomania or mania, movement disorders (dyskinesia), visual disturbance, hypnoaemia and cutaneous bleeding disorders. The SSRIs are also to some extent linked with increased suicidal thoughts and suicides.¹⁰

Despite this, most doctors would argue that careful use of mental health medications does have desirable psychotropic effects and does alleviate symptoms, if only to a degree. And yet in tests run by medical researchers, no psychiatric drug has proved itself convincingly more effective than placebo, non-medical interventions such as counselling and psychotherapy, or even 'caring human association'.¹¹ (A placebo is any device that the patient believes is medically active, e.g. a 'sugar pill', or any procedure which simulates a medical technique but is inactive.)

8 For a summary of the current knowledge, see Yates, WR (2010) Somatoform disorders. *emedicine psychiatry*. 15 July; also see *Demystifying Depression/The Stress System* (2010) wikibooks.org 9 Aug.

9 Ullman, D (1991) *Discovering Homeopathy: Medicine for the 21st century*. Berkeley: North Atlantic Books, 186-189.

10 These side-effects are listed in any recent *BNF*; see *BNF* 72, op. cit. (n. 105, Ch 1), 333-341.

11 See Breggin, PR, op. cit. (n. 107, Ch 1), 66-67 and 159-160. Thomas, P (1997) *The Dialectics of Schizophrenia*. London: Free Association Books, 60-65, cites research showing that on a number of counts the neuroleptics seem slightly more effective than placebo. However, although Thomas recognises the dangers of tardive dyskinesia, he does not at that point discuss neuroleptics as a form of lobotomy, or measure their efficacy against anything but placebo. Others find that, after decades of use and research into their efficacy, if anti-depressant medications relieve symptoms more effectively than placebo, the difference is only marginal. See

A Cochrane review, for example, finds that in the first few weeks of treatment the preferred anti-psychotic, Risperidone, does appear to provide a marginal benefit compared with placebo. But the data is limited, poorly reported and probably biased in favour of the drug since ‘the data became considerably more homogeneous (and positive) when the one study independent of [drug company funding] was removed...’¹² In other words, there is no clear evidence that the reported marginal improvements are clinically relevant. Hence, in effect, Risperidone provides no statistically significant benefit compared to placebo, but what is certain is that the drug often triggers a variety of alarmingly adverse effects.

Similarly, evidence for the value of anti-depressants is not particularly convincing. Depression is the most widespread mental disorder, and probably more research has been carried out on anti-depressant medications than on any other type of psychiatric medicine. A recent meta-analysis of the research indicates that placebo reduces the symptoms of clinical depression by 31-38%; by comparison, anti-depressant pharmaceuticals appear slightly more effective, reducing symptoms by 46-54%.¹³ But there is no clear evidence that the drugs offer relief for more than a few weeks. A review of randomised controlled trials (RCTs) of the type most prescribed, the SSRIs, found that symptoms reduced the most during the first week; and although improvement continued steadily for up to six weeks, it was not by much.¹⁴ Another meta-analysis found no evidence that SSRIs reduce the risk of depression recurring when the course of drugs was finished; the authors of the report suggest they would best be combined with some kind of talking therapy.¹⁵

As regards remission (i.e., apparent recovery), a big study on the efficacy of anti-depressants was run in the USA by the National Institute of Mental Health. Reports from this study do not mention comparisons with placebo, but various versions of the drug proved equally effective for 37.7% of a sample of patients who suffered from a non-psychotic major depressive disorder. Of the initial 2,876 participants, and after the first course of treatment, it was estimated that 27.5% had ‘reached remission’. Almost one-quarter of the participants then dropped out of the study, and after the second course of treatment 21-30% of the remaining 1439 participants remitted. By the third course of treatment, only 310 participants were willing or available to continue, and 17.8% remitted; of the 109 patients who remained to take a fourth course of treatment, 10% remitted. Switching the type of anti-depressant proved effective less than 20% of the time. Finally, a one-year follow up of all the participants deemed to have remitted (a total of 1085, or 37.7%) showed that 93% had either relapsed or dropped out of the study. There were no statistically significant clinical differences in remission rates, response rates, or times to remission or response between any of the medications compared in the study. The best that could be said was that the anti-depressants might help briefly with slightly more than one-third of the patients, but evidence for their utility in the long-term was scanty.¹⁶

Our second Volume takes up the idea that non-medical forms of intervention often prove just as effective as drugs, cause less harm, and as well as alleviating symptoms they can help bring about longer-lasting recovery. Meanwhile, in order to alert the reader to the dubious claims of mental health medicine, the extraordinarily important role of the placebo effect in treatment and recovery is more

Moncreiff, J, Wessely, S & Hardy, R (1998) Meta-analysis of trials comparing antidepressants with placebos. *British Journal of Psychiatry* 172 227-31.

12 Rattehalli, RD et al (2010) Risperidone versus placebo for schizophrenia. *Schizophrenia Bulletin* 36 3 448-449.

13 Khan, A et al (2012) A systematic review of comparative efficacy of treatment and controls for depression. *PLoS ONE* 7 7.

14 Taylor, MJ et al (2006) Early onset of selective serotonin reuptake inhibitor antidepressant action: Systematic review and meta-analysis. *Archives of General Psychiatry* 63 11 1217-1223.

15 Hollon, SD et al (2002) Treatment and prevention of depression. *Psychological Science in the Public Interest* 3 2 39-77.

16 Fava, M et al (2006) A comparison of Mirtazipine and Nortriptyline following two consecutive failed medication treatments for depressed outpatients: A STAR*D Report. *The American Journal of Psychiatry* 163 7 1161-1172; Trivedi, MH et al (2006) Medication augmentation after the failure of SSRIs for depression. *New England Journal of Medicine* 354 12 1243-1252.

fully discussed in Chapter 8, below. Here we briefly note that placebo is a fully researched and well documented phenomenon: it is essentially a form of faith healing which works all the better to the extent that everyone (health-care workers included) is oblivious to the *magical* nature of the psychiatric intervention. We are not suggesting that the active drugs do not have organic effects. Indeed, perhaps the more they influence the patient's metabolism, the more he feels that 'they must be working'. In which case, retarding or 'enhancing' the neurochemistry of the brain and poisoning various of the body's organs - the 'side-effects' and 'cautions' catalogued in the formularies - might help to persuade a patient that something really is happening and that this must be part of the remedy of his so-said illness. With psychiatric medication, one or both of the following events might occur: the patient might begin to feel better *despite* the discomforts caused by the drug but encouraged by the awesome authority of Medicine; or by recovering from the ill-effects of the drug, or habituating himself to them, he might feel as if he is recovering from his asserted illness - while not realising (or forgetting) that the drug had made him feel physically ill, debilitated or disorientated in the first place. Thus, in the absence of any other good evidence, and since (in theory) deciding the presence of a functional mental disorder depends *entirely* on how the patient behaves (including how he says he thinks and feels), it might be true that toxic psychiatric drugs *may* help to make some patients feel better by working like a placebo.

Our opposition to the use of psychiatric drugs is not an inflexible principle. There may be direct benefits, especially 'raising the mood' of someone suffering from depression or sedating someone who suffers from intolerable stress. Nonetheless, we suggest much greater caution and the provision of a genuine choice of alternative therapies. This is because, in general, if psychiatric drugs have any beneficial effects they are only short-term, the drugs are addictive, and they often bring with them a host of unwanted and dangerous side-effects. Most importantly, while they may sometimes help bring symptoms under control, they cannot remedy a patient's basic psychological and social problems.

Standard physicians' drug formularies are of course explicit about the risks of harm, the ill-effects or the unwanted side-effects of the drugs listed. Every psychotropic drug is significantly more dangerous than aspirin (which is probably the most popular drug in the world). *The British National Formulary (BNF)* cautions for aspirin are: asthma, allergic disease, dehydration, impaired renal or hepatic function, the elderly, pregnancy and its interaction with certain other drugs - a list of various drugs, on 27 lines of the page. Contra-indications: children and breast-feeding mothers, gastro-intestinal ulceration, haemophilia, gout. Side-effects: generally mild and infrequent, but high incidence of gastro-intestinal irritation with slight asymptomatic blood loss, increased bleeding time, broncho-spasm and skin reactions in hypersensitive patients.¹⁷ That's it. Aspirin is a simple, plant-derived drug to be taken with caution.

Compare this with the anti-psychotics. The information in this and the following three paragraphs is taken from the introduction to the section: 'Antipsychotic drugs' in *BNF 47* (2004), but since no new medications were introduced in the meantime, the information was essentially unchanged for later editions.¹⁸ Anti-psychotics are recommended for 'tranquillising without impairing consciousness and without causing paradoxical excitement'. In the short term, an anti-psychotic is used to sedate anybody who has this kind of mental disorder, organic or functional, or to alleviate anxiety and depression; and yet: 'caution is required if its use masks the symptoms'. Already there are phrases whose meanings might be interrogated: 'without impairing consciousness'; and 'paradoxical excitement' - such as that caused by ill-effects to the patient's metabolism, or by his anticipation of ill-effects to his body or mind?

BNF tells us that the main use of these drugs is for the relief of the florid, positive symptoms of schizophrenia such as delusions, hallucinations and thought disorders, and to prevent relapse; they are usually less effective with apathetic and withdrawn patients who display 'negative symptoms of schizophrenia'. Sometimes, though, and whereas previously he was withdrawn or even mute and

¹⁷ See *BNF 72*, op. cit. (n. 105, Ch 1), 110.

¹⁸ Joint Formulary Committee (2004) *British National Formulary 47*. London: BMJ Group and Pharmaceutical Press, 173-174; see also *BNF 72*, op. cit. (n. 105, Ch 1), 350-352.

akinetic (motionless, or catatonic), a high dose may restore the acute schizophrenic patient to normal activity and social behaviour. Acute schizophrenia usually responds better than chronic. Long-term treatment may be necessary in order to prevent chronicity. Finally, says *BNF*, withdrawal from an anti-psychotic requires careful monitoring: the patient might relapse disastrously, and often weeks after the treatment ended

An anti-psychotic drug acts to suppress the brain's natural bio-chemistry, and if it is suddenly withdrawn there is a marked physiological compensation, often with frightening organic and psychological effects. If a patient stops taking his medication and experiences an increase in psychotic symptoms, and despite the warning in the *BNF*, this is routinely taken by those who subscribe to the medical model of mental illness as 'proof' that he still needs to be drugged. But this is like saying that because he experiences withdrawal symptoms an addict must stay on heroin forever. The result of this peculiar psychiatric logic is that anyone diagnosed with schizophrenia is likely to be prescribed anti-psychotics for as long as he remains in contact with psychiatry or his GP.

The most troublesome side-effects of the older anti-psychotics are extrapyramidal symptoms. These are caused most frequently by fluphenazine, haloperidol and depot administrations. They are easy to recognise but hard to predict since they depend on the type of drug, the dose and the idiosyncratic biology of each patient. According to *BNF*, symptoms include dystonia (abnormal face and body movements) which may appear after only a few doses, akathisia (restlessness) which may resemble [why 'resemble'?] a worsening of the condition being treated, and a parkinsonian-type syndrome which usually takes longer to develop. Since these symptoms usually disappear if the drug is withdrawn, this might be considered unproblematic. However, this assumes that the patient or even the doctor recognises the symptoms *as* drug effects rather than interprets them as further evidence for the mental illness. As we have seen in Chapter 4, it is entirely possible - and, by all accounts, routine - for a doctor to discount a patient's report of the ill-effects of psychiatric drugging, on the grounds that the patient 'has a mental illness' and is therefore either deluded or exaggerates. Mental health officials ignorant of some of the information in the drug formularies may even find evidence of mental illness in the very restlessness and 'paranoia' caused by the medications.

Any unfortunate parkinsonian effects may be suppressed by administering another drug - an anticholinergic - although routine administration of this antidote is not advised since not every patient experiences ill-effects from an anti-psychotic, and tardive dyskinesia (TD) is made worse by an anticholinergic. TD is the neural damage which causes chronic involuntary muscle movements, and which usually develops after being medicated for some time. This 'side-effect' is a particular concern because there is no effective treatment and it is often irreversible when the patient withdraws from medication. TD occurs frequently amongst patients given the previous generation of anti-psychotics, especially the elderly and those on high doses and long-term prescriptions; but it may also sometimes occur after short-term, low dose treatment, and the treatment of all these patients should be carefully monitored. Hypotension and interference with the body's temperature-regulation are dose-related side-effects; they are liable to cause falls and hypothermia in the elderly. The differences between the anti-psychotics are less important than variability in patient-response and tolerance to side-effects. The tendency to mix-and-match drugs is not recommended since it can be hazardous and there is no evidence that it reduces side-effects. In fact, there are serious side-effects from mixing MAOIs with SSRIs, or taking one too soon after the other. By the time it was realised that the MAOIs reacted with certain other drugs, scores of people had suffered strokes; by 1990, in the UK at least fifteen patients had died.¹⁹

Chlorpromazine, the first of the modern psychotropic drugs (traded as Largactil), is still in use. It is a sedative used particularly for violent patients and agitated elderly people. It is indicated for schizophrenia and related psychoses, for tranquillisation and the emergency control of behavioural disturbances, for short term adjunctive treatment for severe anxiety, and for terminal disease.

The side-effects of Chlorpromazine include extrapyramidal symptoms (reversed by reducing the dose or by taking an antimuscarinic), and 'after prolonged administration occasionally [*sic!*] tardive

19 Gilman, A et al (1990) *The Pharmacological Basis of Therapeutics*. Oxford: Pergamon, 417.

dyskinesia'. As indicated in the section on tardive dyskinesia, below, this warning of an 'occasional' problem is the *BNF* being 'economical with the truth', although the butyophenones, such as Haloperidol, do seem to produce worse TD effects. Other possible ill-effects include hypothermia, occasionally pyrexia, drowsiness, apathy, pallor, nightmares, insomnia and depression; more rarely, agitation, EEG changes, convulsions; but also nasal congestion, antimuscarinic symptoms such as dry mouth, constipation, difficulty with micturation, and blurred vision; cardiovascular symptoms such as hypotension, tachycardia, and arrhythmias; respiratory depression; endocrine effects such as menstrual disturbances, galactorrhoea, gynaecomastia, impotence and weight gain; sensitivity reactions such as agranulo-cytosis, leucopenia, leucocytosis, and haemolytic anaemia, photosensitisation, contact sensitisation and rashes, jaundice (including cholestatic) and alterations in liver function; neuroleptic malignant syndrome;²⁰ lupus erythematosus-like syndrome; and with prolonged high dosage, corneal and lens opacities and purplish pigmentation of the skin, cornea, conjunctiva, and retina; intramuscular injection may be painful, cause hypotension and tachycardia, and give rise to the formation of nodules.²¹

Within the psychiatric pharmacopoeia, anti-psychotics (and among them, chlorpromazine) are not unusually ambiguous, unusually contrary to doctors' intentions or unusually dangerous in their effects. Every psychotropic drug is significantly more dangerous and has significantly more ambiguous effects than aspirin. The reader is referred to the *BNF* for more information on the constituents, indications, cautions, side-effects and contra-indications of the drugs used in psychiatric medicine.

As well as the unwanted, uncomfortable and sometimes dangerous side-effects, there are the risks of the abuse or misuse of the drugs by disturbed patients, of the immediate and dangerous alteration and impairment of brain functioning, and of physiological and psychological addiction. For example, the benzodiazepines (so-called minor tranquillisers) replaced the unacceptably addictive barbiturates as the most widely used hypnotics, sedatives and anxiolytics. Benzodiazepines are still prescribed by GPs, though with cautions about long-term use. Yet Home Office statistics suggests they are linked to more deaths each year than all five illegal 'Class A' narcotics put together. They also cause far worse brain damage if taken in excessive doses. Moreover, there appears to be twenty-four times the risk of perinatal death for pregnant mothers who regularly use a benzodiazepine. The *BNF* has cautioned against their addictiveness since the 1980s, and yet in the UK at the turn of the millennium an estimated one-and-a-half million people were addicted to a benzodiazepine, with at least another one million permanently disabled by years of protracted withdrawal. The risks were well known at least forty years ago, but until quite recently no attempt was made to phase-out the use of these drugs.²² Anyone prescribed a benzodiazepine often finds herself sunk in heavy lethargy and commonly not fully conscious of her activity (or inactivity). When they try to come off the drug, patients suffer frightening and unbearable withdrawal symptoms such as shakes, palpitations and hot and cold sweats; these are accompanied by anxiety, panic, feelings of going mad, and aggressive and suicidal feelings which they and those around them often experience as much worse than the symptoms originally presented to their GPs.

Research shows that these drugs can destroy up to half the benzodiazepine receptors in a foetus. This throws the born child into a permanent state of heightened proclivity to anxiety and panic, thereby predisposing it to compensatory substance addiction. Benzodiazepine was introduced in 1960, and up to 2001, in the UK alone, each year an estimated 50,000 babies were born addicted to the drug: potentially two million were brain-damaged before birth. These children are likely to develop with depleted natural serotonin and opiate levels, and with an irreversible physiological

20 Even on a low dose this condition is life-threatening and can occur without warning.

21 *BNF* 59, op. cit. (n. 10), 208 and 209. The information did not change for later editions; see *BNF* 72, op. cit. (n. 105, Ch 1), 354.

22 A specially commissioned poll found 3.3% of a large sample of the general population on extended repeat prescriptions of benzodiazepines. Panorama (2001) *BBC1* 13 May; also see Bell, M (2000) Addicts in the making. *What Doctors Don't Tell You* 11 7 12.

addiction to benzodiazepine or a similar substance, such as alcohol. A mother's use of the drug during pregnancy is clearly linked to hyperactivity, attention deficit disorder and alcohol and drug addiction in childhood, adolescence and maturity.²³

The magnitude of the problem of benzodiazepine organic harm and addiction became public knowledge as long ago as the mid-1980s, and it certainly ought to be known by doctors: the UK Government issued guidelines in 1988 advising only a low dose and no more than four weeks prescription. This has largely been ignored, and by 2001 probably one-and-a-half million people had been on a benzodiazepine for more than four months - or worse, a mix of the drugs. 28% of the Panorama poll sample who were prescribed a benzodiazepine had been on it continuously for longer than ten years.²⁴ Aside from the irresponsibility of the doctors who continued to repeat-prescribe and mix these drugs - estimated at 90% of all GPs - there is the further scandal of Roche, the first company to market benzodiazepine. They were discovered not informing UK doctors about the ill-effects of the popular drug Mogadon (nitrazepam). To conform to the more stringent Scandinavian regulations, the health services in those countries were informed in 1973, and yet it took until 1984 for Roche to reveal the full information to the UK authorities. On top of this, Mogadon had been marketed as a sedative, even though Roche was always aware it was never suitable for that purpose since its half-life is 30-40 hours. In other words, it still acts with more than half its potency when a patient takes another dose: if she takes it every night, the sleeping pill acts cumulatively to keep her increasingly drugged and chronically dependent.

If this is the history of the sedatives and the so-called minor tranquillisers, which are prescribed for less severe mental disorders, it is not likely that the motives of profit and quick and easy medico-bureaucratic processing of patients would work any less powerfully or with more honesty when it comes to marketing and prescribing any other psychiatric drug.

In general medicine it is well known that adverse drug reactions are largely under-reported by doctors. One reason is that it is difficult to distinguish a response to a disease from that caused by the drugs employed as a remedy. They are always invited to do so, but fewer than 10% of all GPs ever, *in their entire careers*, report a single adverse drug reaction to the Medicines Control Agency. In 2000, a summary of the research made a cautious estimate that in the UK, and throughout medicine, about 6,000 people die each year from a reaction to a drug that was meant to help them. There is no attempt at a proper audit, however, and the true figure is probably much higher. At the same time, another study conservatively estimated that of all kinds of NHS patients, in one year 280,000 suffered from so serious an adverse reaction to medication as to warrant at least six days hospitalisation.²⁵ About one-third of all prescriptions in the UK are for mental health (psychiatric) drugs, and there is no reason to believe that the ill-effects they cause are less hazardous than those produced by the drugs used in general medicine. Of course, reactions reported by a patient being treated for a mental illness are more likely to be ignored, on the grounds that the person is irrational and therefore what he says cannot be trusted.

An important consequence of the ill-effects of psychiatric medication is that whereas it may well be a dangerous 'side-effect' or a result of addiction to the medication, anyone who believes in the medical model of mental illness tends to assume that a patient's bizarre or worrying behaviour is a symptom of his so-said illness. Later in this chapter we discuss the global epidemic of tardive dyskinesia caused by the major tranquillisers; we also comment on the ill-effects - sometimes including psychosis and suicidal feelings - of the popular modern anti-depressant, Prozac.

For now, as another example of medication which causes illness, we mention that psychiatrists increasingly prescribe anti-convulsants as 'mood stabilisers'; and yet it is well-known that if a patient decides to immediately stop taking carbamazepine he is likely to suffer a sudden epileptic seizure, while sodium valproate harms the liver to the point of some patients turning yellow. More than this, valproate has for decades been controversial for its toxic effects on the unborn. Marketed as Depakine

23 Bell, M, op. cit. (n. 22), summarises some of the research.

24 *Panorama*, op. cit. (n. 22).

25 Research cited by Hubbard, B, op. cit. (n. 102, Ch 1), 5-9 and 46.

or Epilim by the French pharmaceutical giant, Sanofi, it is used to treat epilepsy, migraine and (in lieu of lithium) mania in bipolar disorder. In 2016 Sanofi had to compensate a number of French complainants to a total of more than £10m, while representing an association of 2,000 French women who had taken Depakine during pregnancy, a class action was initiated against the company in 2017. All the women had borne severely damaged children, some more than once. Exposing a foetus to the drug runs a high risk of birth defects, and Sanofi is accused of failing to inform pregnant women about the possibility. The drug is now known to carry a 10% risk of serious visible physical abnormalities - spina bifida occurs twenty times more frequently in foetuses exposed to sodium valproate - as well as heart and genital defects; there is also a 40% risk of significant neurological problems - autism and impaired intellectual functioning (learning disabilities). The company had known the risks since the early-1970s, and in France at least 14,000 pregnant women used Depakine between 2007 and 2014.

In 2017 the European Medicines Agency at last began a risk assessment of this medication. Campaigners at a public hearing said that up to 20,000 children in the UK could have been seriously affected, and warnings to women who might become pregnant could have been made more than forty years ago. Recently accessed documentation reveals that a decision was made not to warn patients. The regulators were aware of the risks when they licensed sodium valproate, and at the time health professionals were privately warned: 'This compound has been shown to be teratogenic in animals, meaning it could harm the human foetus.' But in 1973 the Committee on the Safety of Medicines decided that telling patients 'could give rise to fruitless anxiety', and therefore a warning should '...not [go] on the package inserts, so that there would be no danger of patients themselves seeing it'.

In January 2015 the UK Government warned doctors that unborn children exposed to valproate were 'at a high risk of serious development disorders'. And a warning was finally put on UK packaging in 2016. But according to a 2017 survey by the Epilepsy Society, one in every six young women who use the drug are still unaware of the risks, even after a 'toolkit' had been devised for doctors and patients by the Medicines and Healthcare Products Regulatory Agency (which replaced the Committee on the Safety of Medicines).²⁶

Obviously, any medication may be dangerous, and yet, adding to the risks just outlined, testing is generally unashamedly partisan. Trials are mainly conducted by the company which develops the drug, and usually only for a matter of a few weeks; moreover, whereas the target population for a psychiatric drug almost invariably includes children, menopausal women and older people, tests are usually run on small samples of healthy young adult volunteers. In the UK, on the grounds of guarding patents, the drugs industry is highly protected. Under the 1968 Medicine's Act, which was passed after the Thalidomide disaster (where a drug prescribed for morning sickness caused severe birth defects amongst a wide population), the deliberations and findings of the Medicines Control Agency remain secret. Even so, 'fudges' and examples of outright cheating do sometimes come to light: a recent UK study estimated up to 5% fraudulence, and the Federal Drugs Agency in the USA reckons at least 11%. It is worrying that at least 70% of all medical research is underwritten by the drug companies. Apart from this, reports in medical journals have increasingly gained status and credibility by being 'ghost-written' by senior doctors who do not participate in the drug companies' research - that is to say, the studies are only glanced at and then 'signed-off'. This practice is especially prevalent in psychiatry where medication is the main form of treatment. In reality, long-term testing on target populations has always gone on 'in the field', i.e., on patients, *after* the drugs have been marketed and prescribed. Around one-in-five drugs reveals serious side-effects which are

26 Valproate (2017) livertox.nih.gov/; Tegretol (carbamazepine) (2017) www.recoveryconnection.com/; France's Sanofi faces class action suit over epilepsy drug (2016) *Medical Press* 13 Dec. Minelle, B (2017) Epilepsy drug valproate behind thousands of severe birth defects, says French study *Sky News* 20 April. Harrison, S (2017) Epilepsy drug raises risk of birth defects, but women were not told, survey finds. *The Telegraph* 24 Sept. Triggles, N (2017) We've had no help - epilepsy drug victims *The Guardian* 26 Sept. Boseley, S (2017) Birth defect risks of sodium valproate 'known 40 years ago' *The Guardian* 26 Sept.

discovered after testing, when the drug had already entered general use. This suggests that pre-licensing periods are too short and marketing is too aggressive.²⁷

As a matter of fact, and entirely contrary to the standards of good practice and good science, the whole gamut of modern psychiatric drugs is employed in the absence of proper testing for efficacy and dangers. The best that can be said is that the same applies to many drugs and other techniques used in general medicine. This affront to science, ethics and effective healthcare has recently been challenged by the movement for evidence-based practice (EBP) which might now be starting to persuade medical professionals - and their paymasters - that they should properly assess interventions in order to improve the value of treatments, both to the patients and to the taxpayers. Those pushing for EBP want all clinicians to use proven interventions rather than rely on information which might simply be gleaned from drug company publicity, anecdotal, traditional, out-of-date or randomly culled from research papers of dubious scientific quality. We must hope that the National Institute for Clinical Excellence (NICE), established in 1999, will increasingly address itself to these issues.

In the field of mental health, the lack of adequate testing may be illustrated by the case of the anti-psychotic Benperidol. This was introduced in 1966 and is regularly used for managing schizophrenia. Now that past as well as current research reports are included in the computerised indices of the major medical libraries, it is possible to carry out efficient meta-studies. One global search found thirty-five studies of Benperidol. However, only ten were at all concerned with its use for schizophrenia, and nine of those studies had to be excluded - four because they were not properly randomised, three because they did not in fact include people diagnosed with schizophrenia, and two because although they compared different doses of the drug they did not include a placebo group or one receiving a comparative anti-psychotic. In the end, only one out of the 35 studies that purported to offer useful information concerning the management of schizophrenia was stringent enough in its methodology to be counted as properly scientific. At the time there were no studies of the drug awaiting assessment and no ongoing studies. The only piece of research of any value was one poorly reported and unpublished manuscript concerning a small (n = 40), thirty day, randomised controlled and double-blind study; due to the tiny sample, this research was judged insufficient to compare the efficacy of Benperidol with any other drug, with placebo or with no treatment at all.²⁸

The movement for evidence-based practice only began in the 1990s, but this particular meta-study of one anti-psychotic is probably unexceptional. EPB meta-studies also have to take into account the worrying trend we already mentioned: research has largely passed out of the largely state-funded universities and into the commercial sector. It has recently emerged that this is likely to increase the risk that the studies under scrutiny are fundamentally flawed or have been falsified. It has become apparent (and a professional talking-point) that where drugs play a big part in treatment, such as in the fields of cardiology and psychiatry, for cash and other incentives many busy senior doctors and academics are willing to put their names to papers written for them by ghost-writers employed by the drugs companies. One estimate is that by 2002 the authorship of 50% of the articles in the major medical journals was not genuine. Besides this, many doctors who lend their names to drugs studies do not even peruse the raw research data - they see only that data presented to them, which they then summarise (and promote at conferences, etc.).²⁹ What control is there on bias and outright deception if research methods and data are not submitted to the scrutiny of a non-commercial agency?

Because pharmaceuticals was until recently by far the most profitable industry on the planet, EBP runs up against one of the world's most powerful lobbies. At least one-third of the industry's profits

27 See Hubbard, B, op. cit. (n. 102, Ch 1), 17-20, 37 and 39-42.

28 Leucht, S & Hartung, B (2002) Benperidol for schizophrenia: Cochrane Review. *The Cochrane Library* 1. Oxford: Wiley. A double-blind test is necessary in any drug trial in order to pre-empt the possibility of deception, observer bias, placebo or nocebo effects. (Nocebo is apparent harm from an intervention known to be inert.) To be able to properly calculate the efficacy of any drug, until the results have all been collected and processed, nobody involved in a trial - subjects, researchers or commissioning agent (such as a drug company) - must know whether any particular subject received a placebo or the drug itself (or the dosage).

29 Medical research called into question (2002) *The Guardian Weekly* 14-20 Feb, 25.

come from mental health products. In 2001, Britain's largest drug company - GlaxoSmithKline - made £6.2billion pre-tax profits, a phenomenal 31% return on investments. Returns like this are only maintained by the constant introduction of new lines. In the USA in the year 2000, 33% of all drug prescriptions were for new products; in the UK it was nearly 16%. Yet a new drug rarely performs better than the one it is meant to replace, and by the time the new one is developed there are usually only a few years of patent to run. Consequently, the companies spend twice as much on marketing as on research. Neither is the industry really very innovative. Few new drugs actually contain new active ingredients; rather than serving therapeutic needs, companies tend to slightly alter a chemical mix so that the product can be publicised as 'new and improved'. Meanwhile, on average each new drug goes to market at nearly three-times the price of those it aims to replace.³⁰ Naturally, the drug companies exaggerate the prevalence and seriousness of diseases, and another part of their strategy is to subscribe heavily to influential medical organisations and journals. With incentives in cash and kind - running from free lunches to conferences in holiday locations, highly-paid consultancies and cursory, ghost-written research 'authorships' - in effect they bribe doctors to recommend and prescribe their products. Compounding these disturbing developments, approximately one-third of all British MPs declare paid employment by a pharmaceuticals company.³¹

Against this powerful alliance of drug companies, doctors and bought politicians, the movement for evidence-based practice hopes to unmask the ad hoc and rule-of-thumb (guesswork), mix-and-match, and individual-experimental nature of the use of psychiatric medications. In the current political, economic and ideological context, however, we may only wonder how likely it is that the movement for EPB will succeed in changing doctors' blind faith in those unproven treatments which they now prescribe, or be able to turn mental health officials' minds more seriously to approaches other than medication and shock treatment.

Recent evidence from pharmacogenetics

So far, at least in the UK, it would seem that the movement for evidence-based practice has had little influence in the field of mental health. Few doctors seem to hesitate before prescribing a psychotropic. Nor are they required to know anything about an individual patient's capacity to metabolise any drug, or whether, on the contrary, the patient is simply unable to 'take it up' in the required manner and it will actually poison him - and thereby, of course, almost certainly worsen his psychological condition as well as his physical health. In other words, most doctors seem to know little or nothing about pharmacogenetics. They simply continue to experiment on each patient with the traditional 'trial-and-error' method of selecting a likely psychotropic. Knowledgeable 'service users' or 'survivors' - the guinea pigs who suffer from this dicing with their health - deprecate the doctors' usual pharmaceutical guesswork: they call it 'pick-and-mix'.

And yet pharmacogenetics is a very significant medical development. Concerned with individual differences in the capacity to metabolise, retain or excrete specific medications, it has made considerable progress during the last thirty years. Pharmacogenetics may be defined as 'the study or clinical testing of genetic variation that gives rise to differing response to drugs.'³²

Any medication can only ever be therapeutic if it is metabolised efficiently, that is, if it can achieve what the active ingredient is supposed to do, and with minimal 'side-effects' (ill-effects). Equally, if a medication is not metabolised efficiently it does not achieve the desired therapeutic response. In addition, it may well be harmful and the patient experiences serious 'side-effects'; this happens when interactions between the drug and the organism lead to high levels of toxicity in the bloodstream, and they accumulate before clearing from the body.

30 Hubbard, B, op. cit. (n. 102, Ch 1), 11-15, quoting from the medical profession's own research.

31 Hubbard, B, op. cit. (n. 102, Ch 1), 21-25 and 31. Hubbard quotes an estimate by Dr Vernon Coleman that by prescribing their new drugs rather than the cheaper old ones, GPs are able to earn an extra £50,000 per annum from pharmaceutical companies; concerning lucrative payments for what he says are unnecessary vaccinations, see Coleman, V (2013) Doctors have been bought. www.vernoncoleman.com/

32 Pharmacogenetics (2010) www.Wikipedia.

This is recognised in general medicine, which now benefits from many technical developments consequent to research in the field. For example, a variety of pharmacogenetic tests are nowadays routinely carried out prior to treatment with the medications prescribed for arthritis, HIV, breast cancer, Crohn's disease and heart disease. They are precisely to assess the degree of efficacy of the proposed drug for each genetically unique patient, and to reduce the chances of seriously adverse reactions. In those areas of general medicine the tests only take a minute or so and can be done at an out-patient clinic for as little as £10. 'Driving this trend [to employ pharmacogenetic tests] are the 106,000 deaths and 2.2 million serious events caused by adverse drug reactions (ADRs) in the USA each year. As such, ADRs are responsible for 5-7% of all hospital admissions in the USA and Europe, lead to the withdrawal of 4% of all new medicines, and cost society an amount *equal* to the costs of drug treatment.'³³

Psychopharmacogenetics, of course, is the study of the pharmacogenetics of the psychotropic medications. Compared with general medicine, this area of research is neglected. Nevertheless, there have been some studies, and tests are also available - but not through the NHS, which refuses to use them; tests can only be obtained privately, and they are expensive. Doctors who regularly prescribe psychiatric drugs seem unaware of the existence of pharmacogenetics, and of the possibility of psychopharmacogenetic testing. More worrying, and despite the regular use of the tests in the USA and in Sweden, policy-makers in the UK plan definitely *not* to introduce psychopharmacogenetic testing. Apparently, a major reason is the cost; however, unit-costs would fall rapidly if the tests were to become standard practice; besides there are often substantial financial costs when patients are harmed by medications. And what about the human costs?

There are a number of different systems in the body for metabolising medication but most psychotropics are metabolised by the CYP450 Cytochrome system, and this is the most researched. Those enzyme pathways are found primarily in the liver. They include CYP2D6, CYP219, CYP2C9, CYP1A2 and CYP3A4 pathways. Three-quarters of all the psychotropic drugs are metabolised through the CYP2D6 pathway; 16% of all prescription drugs (including psychotropic medications) are metabolised through the CYP2C9 pathway, and 15% through the CYP2C19 pathway.

The main problem is that normal genetic variations in metabolising pathways determine whether a patient processes his medication quickly or slowly. Four groups of metabolisers may be identified: poor, intermediate, extensive and ultra-extensive. If someone is a poor metaboliser (PM) for a particular pathway, his genetic make-up determines that *no* useful metabolising activity will occur. This means that medications requiring that specific pathway simply *cannot* be therapeutic for that particular patient. In addition, it is *inevitable* that the patient will suffer from adverse 'side-effect' reactions. Therefore, if a person is PM for the CYP2D6 pathway (for example), medications should *not* be prescribed if they require that pathway for metabolisation; anyone given such a medication when he is constitutionally unable to metabolise it will experience a reaction like an overdose. In fact, 10% of Caucasians but 40-50% of Asians, Pacific Islanders, Africans and African-Americans are PM for the CYP2D6. PM for the CYP2C19 includes 10-20% of Africans, 15-20% of Japanese and 3-6% Caucasians. 1-3% of the general population is PM for the CYP2C9.

The intermediate metaboliser group (IM) have a pathway which is only 50% efficient. This indicates a lower-than-average dose for an optimal therapeutic response. It is recommended that patients should start with the lowest possible dose, and prescribing any other medications should be avoided since that inhibits or reduces the workings of the pathway. People in this group are also prone to toxic 'side-effects'. 35% of Caucasians are IM.

On the other hand, those in the group of extensive metabolisers (EM) require the optimal dose recommended (e.g., by the *BNF*), since their EM enzyme metabolising activity functions at 100%. Accounting for 7% of the population, there is also a group of 'excessive metabolisers' who eliminate medication from the body too rapidly; for any therapeutic effect, a higher level of medication is required for anyone who is an Ultra-extensive metaboliser (UM).

³³ Pharmacogenetics, op. cit. (n. 32).

When the NHS refuses to employ pharmacogenetic tests before prescribing psychiatric drugs, this not only militates against the drugs working as they are supposed to - perhaps *most* of the time - it also lays open every mental health patient to the risk of poisoning, with perhaps irreversible consequences. In addition, psychopharmacogenetics indicates a significantly higher risk of poisoning for non-Caucasians. It might therefore seem that, as well as financial short-sightedness and the unconscionable callousness of current and projected NHS policy on this issue, the indifference of the psychiatric policy-makers to the plight of the patients is compounded by racism.

Catherine Clarke notes that pharmacogenetics is now a well-established area of knowledge which has been utilised by the pharmaceutical companies for many years - but usually only for their own cynical purposes rather than in the interests of patient welfare. Generally, drug trials proceed in four phases. The first phase includes a group which is representative of the population as a whole. However, research subjects found to be PM are then excluded from the second to the fourth phases. This eliminates all the subjects who would have reported severe 'side-effects'; at the same time, the later phases of the research are conducted on subjects who are *specifically selected* for their *efficiency* in metabolising the drug in question. This enables the drug companies to show the best possible outcome for their new products; it also has the potential *for excluding* from research reports the most severe adverse reactions or 'side-effects', which would have been experienced by those who happen to be PM. In other words, drugs testing is knowingly biased by using pharmacogenetics so as to play-up the beneficial workings of the company's latest drugs and hide adverse reactions.³⁴

Patients' experiences of psychiatric drugs

Surveys regularly document the fact that only about half of all patients report any noticeable benefit from their psychiatric drugs, and about one-quarter report alarming ill-effects.³⁵ Different types of patients are of course given different kinds of medication. A recent survey of those prescribed the most potent - people diagnosed with schizophrenia or bipolar disorder - found that more than three-quarters admitted to 'sometimes not following treatment recommendations': 54% reported that they do so intentionally, and of these, 63% took less medication than prescribed, specifying bad side-effects as the main reason; also, 29% of the respondents were happy with not following their recommended treatment regimes.³⁶

In the previous section we examined the issue of pharmacogenetics, and saw why such a high proportion of psychiatric patients are badly affected by the drugs that are supposed to help make them better. In Chapter 4, we saw that one particular patient was very unhappy about the effects of the anti-psychotic medication forced on him despite his protests. His psychiatric nurse seemed to recognise that he suffered from the ill-effects of the medication but, like the psychiatrist, he took no action. This was an African patient, and therefore likely to be a poor metaboliser (PM) for the usual psychotropic drugs. In other words, *it was most likely* that the drug was poisoning him.

In Chapter 2, however, we saw that Kay Jamison is an enthusiastic advocate for lithium. She believes it saved her life by holding in check her severe manias and depressions. All the same, it is reasonable to ask whether her faith in lithium is justified by sufficient evidence of tangible benefits, or whether she simply has a blind belief in the magic of medical science.

Lithium is a potentially lethal heavy metal. The formularies advise very careful use, monitored against concentrations of blood plasma. It is not to be used together with high doses of an anti-psychotic, it is volatile against a depleted level of sodium, and is not to be employed for more than

34 Clarke, C (2010) Psychotropic medications: Remedies or poisons? The evidence from pharmacogenetics. *Asylum* 17 2 23-27; a number of research studies are cited; see also Clarke, C (2010) Side-effects and psychopharmacogenetics: Policy-makers keep dodging the issue. *Asylum* 17 3 12-16. The discussion in this section is mainly based on the information and argument in those two articles.

35 See text to footnote 2, above.

36 Gibson et al (2013) Understanding treatment non-adherence in schizophrenia and bipolar disorder: a survey of what service users do and why. *BMC Psychiatry* 13 153.

three to five years, due to possible kidney damage. Many side-effects are listed. Jamison is perfectly forthright about those she experienced:

The side-effects I had for the first ten years were very difficult to handle. In a small minority of patients, including myself, the therapeutic level of lithium, the level at which it works, is perilously close to the toxic level.

There was never any question that lithium worked for me...but the drug strongly affected my mental life... [It] also caused severe nausea and vomiting many times a month...when, because of changes in salt levels, diet, exercise, or hormones, my lithium level would get too high. I have been violently ill more places than I choose to remember.

When I got particularly toxic I would start trembling, become ataxic [uncoordinated] and walk into walls, and my speech would become slurred; this resulted...in several trips to the emergency room, where I would get intravenous drips to deal with the toxicity...³⁷

Lithium caused her to fall off her horse. She was also once stopped by the police due to loss of co-ordination when driving. Another time, when exercise and altitude raised her lithium levels, she became disoriented and got lost in the snow, high up a mountain.³⁸ But as important to her was the drug's

...effect on my ability to read, to comprehend, and remember what I read. In rare instances lithium causes problems of visual accommodation, which can lead to...blurred vision.

Reading...was beyond my grasp. I was used to reading three or four books a week... I did not read a serious work of literature or non-fiction, cover to cover, for more than ten years. The frustration and pain of this were immeasurable... I could read journal articles better...but it was with great difficulty, and I had to read the same lines repeatedly and take copious notes before I could comprehend the meaning. Even so, what I read often disappeared from my mind...

After eight or ten years of lithium therapy

...still I was unquestionably raw and unhealed inside...³⁹

Kay Jamison was unfortunate because:

In 1974 the standard medical practice was to maintain patients at considerably higher blood levels of lithium than is now the case. I have been taking a lower dose of lithium for many years, and virtually all of the problems I experienced earlier in the course of my treatment have disappeared..⁴⁰

She writes that:

All of this changed very much for the better when I switched to a time-released preparation of lithium...⁴¹

This is presumably after at least ten years of extra-strength lithium.

She feels things would have been worse without the lithium. She

...took [lithium] faithfully and found that life was a much stabler and more predictable place than I had ever reckoned. My moods were still intense and my temperament rather quick to the boil, but I could make plans with far more certainty and the periods of absolute blackness were fewer and less extreme. Medications not only cut into [my] fast-flowing, high-flying times, they also brought with them seemingly intolerable side-effects. [But] it took me far too long [i.e., when she was not taking the medication] to realise that lost years and relationships cannot be recovered, that damage done to one's self and others

37 Jamison, KR, op. cit. (n. 6, Ch 2), 93. Note also the length of time she used lithium: obviously much longer than ten years, despite the *BNF* cautioning five years at the most.

38 Jamison, KR, op. cit. (n. 6, Ch 2), 94.

39 Jamison, KR, op. cit. (n. 6, Ch 2), 94-95 and 153.

40 Jamison, KR, op. cit. (n. 6, Ch 2), 92-93.

41 Jamison, KR, op. cit. (n. 6, Ch 2), 93.

cannot always be put right again, and that freedom from the control imposed by medication loses its meaning when the only alternatives are death and insanity.⁴²

Then, finally, in love and feeling secure, she was persuaded to reduce the amount of lithium she was taking.

The effect was dramatic. It was as though I had taken bandages off my eyes after many years of partial blindness... I realised my steps were literally bouncier...and I was taking in sights and sounds that previously had been filtered through thick layers of gauze... [T]he bumps on the sidewalk were far more noticeable; I felt more energetic and alive. Most significant, I could once again read without effort. It was...remarkable... I was feeling more beauty, but more real sadness as well... [There had been a] dreadful muffling of the senses.⁴³

She writes that her

...moods [then] held at a more even keel for longer than I could remember [and] lowering my lithium level had allowed not only a clarity of thinking, but also a vividness and intensity of experience back into my life..., [although] my moods still shifted often and precipitously enough to afford me occasional intoxicating, mind-on-the-edge experiences... [However] ...it was clear that a low-grade, fitful instability had become an integral part of my life.⁴⁴

All this reads like the exchange of one hell for another. Her experience of manias and depressions must have been awful indeed. In her view, though, Jamison was lucky. She was 'one of the gang', a psychologist working in psychiatry, surrounded by supportive doctors who were always ready to help her and to monitor her lithium and sodium levels.

Still, from another perspective she may have been unlucky. In the early days she did try to go without lithium, and in despair always went back to it. Perhaps this corresponds to the fact that nowhere in her book is there an indication that she ever met anyone who could suggest to her any useful psychological enquiry into the roots of her malaise. With her colleagues, she shared a belief in the medical model: they all supposed there is a genetic cause to the malaise. This idea is not supported by any evidence - no genetic difference has ever been shown for any diagnosed manic-depression (bi-polar disorder).⁴⁵ Never mind - Jamison was surrounded by confident, 'no-nonsense' sceptics of psychological analysis who were so enthusiastic about medication that for ten years she was lucky not to have suffered seriously from an overdose. In the end, her manias and depressions turned out to be no worse on the lower dose of lithium than they had been on the higher.

Jamison's account is purely anecdotal. She offers no reasoned arguments or proofs for lithium, or against alternative treatments. She says nothing at all to persuade us that her condition would necessarily have been worse without lithium treatment. Contrary to her assertion that there was never any question that lithium worked for her, however, she provides much evidence to support the proposition that its work on her was deleterious and nearly fatal.

None of what we quote here is in any way inconsistent with a view opposite to that of her rescue by lithium. Perhaps somewhat abated due to the run down of her whole organism by chronic, near-lethal poisoning, Jamison's manias still continued throughout her treatment with lithium. And if her manias and depressions were indeed held in check, this might have been the result of a weekly replenishment of placebo, i.e., the reliable and reassuring attentions of a sympathetic, charismatic and persuasive psychiatrist.⁴⁶ In Chapter 8 we explore the remarkable healing power of faith or placebo - and of love. Jamison does in fact recommend the power of love, which at one period in her life

42 Jamison, KR, op. cit. (n. 6, Ch 2), 153 and 6.

43 Jamison, KR, op. cit. (n. 6, Ch 2), 161-162.

44 Jamison, KR, op. cit. (n. 6, Ch 2), 163, 167 and 169.

45 Has it ever been tested? Could it be tested? We explore these questions in Chapter 12, below.

46 When we discuss the healing power of faith or placebo, in Chapter 8, we return to the case of Kay Jamison so as to illustrate this dynamic. See the section: A case of placebo and psychiatric faith healing?

relieved her manias and depressions. In spite of this, she could never bring herself to depend on it completely.

Leaving that example of an experience of a well-established anti-manic or mood stabiliser, we turn to another person's exposure to the ill-effects of medication - this time a popular anti-depressant. In the next section we discuss the growing controversy around the SSRIs. One-quarter of all patients prescribed one of these drugs report serious ill-effects.⁴⁷ Here we illustrate the problems they can cause by reference to the experience of a mother in her forties who was prescribed Seroxat to help her through a period of depression. She took the drug for six months but then decided to stop. There were two main reasons for this decision: whereas she had never done so before, she rapidly put on weight, and the drug simply made her feel 'generally grotty'. The only advice from her doctor was that she must not just stop taking the drug. So she took half the dose for four days, and then stopped. Then, she says,

Very quickly after that I was so ill I actually thought I was dying. I found it difficult to stand upright, and I was badly disorientated. I also had physical symptoms like stomach upsets and chest pains, but it was the disorientation and confusion that was worse. I also had these feelings like I was having electric shocks inside my head every time I moved my head or eyes - this was happening every couple of seconds.

I found it really hard to concentrate and my short-term memory was just atrocious, to the extent that it was quite dangerous - I would start cooking something and then walk out of the room and forget all about it. I would get completely lost in places I went to every day. It was like my brain had gone to mush.

I would spend all day pacing around the house, completely agitated and confused, and when the kids came home I would just sit them in front of the television and feed them pizza. And at night I would have these hyper-real dreams which felt more real than the times I was actually awake.

And I had this strange thing where, when I was lying in bed, my feet would get so hot I would actually have to check they weren't on fire. It was very odd.

After four days of this, the patient went back to her doctor who put her back on Seroxat and advised reducing the dose more gradually. But even when her intake had been reduced to just one milligram, the withdrawal symptoms returned until she got used to the new dosage and could cut back again. It took her 'ten horrific weeks' to get off the drug.⁴⁸

Newer and better drugs?

Research scientists and the agencies which authorise drugs for general use are aware of the dangers of the various psychiatric drugs, of course. By means of their drug reference books, every doctor also ought to know the dangers.

This is probably why the anti-psychotic Thioridazine was popular with doctors since the 1960s, especially for casual and routine use with the elderly: it seemed less likely to produce extrapyramidal symptoms. It was also used routinely as the first alternative to any anti-psychotic that caused any patient troubling side-effects. However, it was increasingly recognised that there was a high incidence of anti-muscarinic effects, and possibly an increased risk of cardio-toxicity;⁴⁹ studies also showed harmful interactions with one of the new SSRI anti-depressants, fluvoxamine. Finally, research showed that of all the anti-psychotics, Thioridazine had an especially significant cardiac risk.⁵⁰ To the consternation of many doctors, the UK's Medicines Control Agency ruled that Thioridazine would only be allowed strictly licensed use after March 2001, and that it had to be replaced by one of the newer atypical antipsychotics.

47 See the discussion of the dangers of Seroxat in the text to footnotes 67-73, later in this chapter.

48 Quinn, J (2004) When the drugs don't work. *Bristol Evening Post* 10 Dec.

49 See Joint Formulary Committee (2000) *British National Formulary* 39. London: BMJ Group and Pharmaceutical Press, 173 and 177.

50 Bracken, P et al (2000) Treatment of schizophrenia. *British Medical Journal* 320 1158-9.

At that time the *BNF* stated that these newer drugs ‘may be better tolerated’ than the old antipsychotics, and that extrapyramidal symptoms and prolactin elevations ‘may be less frequent’ than with the older drugs.⁵¹ Unfortunately, fund-holding doctors and psychiatrists were until recently caught in a financial bind since the new generation drugs were within patent and far more expensive than the old ones. Several years after their introduction, and even though the profession considered them superior to the older drugs, 25% of all community psychiatrists had still never prescribed the new atypical anti-psychotic drugs, and only 10% had prescribed them for more than ten patients. A new drug might cost *up to thirty-six times* as much as the old ones.⁵²

Perhaps there has not been enough time to discover whether the new drugs are in fact more beneficial and less harmful than the previous generation. In 2000, *BNF* stated that the atypical antipsychotics ‘*may be better tolerated than other anti-psychotics*’ and that ‘*extrapyramidal symptoms and prolactin elevation may be less frequent than with older anti-psychotics*’ (our italics). At the same time, it indicated as many or more dangers for some of them than for the older anti-psychotics.⁵³ By 2006, however, a major study had revealed that the atypicals are in fact no more effective than the previous generation of antipsychotics - and on average they cost 30% more. Neither do they now seem safer. For example, Eli Lilly had to make a \$690m payout to 8,000 plaintiffs in the USA who claimed that Zyprexa caused diabetes; and there were rumours that officials in government agencies were bribed to suppress test results.⁵⁴

The history of the development, testing and marketing of other anti-psychotic drugs is often as worrying. Clozapine (Clozaril), for example, is recommended for schizophrenia where the patient does not respond to, or is intolerant of, conventional anti-psychotic drugs. The history of the introduction, withdrawal, and re-introduction of Clozaril is revealing. Apparently it does not suppress dopamine neurotransmission in the motor-regulating areas of the brain, and therefore it carries less risk of tardive dyskinesia; instead, its powerful lobotomising effect works on the frontal lobes. Yet this does not mean that it does not produce tardive dementia, tardive psychosis and other central nervous system disorders. In fact, nobody really understands all of its effects since it was certified by the Federal Drugs Administration (FDA) after testing on only a few hundred people for only six weeks. In the UK and Europe, it was first used in the mid-1970s. However, its use was later discontinued since, as well all the other usual side-effects of an anti-psychotic, it produces potentially fatal white blood counts and was found to harm the immune system of many patients. Evidence also emerged about reactive psychoses after withdrawal from the drug: taking the patient off the drug was very difficult, and yet the longer the patient stayed on it, the greater the risk of the deterioration of his higher mental functions.⁵⁵ Besides this, it is well-known that patients administered Clozaril for any length of time always become sluggish and obese.

For all that, by the 1990s psychiatrists had become so worried about the epidemic of tardive dyskinesia caused by the other anti-psychotics that Clozapine was re-introduced as ‘the drug of choice of the safer, new generation of atypical anti-psychotics’. Its administration is so immediately difficult and risky that it is expensively packaged with a full kit for ongoing individual monitoring and antidote. This is convenient to the drug company which makes it: two drugs and a full monitoring kit equals more profits.

When a patient is recommended Clozaril he is therefore presented with the choice of remaining psychotic or risking the breakdown of his immune system. A whole separate service was established in order to monitor the effects of the drug on each patient’s immune system - the Clozaril Patient

51 *BNF* 39, op. cit. (n. 49), 178.

52 Bird, L, op. cit. (n. 21, Ch 1), 32.

53 *BNF* 39, op. cit. (n. 49), 178.

54 A typical story, op. cit. (n. 45, Ch 5), which cites Rosenheck, RA et al (2006) Cost-effectiveness of second generation antipsychotics and Perhenazine in a randomised trial of treatment for chronic schizophrenia. *American Journal of Psychiatry* 163 2080-2089; also see Lamb, T (2005) Lilly plans to settle most Zyprexa legal cases for \$690 million. *Drug Injury Watch* 15 June.

55 See Breggin, PR, op. cit. (n. 107, Ch 1), 85-86 and 362.

Monitoring Service (CPMS). To begin with, the patient has to be admitted to a hospital or unit, and a complicated system of gradually increased dosage must be drawn up. Initially, there is a weekly blood test which is sent to the CPMS. Further doses are then authorised by a 'green' or 'amber light' ('go' or 'proceed with caution') or stopped by a 'red light'. These signals refer to the danger-level of the white blood cells. Dosage is gradually increased, and if all goes well the tests become less frequent. Even so, testing remains necessary until the patient stops taking the drug (i.e., often for the foreseeable future). If a patient complains about the blood test, he is offered a local anaesthetic cream (Emla) so as to reduce the pain of the needle. All this exact calculation, blood testing and nursing amounts to an impressive ritualistic endorsement of the medical model of mental illness.⁵⁶

Clozaril has to be taken by mouth, and of course patients are notoriously non-compliant. This began a race to develop an injectible atypical anti-psychotic. The winner was Risperdal Consta - another spectacular medical commodity. Because this drug is not soluble, it requires a special kit to be 'reconstituted'. Like Clozaril, it is expensive and requires a certain amount of nursing time.

Neither the therapeutic effects nor the ill-effects of any psychotropic drugs seem to have been subjected to systematic audit, and there is precious little unbiased research. Many patients and carers were worried for years, and finally some psychiatric officials became anxious about the long-term organic harm that seems to be associated with 'the atypicals'. For instance, there is considerable anecdotal evidence that an unusual number of patients who have had more than a short course of Clozaril show signs of a degenerating endocrine system: they become obese or develop diabetes or a thyroid condition. A review of 150 research papers also demonstrated conclusively that the second generation of atypical antipsychotics are no more beneficial than the types they were supposedly designed to replace; only clozapine was consistently superior.⁵⁷ It has been reported that '[a]s a group they are no more efficacious, do not improve specific symptoms, have no clearly different side-effect profiles than the first generation antipsychotics, and are less cost-effective.'⁵⁸ On top of which, they are all known to carry a high risk of serious adverse side-effects. Only four of the ten reviewed drugs were better than the old type, and then only marginally. The newer drugs caused fewer extra-pyramidal effects (uncontrolled Parkinsonian-type movement), but they all caused more weight-gain than the earlier type. A metastudy also found that research and the publication of results (or not, as the case may be) was almost always deliberately biased. An editorial in *The Lancet* concluded that the atypical antipsychotics are 'by and large a spurious invention' that has been cleverly manipulated by the drug industry for marketing purposes.⁵⁹

A sceptic might discern the powerful influence of the drugs lobby in the formulation of official drug guidelines and directives. The dangers of Thioridazine were known for a long time. What was new, though, if the old anti-psychotics could be discredited, was a wonderful marketing opportunity for the new generation of drugs, and therefore higher profits. Not long ago it was also suggested that the use of Droperidol (another popular phenothiazine anti-psychotic) should be discontinued for old people. After forty years of prescription, some older patients were suddenly taken off the drug, ostensibly because of long-term evidence of EEG anomalies and a few sudden deaths. In fact, the side-effects had always been known. One interpretation of these changes is that recent policy directives concerning the old anti-psychotics have much less to do with genuine newly-discovered dangers than with lobbying, promotion and other pressures from the drug companies trying to sell the much more profitable 'latest generation' drugs.

In the face of all the well-funded commercial propaganda, lobbying and influence, it is difficult to persuade people that what is presented as scientific or technical advance is not necessarily progress; to persuade them, for example, that the latest drugs or 'models' of drugs are not *automatically* more

56 Recently, as a cheaper version of the same chemical, Denzapine began to replace Clozaril.

57 Leucht, S et al. (2009) Second-generation versus first-generation antipsychotic drugs for schizophrenia: a meta-analysis. *The Lancet* 373 31-41.

58 Tyrer, P & Kendall, T (2009) The spurious advance of antipsychotic drug therapy. *The Lancet* 373 4. For such an august journal, this questioning of the utility of an entire class of psychiatric drugs was remarkable.

59 Tyrer, P & Kendall, T, op. cit. (n. 58).

effective and less dangerous than the old. To compound this state of affairs, there is little ongoing research which is not funded by the drug companies. Because they are said to be safer, the SSRIs have largely replaced the tricyclic anti-depressants, especially for treatment of the elderly. Yet there is no evidence that they are *actually* safer.⁶⁰ The drug companies are always eager to promote their latest products, of course, and aggressive marketing works by playing on everyone's hopes and fears.

Amongst the anti-depressants, the 'wonder drug' of the 1990s was the SSRI Prozac (fluoxetine). It has effects which some patients find helpful, but according to the consensus of medical opinion it is no better and perhaps worse than the previous generation of drugs. This feeling was confirmed by meta-analyses of research which make it clear that for patients with mild depression there is '...no difference in efficacy between TCAs (tricyclics) and SSRIs'; for depression in general 'there are no clinically significant differences in effectiveness between SSRIs and TCAs'; and for the elderly 'SSRIs and TCAs have the same efficacy'.⁶¹

Prozac acts like any other stimulant (such as amphetamine or cocaine), and it causes as many unwanted side-effects as often as any other drug. An early Prozac study, for example, showed 43% of subjects reporting two or more side-effects; these included 29% headaches, 24% nausea and 19% somnolence.⁶² It is also known to trigger anxiety and agitation, insomnia and bizarre dreams; it can lead to loss of appetite, diarrhoea, dry mouth, sweating, dizziness, impotence, inability to achieve orgasm, seizures and rash; it can cause hypoglycaemia, anxiety, chills, cold sweats, confusion, weakness and low levels of blood sugar; occasionally it produces a severe rash, fever, joint pain and swollen lymph nodes; a 'Prozac syndrome' may develop: hot flashes and flushing, agitation, nausea, muscle tremors and sweating; overdoses have led to convulsions and death; it is dangerous to combine Prozac with the MAOI antidepressants and other drugs; it can cause a psychosis; it can be addictive and there are withdrawal reactions which compel users to continue using it; it sometimes seems to encourage compulsively aggressive and suicidal behaviour. By the millennium, some professionals were worried that it was becoming clear that the drug companies often hid or failed to publish evidence for just as common and just as significant ill-effects from the SSRIs as from the type of drugs that they replaced.⁶³

The general medical belief is that serious or chronic depression is due to a chemical imbalance in the brain - specifically to a low level of the neurotransmitter, serotonin. There is no evidence for this. On the contrary, despite forty years of research, no difference has been found in the serotonin levels of depressed patients and healthy controls, and neither have depressed patients improved when given huge amounts of serotonin.⁶⁴ Apparently, an SSRI lobotomises the individual in the same manner as a tricyclic anti-depressant. Furthermore, the patient requires an ever-increased dosage in order to maintain the effect: a recent meta-analysis of the research also found that although the SSRIs are usually prescribed for many weeks or months (or longer), if a patient experiences any benefit this will tail-off very rapidly after the first two weeks.⁶⁵ An SSRI produces temporary neural disorders in the same way as any neuroleptic, and there is evidence that, amongst the other dangers, prolonged use can lead to similar akathisia - severe anxiety, restlessness, sleeplessness and jerking, and continual

60 See Elderly at greater risk with the new antidepressants. (1999) *What Doctors Don't Tell You* 10 5 9.

61 *Cochrane Database Syst Review* 4 (2000) CD001130, *Cochrane Database Syst Review* 2 (2000) CD001851, and *Cochrane Database Syst Review* 4 (2006) CD003491; all reported in Edwards, A (2006) The great Prozac conspiracy. *What Doctors Don't Tell You* 17 6.

62 Perry, PJ et al (1989) A comparative trial of fluoxetine vs. trazadone in outpatients with major depression. *Journal of Clinical Psychiatry* 50 8 290-294.

63 As well as increased risks of suicidal tendencies, many subjects experience insomnia, sexual dysfunction and akathisia ('overwhelming distress' and 'unbearable discomfort') which may be mistaken for worsening depression, and thereby prompt GPs to increase the dosage. See Edwards, A, op. cit. (n. 61), which quotes several Cochrane meta-analyses; also see Blake, TJ, Tillery, CE & Reynolds, GP (1998) Antipsychotic drug affinities at α 2-adrenoceptor subtypes in post-mortem human brain. *Journal of Psychopharmacology* 192 214.

64 For references to the relevant research, see Hubbard, B (2008) The great Depression myth. *What Doctors Don't Tell You* 14 12 6-9.

65 See SSRIs: Bad prescribing habits. (2007) *What Doctors Don't Tell You* 18 3 16-17.

involuntary motor activity. Prozac quickly became the leading SSRI. It also became popular as an illegal stimulant. Once again, though, it soon turned out that it was not a new psychiatric wonder-drug. It was only a marvel of advertising and promotion hyperbole, which pushed it into exceptional media prominence during the 1990s.⁶⁶

Like Prozac, the anti-depressant Seroxat (paroxetine) is an SSRI. It is a best-seller for Britain's biggest pharmaceuticals company, Glaxo-Smith-Kline. The *BNF* gives the same cautions as for Prozac. In the USA, paroxetine is marketed as Paxil, and in 2001 GSK was sued and had to pay compensation when a man prescribed with the drug killed several members of his family and then committed suicide. Doctors were then warned to be careful when prescribing it. Also that year, a newspaper investigation revealed GSK's unpublicised pre-licensing trials of paroxetine, which only used healthy subjects: on average, in 34 different studies, one-quarter of those given the drug became 'disturbingly agitated'.⁶⁷ GSK had nevertheless promoted the drug as undoubtedly beneficial and safe. However, in the USA, in 2004, the company faced fraud charges for suppressing the information from its own clinical trials: four different early trials had shown that paroxetine was no better and perhaps worse than placebo, and too often it was harmful - it was addictive and regularly caused suicidal behaviour amongst children and teenagers. And in 2017 a widow successfully sued GSK for \$3million because her husband committed suicide while taking Paxil for depression and anxiety; she claimed the company had failed to warn her husband's doctor of the increased risk of suicidal behaviour when taking the drug.⁶⁸

GSK also received bad publicity in the UK, as did the Medicines and Healthcare Products Regulatory Agency (MHPR), which is supposed to protect patients by monitoring drug tests and regulating medicines. In 2003, a television documentary found that the suicide rate for patients prescribed Seroxat was more than double that reported by the company to the drugs regulator. The 'yellow card' system of reporting adverse drug effects is entirely voluntary and notoriously under-used by GPs,⁶⁹ and whereas the MHPR said it knew of only seven suicides during a two year period, there was an unprecedented viewer response to the program, and eleven more Seroxat-related suicides were reported for the two years. At the same time, a MIND survey of patients prescribed Seroxat found 97% reporting unwanted or uncomfortable reactions, and nearly 50% reporting powerful urges to self-harm or commit suicide. Respondents also reported that they were, on average, given only seven minutes of a GP's time before being prescribed the drug. So much for the care that doctors are advised to exercise.⁷⁰

After trials in 2003, the MHPR did ban Seroxat and all other SSRIs (except Prozac) for use with children - although it had never been cleared for children in the first place. In 2004 the chief executive of MIND resigned from a review of the modern anti-depressant drugs. He said that the MHPR had failed to pass on to doctors and patients concerns about the safe dosage for Seroxat, despite being fully aware of the dangers for ten years: it very often causes agitation, panic attacks and feelings of aggression, and is associated with self-harming and suicide, as well as causing serious withdrawal symptoms which tend to prevent anyone who is addicted from ever coming off the drug.⁷¹ It transpired that the MHPR was supposed to have scrutinised the clinical trials of Seroxat several times after its introduction, yet in fact its officers had signed-off nothing more than summaries offered by the drug company's own researchers; only after the scandal erupted did the

66 For example, like any big celebrity, it made the cover of *Time* magazine. The case of Prozac is discussed by Breggin, PR, op. cit. (n. 107, Ch 1), 162-169.

67 Boseley, S (2001) Suicide fear over anti-depressant. *The Guardian* 10 July.

68 Glaxo faces drug fraud lawsuit (2004) *The Guardian* 4 June; Wong, G (2017) \$3 million awarded to widow who sued pharmaceutical firm over husband's suicide. *Chicago Tribune* 21 April.

69 Note (2006) *What Doctors Don't Tell You* 17 7 5. This reports findings in the *Journal of the American Medical Association* 296 1086-1093 (2006) that, as against WHO estimates of actual incidence, across the USA, UK, Sweden, Italy, Canada and Portugal, doctors record less than 10% of adverse reactions for all types of drugs.

70 Seroxat: Emails from the Edge (2003) Panorama. *BBC1* 11 May.

71 Medical discussion (2004) Woman's Hour. *BBC Radio 4* 16 March.

MHPRA begin to inspect the raw data of any of the studies. Until 2003, when public and professional pressure forced it to begin to warn patients, the MHPRA always denied that there was any evidence that Seroxat was seriously addictive and could cause other problems. Now it admits that a full one-quarter of all patients report that Seroxat has alarming and painful physical, psychological, addictive and withdrawal effects. It also became clear that this evidence lay unpublicised in the regulator's archive for at least thirteen years - a revelation which suggests criminal collusion between the MHPRA and the manufacturer.⁷² We can be thankful that these issues were finally raised at the highest levels and brought to the public's notice. At the end of 2004, the UK's National Institute for Clinical Excellence (NICE) referred particularly to Prozac and Seroxat when it urged doctors to be much more careful when prescribing an SSRI.

None of the revelations about this medical, commercial and regulatory chicanery have stopped the world-wide explosion in the diagnosis of depression and the prescription of SSRIs. By 2008 they accounted for 80% of the world market for anti-depressants, and generated sales of more than £5 billion per annum. Prices have remained more or less steady for the last decade, but by 2011 the global antidepressant market was valued at \$11.9bn, in 2014 it was \$14.51bn, and it is expected to generate \$16.8bn by the end of 2020.⁷³

In perhaps the most significant of all the developments in this saga, early in 2008 a study was published which included all the available data for several major SSRIs, including findings from clinical trials which the manufacturers had chosen not to publish. Under the Freedom of Information Act, the authors accessed the full data from the American Food and Drug Administration (FDA), which licenses medicines in the US and requires all the data when making its decisions. Full information on some SSRIs was still withheld, but data on fluoxetine (Prozac), paroxetine (Seroxat), venlafaxine (Effexor) and nefazodone (Serzone) was included. This metastudy became front-page news since it appears that, on average, patients' conditions do improve when they are given an SSRI, *but patients given a placebo improve just as much*. Only the most severely depressed patients seemed to benefit slightly more from the active drug than from a placebo. In 2007 NICE went so far as to recommend that counselling should be tried before doctors prescribe antidepressants. The main author of the metastudy was a consultant for the NICE guideline, and in his opinion '...analysis would suggest that the prescription of antidepressant medications might be restricted even more'.⁷⁴

Summary: the well-known dangers of psychiatric drugs

Some things are clear. First, when drugs like these are prescribed, the skills of a trained medic are needed simply to monitor and hopefully ameliorate the harm they can cause. Secondly, we cannot be sure that, on balance, patients are helped by the policy of near-universal medication. Thirdly, if the sequence of events considered in Chapter 4 are representative - which we can believe since it was puffed as illustrating 'good practice' - a psychiatric patient's complaints about the ill-effects of his medication are likely to be ignored, as a matter of course. If it suits the agenda of the psychiatrist, all the contra-indications and cautions in all the drug formularies, and all the physiological signs or complaints by the patient will not prevent his doctor from prescribing any drug or combination of drugs, whatever the patient's condition and however much he may protest; and a psychiatric nurse will readily administer the treatment. This irresponsible attitude towards drugging puts every mental health patient at serious risk of contracting an iatrogenic illness - that is, a real illness caused by the medical attentions themselves; these include terrifying 'side-effects', addiction, various forms of organ harm, permanent maiming, and sometimes death.

72 Taken on Trust (2004) Panorama. *BBC1* 3 Oct.

73 See Hubbard, B, op. cit. (n. 64); also: Antidepressants Market to 2018: Despite safety concerns, Selective Serotonin Re-uptake Inhibitors (SSRIs) continue to dominate in the absence of effective therapeutic alternatives (2012) *PRNewswire* Oct; Global depression drug market poised to surge from US\$14.51 billion in 2014 to US\$ 16.80 billion by 2020 - MarketResearchStore.Com (2016) *Nasdaq* globenewswire.com/newsrelease/2016/05/10/ 74 Kirsch, I et al (2008) Initial Severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *Public Library of Science: Medicine* February.

Physical restraint is nowadays almost completely replaced by chemical restraint. 'Rapid tranquillisation' is regularly employed as the quickest and easiest way to subdue a troublesome patient, usually by means of a high dose of an anti-psychotic such as Haloperidol or the newer atypical, Risperidone. (In psychiatric units and prisons, those on the receiving end know this as 'the liquid cosh'.) The scandal of the harm caused by the routines of psychiatric tranquillisation is long-running, seldom investigated and less frequently reported; only very occasionally does it come to the attention of the courts. In the mid-1990s, MIND estimated that in the UK at least one psychiatric patient was killed by over-sedation every week. In the meantime nothing has been done to remedy the situation: patients still regularly die, there is rarely a prosecution, and no doctor or health worker has ever been found guilty of an offence in relation to such a death. These 'accidental deaths' generally occur when a patient resists staff as they try to restrain him, very often for medication; the ensuing struggle is only resolved by repeated injections of a powerful sedative.⁷⁵

In addition to this unpublicised scandal, between 1993 and 1999 autopsies in the UK found that 2,598 people died as an immediate result of a routine prescription of a tricyclic anti-depressant. Desipramine was the worst offender - only 45,000 prescriptions had been made before its use was discontinued because it was clearly the cause of death in nine cases.⁷⁶ These figures only relate to reported and investigated deaths. The number of cases where an anti-depressant or other psychiatric drug is actually a factor in harm or death is likely to be far higher.⁷⁷

Mental health patients often suffer from addiction or report uncontrollable or irreversible adverse side-effects. It is more than fifty years since the spectre of tardive dyskinesia reared its head. TD is the terrible neurological damage done to very many psychiatric patients; it became a world-wide aetiological plague, with no known remedy. 'Tardive' = late-developing or delayed, 'dyskinesia' = abnormal and unwanted movements of the body; the disorder can afflict any of the voluntary muscles, from head to toe. Further, it seems that any major tranquilliser (neuroleptic) can cause the condition. This is hardly surprising, since psychiatric authorities readily admit that these drugs act by 'imitating a neural disease'. Why speak of 'imitation', though? A disinterested view, one better borne out by the neurological facts, is that the major tranquillisers *cause* neural disease. This does not seem to trouble most doctors, who are prepared to risk sacrificing the patient in this manner so as to produce the desired psychiatric effect of 'relieving the symptoms' of psychosis.

75 *MIND Report on Deaths Caused By Neuroleptic Drugs* (1994) London: MIND. More recent statistics from The Forum for Preventing Deaths in Custody show that since the millennium, people die at the rate of nearly 600 per annum in the UK's prisons, police cells and other units. Two-thirds of these deaths are registered as 'natural causes', the rest as self-inflicted, accidents, overdoses or killings. The report suggests that many of the deaths could and should have been prevented. In the year to April 2007 there were 523 deaths in custody, the great majority registered as 'natural causes' in psychiatric facilities. Yet how natural is a cause when psychiatric drugs are known to be potentially lethal, and when we know that there is an unacceptable rate of death by over-sedation? The report recognises the high proportion of people with a diagnosed mental disorder in the prison system; the Government's statistics included 73 self-inflicted deaths in prisons and a further 41 in secure mental health hospitals. Custody death total 'too high' (2007) bbc.co.uk/search/news 21 Sept.

76 Buckley, NA & McManus, PR (2002) Fatal toxicity of serotonergic and other antidepressant drugs: analysis of United Kingdom mortality data. *British Medical Journal* 325 1332-1333.

77 Of course, in every field of medicine there is risk of harm. There is no reason to suppose that New Zealand is exceptional, yet in that country in the most recent year for detailed official statistics (1998), 1,524 patients of all kinds died due to an adverse reaction to a pharmaceutical medicine, and there were also 4,222 deaths caused by medical injuries due to mistakes by doctors or medical staff (in a population of 4 million). An Australian study indicated that one-in-ten patients presenting to a GP had experienced an adverse pharmaceutical drug event in the preceding six months; 50% of those were in the range moderate-to-severe, while 8% required hospitalization. Another study estimated the annual costs of complications due to medication errors in US hospitals at \$1.5 billion dollars. Studies also show that prescription drug errors double a person's risk of dying in hospital. Costs incurred by US hospitals as a result of drug-related injury or death was recently estimated at \$76.6 billion. This was three-times the cost of all diabetes care in the USA. See Natural medicines: The safest way to avoid death (2011) www.pro-masystems.co.nz/nicolaas_vegt.

The first of the modern major tranquillisers was chlorpromazine (Largactil). The biochemists who prepared it for psychiatric use were aware that it needed careful monitoring since, in their words, 'extensive consumption might cause general cerebral dysfunction'. Even though its creators warned that widespread use might precipitate an epidemic of incurable brain dysfunction, the pharmaceutical company that marketed it removed this caution from their research paper before it was widely published. The company was then happy to advertise the drug as an effective control for psychosis and agitation. The world's psychiatrists grabbed at the new 'miracle drug'.⁷⁸

The *BNF* lists the ill-effects of all the anti-psychotic drugs. Referred to as 'side-effects', they may appear at any time, even immediately. *BNF* suggests that the extrapyramidal symptoms are the most troublesome, and lists the drugs which usually cause them. All depot preparations are more likely to cause unwanted side-effects than a pill taken by mouth; of course, it is 'the worst cases' or 'unreliable' patients who tend to be on depot injections. The side-effects are: parkinsonian (including tremor), dystonia (abnormal face and body movements), akathisia (restlessness) 'which may resemble an exacerbation of the condition being treated', and tardive dyskinesia (which is really any or all of the above but about which the *BNF* says: 'usually takes longer to develop'). Parkinsonian symptoms remit if the drug is withdrawn, and they may be suppressed by antimuscarinic drugs. Hypotension and interference with temperature regulation are dose-related side-effects and are likely to cause serious falls and hypothermia in the elderly. Neuroleptic malignant syndrome is a rare but potentially fatal side-effect of some of the drugs; this manifests as hypothermia, fluctuating level of consciousness, muscular rigidity and autonomic dysfunction, with pallor, tachycardia, labile blood pressure, sweating and urinary incontinence. There is no effective antidote, and it may last for ten days after discontinuing the neuroleptic; but it may also be 'unduly prolonged' if administered by depot.⁷⁹

Tardive dyskinesia usually begins to affect a patient after six months to two years of anti-psychotic medication, but it can also occur after just a few weeks. At first, the drug disguises the onset of TD by suppressing the overt signs, such as uncontrollable twitches, spasms and writhing. The symptoms worsen the more the patient tries to control them or carry out voluntary actions. Some patients also suffer from tardive dementia, a complete deterioration of the mental faculties; this condition is permanent - there is no cure. The American Psychiatric Association finally admitted that of patients who are (or were) on a major tranquilliser for between six months and two years, at least 10-20% develop more than minimal TD; in fact, research finds an average 40% risk of irreversible TD for older patients or long-term administration of such a drug. Other researchers have found that the risk is higher than 50% for long-term patients and for those over the age of sixty. There is now a consensus that giving a major tranquilliser to a patient for more than fifteen years will almost certainly lead to unrelieved parkinsonian-type symptoms. And yet patients are still routinely informed that they might have to be on these drugs for the rest of their lives.

The major tranquillisers caused a world-wide epidemic which affected millions. The psychiatric establishment was in denial and tried to hide the facts for decades. Even though many professional bodies preferred to fudge and cheat in the research that they commissioned, the epidemic is now well documented.⁸⁰ It has been conservatively estimated that 250 million people were treated with a neuroleptic drug between 1953 and 1991, and the American Psychiatric Association finally admitted that tens of millions have suffered 'seriously' from this medical mistake.⁸¹

Doctors should be aware of the magnification of drug effects on smaller bodies, and that the risks to any developing human organism are pretty much unknown. Of course, psychiatric drugs are only tested on fully informed adults - generally healthy ones, at that - and yet over the last few decades there has been a continuous year-on-year rise in the number of children prescribed psychiatric drugs. This amounts to wholesale, forcible, trial-and-error experimentation on an ever-growing number of

78 See Breggin, PR, op. cit. (n. 107, Ch 1), 73-74.

79 *BNF* 59, op. cit. (n. 10), 209.

80 This is fully discussed by Breggin, PR, op. cit. (n. 107, Ch 1), 89-90.

81 Breggin, PR, op. cit. (n. 107, Ch 1), 90.

captured and defenceless guinea pigs. What seems to appeal to increasing numbers of anxious parents and teachers is listing symptoms and tagging a ‘syndrome’ of undesirable behaviours with a psychiatric label, and then prescribing a drug. Two studies found that the recent cuts in special education, counselling and psychotherapy services were accompanied by a worldwide surge in the prescription of all types of psychotropic drugs for children.⁸² In typical mental health doublespeak, prescription of a psychiatric drug to a child is officially banned in the UK - except at the discretion of the doctor. Britain has seen one of the biggest recent increases in their use with children. More than two-thirds of the mental health prescriptions for children are for depression: juvenile anti-depressant prescriptions rose 70% in the decade to 2002 (including a 68% increase between 2000 and 2002). Prozac is particularly popular for treating children diagnosed with depression.⁸³

Until recently, ‘bi-polar disorder’ was rare amongst children. Now it is increasingly fashionable as an explanation for symptoms such as ‘silliness, separation anxiety, night terrors, fidgeting, carbohydrate cravings, excessive bossiness, bedwetting, lying, social anxiety, and difficulty getting up in the morning’.⁸⁴ In order to control their moods and alleviate apparent depression, children are often prescribed a variety of drugs to be taken simultaneously. Typically, this includes an anti-psychotic (Risperdal or Seroquel), a mood stabiliser (Depakote), a stimulant (Ritalin), and perhaps other drugs such as a non-stimulant for ADHD (Strattera), as well as an anti-asthmatic. And yet there is no clear evidence that the anti-depressants are particularly helpful. In addition, it is known that the serotonin and noradrenaline reuptake inhibitor (SNRI) atomoxetine (Strattera) makes children drowsy, fatigued and lose interest in eating - older patients report dry mouth, insomnia, constipation, nausea, dizziness, sweating, painful urination, sexual problems and heart palpitations. Risperidone (Risperdal) is prescribed for mania, but it often makes the patient drool, and causes sexual dysfunctions and obesity; Depakote (divalproex) is liable to cause pain, and is linked with life-threatening pancreatic disease.

The most popular drug for children is Ritalin. This is an amphetamine which was used extensively for many years: it is a psycho-stimulant that found its first medical use (for adults) as a slimming agent, and was only later recommended for depression (again for adults). Soon after it was introduced it fell from favour, but in the last thirty years it has been in widespread use. Ritalin is prescribed for attention deficit disorder (ADD) and attention deficit hyperactive disorder (ADHD). We discussed those two diagnoses, and their increasing attribution to troublesome children and adolescents, in Chapter 5, above.⁸⁵

Each year the number of prescriptions of Ritalin to British children increases significantly; in 2004 it was 359,000, in 2010 it was 661,000, and by 2014 it was more than 922,000. 5% of the UK’s schoolchildren had an ADHD diagnosis in 2014 (10% in the USA). In a big UK survey of Ritalin’s use, 53% of the children reported experiencing ‘unpleasant’ side effects.⁸⁶ This is unsurprising since the drug’s effects, side-effects and cautions are as extensive as any other potent psychoactive medication. They include: stimulating the heart, suppressing growth, inducing muscle tics, rashes, nausea, headache, seizures, stomach-ache, visual disturbances, and psychosis. There have been no long-term studies for either the safety or efficacy of Ritalin. Its use for ADD/ADHD is supposed to be part of a program controlled by specialists. In practice, like most other psychiatric medications, it is over-prescribed and mixed with any number of other psychiatric and general medicines. Ritalin is highly addictive, and it now seems likely that long-term use also causes the very hyperactivity it is

82 In the USA, prescriptions of anti-psychotics to minors (under eighteen) increased 600% during the decade to 2005. None of the drugs were tested or approved for use on juveniles. Note (2006) *What Doctors Don’t Tell You 17* 5 4; that article cited research in *The Archive of General Psychiatry* 63 679-85 (2006).

83 Tanne, JH (2006) Antipsychotic use among US young people has risen sixfold. *British Medical Journal* 332 1407.

84 Tan, T (2005) Psychiatric labels: when the name invents the condition. *What Doctors Don’t Tell You 16*:4 1-4 and 11.

85 See text to footnotes 28 to 30 in Chapter 5, above.

86 Borland, S (2015) Ritalin use soars as prescriptions reach 1m a year. *Mailonline* 16 Aug; Experts call for caution over Ritalin (2015) *BBC News* 25 Nov.

supposed to counteract. This has not stopped its prescription for the management of children in schools and special institutions, since the initial effect on the brain is to make the child docile.⁸⁷

During the last thirty years or so, many psychiatric patients and ex-patients have become worried about the side-effects and long-term effects of routine drugging.⁸⁸ By contrast, doctors seem to have settled for the lobotomising and mood-altering effects of the various mental health medicines. They do not seem to regard the risks of psychiatric drugs and in many cases the lack of evidence for their efficacy as any reason to approach the problem of emotional and mental distress from another, non-medical perspective. Of course, to do so would question the medical nature of functional mental disorder and imply the redundancy of doctors as the final arbiters of the official response. This is unimaginable. Faced with the failure of drug therapy - as measured against non-medical interventions, placebo or no therapy at all - and the failure to find anything that looks like a cure, psychiatry and the pharmaceutical companies simply resort to further bio-chemical, neurological and genetic research, and try to devise new 'wonder drugs' or remix the old ones. Psychiatrists keep hoping that with ever more biochemical research, more effective and less damaging drugs will emerge to take medicine to better levels of symptom management, or even towards that elusive cure.

The standard treatment for schizophrenia is long-term anti-psychotic medication. It has been known for some time, however, that most patients diagnosed with schizophrenia or schizo-affective disorder do not take their anti-psychotic medications as prescribed (74%), and many stop taking them altogether (26%).⁸⁹ In spite of this, nobody knows how useful the medications really are - very few studies have compared the outcomes of these patients on or off their drugs. One such study found that 35% of the patients who had stayed off medications for 18 years had significantly higher levels of general and social functioning compared to patients who continued taking antipsychotic drugs over that period.⁹⁰ Another found that non-medicated patients who had been off antipsychotic medication for more than a year had fewer symptoms, were better functioning, and were less often on disability benefits or readmitted to a psychiatric hospital.⁹¹

Recently there was also a small-scale study which found that in matched groups of medicated and non-medicated patients diagnosed with schizophrenia, while the two groups did not differ significantly in their symptoms or levels of distress, the non-medicated group scored higher on levels of general functioning and spent less time in psychiatric facilities, both inpatient and outpatient. Patients in the off-medication group who had never taken an anti-psychotic also reported feeling depressed significantly less often than those who had previously been medicated. The researchers were surprised to find that the increase in functioning was not explained by levels of social support or coping strategies - the only major difference was that the medicated patients were more likely to turn to professionals for non-medical help. Also, the longer patients had been off medication (in relation to the duration of the disorder), the higher their level of general functioning.

Taking into account the common side-effects of [antipsychotics] such as sedation or akinesia (e.g. 'feeling slowed down' or 'feeling like a zombie'), an alternative explanation for higher functioning in non-medicated participants is that medication itself impairs functioning in those individuals who experience those restraining side-effects. This is surprising as sudden withdrawal from [antipsychotics] has generally been found to be

87 See *DSM-IV-TR*, op. cit. (n. 12, Ch 5), 303-313.

88 For example, see Cobb, A, op. cit. (n. 3).

89 Study finds improved functioning for 'schizophrenia' without antipsychotics (2016) *Mad in America* 25 July.

90 Harrow, M (2012) Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study. *Psychological Medicine* 1-11.

91 Moilanen, J (2014) The use of antipsychotic medication and its association with outcomes and brain morphometry in schizophrenia: The Northern Finland Birth Cohort 1966 Study. *Acta Universitatis Ouluensis Medica* 1363

associated with increased risk of relapse. Our results indicate that there are patients who are able to withdraw responsibly and successfully from medication on their own.⁹²

Meanwhile, the Therapeutic State tightens its grip. The UK government's *National Service Framework for Mental Health* instructs GPs to compile a Severe and Enduring Mental Illness Register. Ostensibly, patients are only listed voluntarily, but since the register includes patients' records, GP assessments, prescription details, levels of compliance, etc., this appears to compromise the right to privacy, and it increases unwarranted surveillance. At the same time, recent changes in the privacy laws specifically allow the drug companies to access such data for the purposes of their own research.⁹³

To summarise: no psychiatric drug has reliable, immediately desirable *mental* effects, but only noticeable physical effects on *several* of the body's organs, including the brain and the nervous system. These may or may not cause the patient to act differently in relation to his circumstances - including the circumstance of being drugged. Drugs can sedate and subdue someone or make him euphoric, but they cannot make him adopt a more convenient persona. The judicious use of certain drugs might well have a place, in certain limited circumstances (e.g. temporary sedation in the case of insomnia). In general, however, drugs should be administered carefully to patients who are informed about their purposes and their effects, and who freely consent. Anything else is questionable and likely to be detrimental to the patient's peace of mind and harmful to his physical health.

Coda: diagnosis and medication as identity-forming ritual and social control

Someone incapacitated due to an emotional or psychological crisis is said to 'have a functional mental disorder' precisely because there is nothing in the structure or dynamics of his brain to suggest the presence of *actual illness*: medical tests (neurological, etc.) prove negative. This is the situation with the great majority of psychiatric patients. In which case, as a prerequisite for modifying someone's aberrant beliefs or behaviour - or better still, helping him with his real problems - why would a *medical* diagnosis be necessary? In the previous chapter we contested the idea that mental health diagnoses are a part of bona fide medical science: they derive from a kind of 'common sense' taxonomy of behaviours, attitudes and beliefs, and not from any scientific evidence.

When someone is in the throes of a personal crisis, how could it help to give him *misinformation* about his condition - to call it 'his illness'? It can only hinder recovery when he is *falsely told who he is* - i.e., when he is assured by every official that he suffers from a well-known mental illness, that there is 'a chemical imbalance' in his brain and his genetics are probably out of kilter, and that he must therefore submit to potentially toxic medication. On the other hand, what the person does need is *not to be misled or otherwise impeded from discovering who he is, in relation to the problems that really do face him*.⁹⁴

Nor is the policy of near-universal psychiatric medication based on plausible theory or sound evidence. If someone diagnosed with a mental disorder is not really ill, and there is no clear evidence for its superior efficacy compared with other possible responses, why would the official remedy almost always be drugging - and in effect, 'for as long as it takes'? And yet in mental health practice there is ongoing experimentation on the patients with a whole variety of drugs. It is normal for 'difficult cases' (i.e., particularly puzzling individuals) to be prescribed, in sequence or often simultaneously, a variety of medications with different effects and side-effects (ill-effects). Except by

92 Jung, E et al (2016) Symptoms, functioning and coping strategies in individuals with schizophrenia spectrum disorders who do not take antipsychotic medication: a comparative interview study. *Psychological Medicine* 1-10.

93 *A National Service Framework for Mental Health: Modern standards & service models* (1999) NHS; Johnston, E (2002) Drug company funding: Profit or loss? *Asylum* 13 3 17.

94 This is the crux of the argument developed throughout Volume 2. Meanwhile, towards the end of this Volume (in Chapters 12 to 15) we offer more arguments and evidence to support our position, as well as suggesting why medical diagnosis for a personal crisis is so seductive an idea.

trial and error, case by case, nobody knows if or how the drugs interact; neither can the professionals know that there are no long-term detrimental organic effects from this casual but widespread practice.

Typical is the case of a twenty-eight year-old female patient. Her diagnosis remained the same during five years of psychiatric contact, but at various times she had been prescribed: Olanzapine, Citalopram, Seroxat, Haloperidol, Sulpiride, Lorazepam, Temazepam, Zopiclone, Lithium, Paroxetine, Diazepam, Risperidone, Clozaril, and Prozac. As long as she was not too bothersome to the psychiatric authorities, the fact that she continued to suffer from psychotic symptoms (including auditory hallucinations) was never considered evidence that any drug did not work. Once, this patient said to a nurse: 'You can give me as many drugs as you like, but you won't stop me hating my family.' Of course, that interesting remark was not pursued officially, therapeutically or otherwise.⁹⁵

If there is nothing to indicate that psychiatric diagnosis is scientific yet much to suggest that it is arbitrary, nor any evidence that the drugs are particularly successful at curing or alleviating mental disorders, why the tremendous faith in medication? This must be a matter of the high standing of Medicine in the imaginations of both the general public and the officials themselves, and hence to a great extent the placebo power of the myth of medicinal potency. A cynic might suppose that so many intelligent and highly trained people - the doctors - could only misrepresent the nature and cause of functional mental disorder, and the appropriate response, by deliberate bad faith, fraud, and the lure of financial gain. However, it seems to us that this is generally unlikely: surely most doctors and mental health workers are well-intentioned, and what would be the benefit to the public?

Much of the argument later in this Volume is devoted to answering the question of the puzzling choice of medicine for managing all those mental disorders which have no organic cause. In Chapters 13 and 14, below, we address the enigma of the general emotional investment in the medical model of mental illness, and the psychological and social motives for everyone's blind faith in the official mental health response. As a teenager, John Modrow endured a period of crisis in which he experienced psychotic delusions, and he was given the high potency phenothiazine anti-psychotic, trifluoperazine (Stelazine). Here, as an initial insight, we offer his explanation of the part played by diagnosis and drugging in the rituals (medical routines) which define the psychiatric patient's identity. He writes that he had

...come to the psychiatric clinic with the conviction that I was a very unique person with a sacred mission, but I walked away... miserably clutching a bottle of Stelazine with the vague and uneasy suspicion that I might not be anything more than an emotional cripple. The...suspicion grew more and more into a certainty each time I took one of my Stelazine tablets. More than words could ever have done, taking those pills indoctrinated me with the notion that I was a defective person whose only claim to uniqueness consisted of a biochemical defect, probably genetic in origin.

Instead of having a tranquillising effect, many neuroleptic drugs actually *increase* the patient's anxiety. This was true in my case. Taking Stelazine made me nervous. However, in my naiveté, it never occurred to me that my increased nervousness was caused by the drug I was taking... I thought I was taking the drug in order to control my nervousness. Consequently I began to view myself as a 'nerve case' - which certainly didn't help my self-esteem.

What I had been taking did not 'cure' anything but was merely a chemical lobotomy or strait-jacket whose sole virtue stemmed from the fact that *it tranquillised the people around me*, and thus kept them from locking me up. [Our emphasis]

Psychiatrists are fond of stressing how much suffering schizophrenia causes. However, I can truthfully say being labelled a schizophrenic has caused me a hundred times as much suffering as the so-called 'illness'. Since recovering my sanity in 1961, I have spent decades struggling to gain some measure of self-understanding and self-esteem. In this

95 Information from Lin Bigwood.

regard, I never fully recovered from what psychiatry and my parents did to me until I finally realised I had never been ill in the first place.⁹⁶

As John Modrow knew full well, psychiatric drugs do of course have real effects as well as symbolic ones: 'paradoxically' - as the psychiatrists and drug formularies say - Stelazine made him feel nervous.

It should be recognised that staff and other interested parties tend to act differently towards a psychiatric patient according to whether or not he obediently takes his medication: for the purposes of bureaucratic order and their own peace of mind, officials identify him as 'good' or 'bad', 'gaining insight' or 'deluded'. Mental health officials claim that they simply carry out technical procedures; they do not acknowledge a moral or political dimension to their practices. Nonetheless, since it affects his relations to the community of the 'obviously' sane - and hence his 'progress', 'recovery' or 'remission' - everyday politics of care and treatment are bound to influence a patient's attitudes and his reintegration into society or further alienation from it. In accordance with the medical model, a patient is only able to become reintegrated (or 'recover') by fully accepting the official definition of the situation. This means he must docilely accept that identity and conform to that behaviour decreed by power; of course, this has to include submitting to whatever treatments the doctors wish to employ, however much they may frighten, hurt or harm him.

Despite the experiences of Modrow and millions of others, a case might be made for expedient but careful and voluntary use of some drugs as an occasional tactic, but surely not, as is presently the case, as a standard and coercive strategy. Modrow was sixteen when he was prescribed a major tranquilliser. This is still not unknown, and powerful psychotropic drugs should certainly be outlawed for use with minors.

Unlike general medicine's routine remedy of many illnesses, there is no proven medical remedy for any functional mental disorder. Research shows that some psychiatric drugs are more harmful than others, but there is none to indicate that any are more effective than others, or significantly more successful than placebo or a 'talking cure'. Rather, as we will see when discussing the placebo effect (in Chapter 8, below), it seems that *any* kind of sympathetic and apparently positive intervention is more beneficial than none. Just because some patients 'get better' when administered a drug really proves nothing at all, especially since just as many patients - or more - continue to experience the same symptoms the drug is supposed to remedy. It is a myth that psychiatric drugs cure or 'manage' mental illness. Whenever a patient is given medication and his symptoms seem to abate, the prescribing doctor (or any other believer) receives positive reinforcement for his faith in the medical model by the simple expedient of never examining his assumptions; thereby, he never recognises the crucial flaws in the arguments by which he concludes that functional mental disorder has an organic cause and requires a medical remedy. There is, in fact, no body of research evidence to show a strong positive correlation between psychiatric medication and recovery: those who believe in the medical model simply ignore the equal or greater number of instances when medication fails.

In terms of the *actually scientific* or *really medical* status of drugging, this perception of an experienced service-user is apposite:

In every branch of medicine except psychiatry treatments sometimes fail. In psychiatry this role is reversed and we find that it is the patient who has failed treatment. We often hear about the patient who is drug resistant. We do not hear about drugs that do not work for the patient. We are continually told that the super drug - the cure - is just around the corner. This is some corner it is now so long it has become a circle.⁹⁷

96 Modrow, J, op. cit. (n. 35, Ch 2), 146-48 and 245. As this book proceeds, Modrow's assertion that he 'had never been ill in the first place' finds supporting evidence and argument.

97 Coleman, R (1998) *The Politics of the Madhouse*. Gloucester: Handsell, 21-22.

Chapter 7: SHOCK TREATMENT & PSYCHOSURGERY

‘Don’t worry,’ the nurse grinned down at me. ‘Their first time everybody’s scared to death.’

I tried to smile, but my skin had gone stiff, like parchment.

Doctor Gordon was fitting two metal plates on either side of my head. He buckled them into place with a strap that dented my forehead, and gave me a wire to bite.

I shut my eyes.

There was a brief silence, like an indrawn breath.

Then something bent down and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant.

I wondered what terrible thing it was that I had done.

Sylvia Plath¹

Electroconvulsive therapy (ECT) is the most obviously invasive psychiatric treatment still in regular use. We review its invention and development, and give an account of the research and the issues around its efficacy. While there is sporadic anecdotal support for the benefit of shock treatment, there is unequivocal evidence for brain trauma and worrying cognitive and psychological effects; research also finds that most patients report no benefits, many experience ill-effects, and the great majority would not wish to have the treatment again. We discuss the symbolic significance of electroshock as a spectacular display of the potentially annihilating power of the psychiatrist. We also briefly discuss psychosurgery, which is now only rarely carried out.

The use of electroconvulsive therapy today²

Electroconvulsive therapy (ECT), commonly known as shock treatment, has been in routine use for eighty years. At first it was employed to try to remedy schizophrenia, and then experimentally for all kinds of psychiatric conditions. It is still used occasionally for some disorders but mainly for severe and intractable depression, for which it is officially the ‘treatment of choice’. Use of the technique has declined from the high levels of the 1950s and 1960s, but as recently as the year 2000 one-quarter of all psychiatric in-patients were subjected to at least one course of shock treatment. Its endorsement by the psychiatrists’ professional association is unqualified.

Normally administered twice a week, a course of shock treatment is for at least five sessions, but many patients are given more; these days, a course is notionally expected to be for six to eight treatments, although it may run to twelve. The Royal College of Psychiatrists (RCP) advises that generally it takes two or three sessions before the patient sees any difference and four or five for noticeable improvement, but if the patient feels no better after twelve treatments, “...it is unlikely that ECT is going to help and the course would usually stop.” Across the UK, psychiatrists who employ shock treatment were recently asked about the clinical outcomes for 2,148 patients. Using the standard Clinical Global Impression Scale to assess its effectiveness, they reported that 91.5% of the patients improved after the treatment, compared with just 1.7% who had become worse; 51.7% had

1 Plath, S, op. cit. (n. 15, Ch 2), 138. Plath received the original, unmodified version of ECT.

2 Except where otherwise indicated, summaries of the research quoted in this section are from Thomas, P, op. cit. (n. 75, Ch 1).

been rated ‘severely ill’ at the start of treatment, and 41.3% were considered ‘much improved’ by the end of treatment.³ Perhaps these findings are unsurprising, for it hardly seems objective to ask the partisans of a controversial technique about its efficacy, and neither were the patients asked to rate the treatment or their own outcomes.

For the first twenty years or so after its invention, patients were subjected to the unседated shock treatment experienced by Sylvia Plath. ECT passes through the head anything between 70 and 170 volts with a current of 500 to 1000 milliamperes, generally for two-tenths of a second, but sometimes for longer. Without sedation, the jolt to the brain is enough to produce a *grand mal* epileptic seizure. This is exactly what the doctors look for, although today, so as to prevent the whole body from jerking violently, the treatment is ‘modified’: that is, the patient is first of all given a muscle-relaxant and a short-acting anaesthetic. With bilateral ECT, the current is passed across the whole brain; with unilateral, it passes through one side. Both cause a seizure in the whole of the brain and a whole-body fit. Doctors look for a seizure lasting between twenty and fifty seconds. Psychiatrists in the UK used to favour bilateral treatment since it is reckoned quicker and more effective. However, there was recently some concern that it might cause more and worse side-effects (ill-effects) than unilateral treatment; consequently that method may now be more popular.

Because seizure thresholds vary by a factor of 40, in theory the exact dose should be corrected for each individual. The threshold is higher for men than for women and it rises with age. Psychotropic drugs can also raise it, as can some of the anaesthetics used during the process. This leads some physicians to give a bigger dose than the estimated threshold, ‘just in case’ or ‘for quicker results’. This expedient runs a greater risk of irreversible brain damage. In fact, administering shock treatment is not an exact science, and its routine use is fairly casual. Research used to indicate that training and supervision of ECT was inconsistent, poor or sometimes non-existent - at least in the UK. In response to criticisms, in 2003 the RCP set up the ECT Accreditation Service (ECTAS) to improve standards of practice.

Statistics on ECT are not collected regularly, but the RCP sponsored a study which found that 200,000 individual shocks were administered in the UK during 1979. There were great differences between regions and between different facilities. Psychiatric patients in Yorkshire, the region with the highest use, were three times as likely to be given ECT as those in Oxfordshire, the lowest. Per capita, some hospitals gave the treatment seventeen times more often than others. These differences were not explained by any obvious links to demographic or socio-economic factors: they seemed to depend purely on the whim of whichever doctor held psychiatric power in each locality.⁴

By 1986, 139,000 uses of ECT were recorded for England alone: it was given to every fourth inpatient. In the UK in the mid-1990s, 20,000 patients per year - still one in four of those hospitalised - were given at least five sessions of ECT. Most were nominally voluntary treatments, but each year some 3,000 patients were given electroshock against their will. By 2003 the numbers given ECT had fallen to about 9,000, of which 1,500 were compulsory treatments.

Freedom of Information law was recently used to access the data of four-fifths of the English mental health trusts; although record-keeping is poor and sometimes non-existent, this showed that more than 22,600 individual ECT treatments were carried out in 2015-16, a rise of 11% over four years. The number of patients treated also increased, albeit more modestly, to more than 2,200 (perhaps 2,800 for the whole of England). This suggests that, on average, individuals undergo more ECT than before: the average number of treatments per patient rose from 9.6 in 2012/13 to 10.1 four years later.⁵

3 *Information about ECT (Electroconvulsive therapy)* (2015) London: Royal College of Psychiatrists; Buley, N, Hodge, S & Hailey, E (2015) *ECT Minimum Dataset 2014-15 Activity Data Report: England, Wales, Northern Ireland & Republic of Ireland*. London: Royal College of Psychiatrists, 13.

4 Pippard, P & Ellam, L (1981) *Electroconvulsive Treatment in Great Britain, 1980: a report to the Royal College of Psychiatrists*. London: Gaskell, 108.

5 Davis, N & Duncan, P, op. cit. (n. 75, Ch 1). The realities and fictions of assent under duress are discussed further into this chapter.

These days the Care Quality Commission (CQC) monitors the operation of the Mental Health Act and its amendments. The CQC Annual Report contains some statistics and comments on the use of ECT, but only concerning patients considered incapable of making a decision about treatment and therefore treated without their consent. The CQC has a panel of psychiatrists who vet all compulsory treatments, known as second opinion appointed doctors (SOADs). These officials rarely withhold approval for treatment, so the number of SOAD visits is nowadays the best approximation we can get to the number of people being given ECT without their consent. The 2013 Report for England finds that during the year ending March 2012 there were 1006 completed SOAD visits; about one-quarter of the patients had already been given at least one session before the SOAD visit. This was a slight increase (about 3%) on the previous year. However, the CQC Report for 2012-13 showed 1,464 SOAD visits for the UK - an increase of about 20% in twelve months. The Report for 2011-12 indicated that more than 85% of those given ECT against their will were women. The 2014 Report offers no details about those given shock treatment against their wishes - nothing about age or gender, or whether the course of ECT had been started before the SOAD visit. Over the past thirty years, in England, the use of ECT on consenting patients has apparently diminished by about 80%. Still, the number of patients treated compulsorily has not shown such a significant decline, and the recent sudden increase is not explained in the CQC Reports.⁶

There are a number of reasons for shock treatment remaining a significant but contentious therapy, out of all proportion to the bare statistics. For instance, the mental health charity Mind found an alarmingly high use of the emergency powers permitting shock treatment without a second opinion. In its study, shock treatment was also used in a surprising 20% of all cases of 'sectioning' (compulsory hospitalisation). Nor are children exempted from ECT. Despite apologists saying that electroshock is used only as a last resort - as advised by the NICE Guidelines in 2003⁷ - another survey of patients found that 18% of those given ECT were not offered *any* other treatment, and that 85% of the sample had never received any kind of counselling or psychotherapy; 76% had already been medicated; 78% said they would not want to have shock treatment again. The same survey found that while 35% reported ECT as 'damaging', 13.6% did find it 'very helpful'. A further survey found that 47% of the sample considered ECT 'unhelpful', but 30% found it 'helpful'.⁸

The Royal College of Psychiatrists reports ECT data for the UK and Ireland (but not Scotland). For the year to March 2017, three-quarters of the NHS clinics submitted data: 1821 courses of ECT had been given to 1682 patients; for the whole of England, another study estimates that each year shock treatment is administered to between 2,100 and 2,700 people. In the RCP data set, the mean number of treatments per course was 9.8, while 139 people had more than one course. 67% of the recipients were female, and the mean age of all the patients was 61. In March 2017, across 48 clinics, 161 patients were receiving maintenance ECT; the mean age was 66, and 74% were female. 88.2% of all those getting shock treatment were referred for major depression; other diagnoses, in decreasing order of frequency, were psychosis, bipolar/mania, personality disorder, anxiety, and a few were for dementia. 51.8% of patients were informal and capacitous at the start of treatment; 46.4% were considered severely ill, and 42.6% 'much improved' by the end of their treatment.⁹

There is little recent research on the topic, let alone on how it is experienced by patients. Mind conducted a survey which threw light on how ECT was delivered in the UK at the close of the 20th century. Government statistics showed that during a three month period in 1999, 2,800 patients were

6 *Report [ECT]* (2013) London: Care Quality Commission; *Report* (2014) London: Care Quality Commission. The most recent *Report* does not seem to offer clear information on the administration of ECT.

7 *Guidance on the Use of Electroconvulsive Therapy* (2003) London: National Institute for Clinical Excellence (April). NICE recommended using ECT only for particularly intractable depression.

8 *ECT Survey* (1995) Sheffield: United Kingdom Advocacy Network; also, Faulkner, A, op. cit. (n. 2, Ch 6); both are cited in Bird, L, op. cit. (n. 21, Ch 1), 31.

9 Buley, N, Copland, E & Hodge, S (2017) *ECT Minimum Dataset 2016-17: England, Wales, Northern Ireland & Republic of Ireland*. London: Royal College of Psychiatrists, 3; Read, J et al (2017) An audit of ECT in England 2011-2015: Usage, demographics, and adherence to guidelines and legislation. *Psychology & Psychotherapy: Theory Research and Practice* July.

given 16,000 sessions of ECT (equivalent to 11,200 patients and 64,000 sessions per year); the most common diagnosis (53%) was 'depression'. 700 of these patients (25% of the total, = 2,800 per year) had been detained under the Mental Health Act, and less than one-third of the detained patients consented to treatment.

The Mind survey polled 418 patients given shock treatment in recent years. More than half said they did not realise that they could refuse to give consent, and nearly three-quarters said they had no recollection of being given any information about possible side-effects. Of those consenting to treatment in the previous two years, 48% had received no information about how the treatment would work, and 45% none about possible side-effects. Only 8% of all the respondents had the opportunity to consult an independent advocate before making a decision about whether to consent to ECT (15% of patients receiving treatment in the two most recent years).

The great majority of the patients in the sample (84%) reported troubling side-effects from ECT: 40% reported permanent loss of long-term memories, and 36% permanent difficulty in concentrating. Among those given treatment within the previous two years, 30% reported that it had caused them permanent fear and anxiety. 32% of recent recipients of ECT felt hopeful before treatment, but 29% had felt terrified, and 22% felt they had been given treatment as a punishment. In the short term, 36% of the more recent recipients of shock treatment found it helpful or very helpful, but 27% found it unhelpful, damaging or severely damaging; in the long term 43% felt that the treatment had been unhelpful, damaging or severely damaging. Two-thirds of the whole sample said they would not want it again (49% of those given ECT in the previous two years). The survey also found that respondents from black or minority ethnic communities were more likely to have been compulsorily detained, and to have been given shock treatment without their consent. They also reported a more negative view of ECT than the overall sample: 50% found it unhelpful, damaging or severely damaging in the short-term, and 72% in the long-term.¹⁰ On balance, then, it seems that more patients feel that ECT is unhelpful or positively harmful than report a definite benefit.

Since there is no regular full audit, there is no way of computing the physical risks from shock treatment in the UK. In all medicine, the risk from anaesthetic alone rises with age. Research from Texas gives an alarming figure of 1 death per 200 ECT sessions. Another study from the USA shows that of patients over 80 years old and receiving ECT, 27% had died within the year, whereas only 4% had died from a matched group treated only with anti-depressants; and within two years, 46% of the group given electroshock had died, but only 10% of the matched group. There is no reason to suppose that the rates could be very much better in the UK. As well as this disquieting evidence, other studies show higher rates of suicide following shock treatment than for matched patients not given the dubious assistance of electricity.¹¹ Meanwhile, the decreased use of ECT has not affected suicide rates in patients receiving the treatment. In the eight years to 2006, 71 of the 9752 suicides in the UK were undergoing a course of ECT at the time of death; this averaged 9 deaths per year, a rate of 1.08 per 1,000 patients treated.¹²

NICE recommends ECT as a backstop for mania and catatonia, but it is now mainly used to treat severe depression, and mostly in the elderly: those over the age of 40 are much more likely to be given shock treatment, and most recipients are between the ages of 61 and 80. Women are at least twice as likely as men to be given ECT. Research shows that it is often given to those who actually have good cause to be depressed because of serious physical health problems. It also seems that electroshock is often employed without fully taking into account the individual's medical history, such as giving proper consideration to the physiological and social changes a woman begins to undergo in middle-age, and the effect these may have on her psychological condition. Although only a small proportion of patients are not already medicated, and even though doctors assume that medication increases the dangers, the combination of drugs and ECT is poorly researched.

¹⁰ *Patients' experiences of ECT* (2000) London: Mind.

¹¹ See research cited in Thomas, P, op. cit. (n. 75, Ch 1).

¹² Hunt, IM et al (2011) Electroconvulsive therapy and suicide among the mentally ill in England: a national clinical survey. *Psychiatry Research* 187 1-2, 145-149.

Post-mortem research delivers the only certain knowledge of the organic effects of ECT: it burns and destroys brain cells. Research into patient-outcomes indicates that the technique may have short-term benefits in some cases of severe depression. The usual short-term effect is memory-loss - itself a problem to the patient - but this probably accounts for reports of immediate benefits, since the patient temporarily forgets her usual worries. Loss of memory is also the major long-term effect, along with apathy, learning difficulties, and loss of creativity, drive and energy;¹³ other ill-effects are headaches, sometimes dangerous respiratory and coronary complications, and strokes and falls which result in fractures (which, in turn, often lead to complications and hence to the risk of earlier death in elderly patients subjected to ECT).

The one benefit from shock treatment which has been reported with any reliability, for some patients, is the remission of their symptoms for a month or so. This is noted for some patients in a condition of deep and almost psychotic depression, who are perhaps insomniac and have stopped eating and lost the will to live. ECT is employed rather more generally, however. It is cheap and easy to administer, and it is used disproportionately on women and the elderly. These factors indicate the possibility of unacknowledged systemic abuse, a pseudo-medical 'quick fix' rather than a level-headed and equitable medical use.

Psychosurgery

Before continuing the discussion of electroshock, we briefly consider the other technique which, as therapy, intends to rupture cells and connections in the brain. The first modern attempts at psychosurgery were in 1888, but an apparently simple and reliable method was developed in Portugal during the 1930s: the first lobotomy - overt brain-slicing - was carried out in 1935. The country was then under a fascist dictatorship, a fact which, as we will see, resonates with the development of electroconvulsive therapy. Nearly all psychosurgery has followed the original form of pre-frontal lobotomy (or leucotomy).¹⁴ This involves surgically cutting and destroying brain tissue in which there is no manifest disease or injury, so as to change the thoughts, feelings or behaviour of a patient who suffers from a functional mental disorder. The idea is to sever neural connections between the frontal lobe and the rest of the brain - to what extent depends on the whim of the surgeon involved.

As well as a risk of death, rather than curing a specific mental disorder, leucotomy tends to cause various kinds of havoc to a patient's general mental functioning, sometimes to a disastrous extent. Due to its cost, ambiguous efficacy and levels of over-damaging or undesirable results - including perhaps a 6% risk of death.¹⁵ - psychosurgery has largely fallen into disuse over the last forty years or so. Nonetheless, an estimated 50,000 Americans were lobotomised in the years between its introduction in the mid-1930s and decreasing use from the early-1960s. By the late-1970s, each year somewhere between 300 and 1,000 patients were still subjected to lobotomy in the USA, but since then the number of operations has declined sharply. Statistics are not readily available for the UK, but by 1960 there had been at least 15,000 leucotomies, and until 1970 operations still ran at about 400 a year.¹⁶ No more than 28 psychosurgical operations were carried out in the UK in any year since 1983, and there were none in England between 1999 and 2009; one was performed in 2010.¹⁷ London's Brook Hospital carried out the greatest number of leucotomies in Europe; it

13 In a meta-analysis of twenty-seven studies, it was found that the belief that memory loss is only temporary is only partly correct: at least one-third of all patients reported persistent and long-term memory loss; also, contrary to what psychiatrists seem to believe, 80% of patients with severe depression reported no recovery after a course of ECT. Rose, D et al (2003) Patients' perspectives on electroconvulsive therapy: A systematic review. *British Medical Journal* 326 1363.

14 Leucotomy is the preferred term in the UK.

15 Frank, LR (Ed) (1978) *The History of Shock Treatment*. San Francisco: LR Frank, 184. This book is the classic collection of information, from both sides of the debate. Also see Shorter, E & Healy, D (2007) *Shock Therapy: A history of electroconvulsive treatment in mental illness*. New Brunswick: Rutgers University Press.

16 Berke, JH (1977) *I Haven't Had To Go Mad Here*. Harmondsworth: Penguin. Chapter 4, 89-114 gives a history and discussion of psychosurgery.

17 *Monitoring the use of the Mental Health Act in 2009/10* (2010) London: Care Quality Commission, 93.

performed more than 1,000 operations between 1970 and 1990.¹⁸ To counteract particularly disabling fears, obsessions and anxieties, some doctors still advocate modified techniques of psychosurgery, using radioactive implants or electrode probes. These are supposed to target brain tissue more accurately, permitting a monitored and progressive assault on brain tissue. Units in Cardiff and Dundee still carry out a few operations each year.

The effects of psychosurgery are generally more profound than those of drugs or ECT. Throughout the world many more than 100,000 psychiatric patients must have been subjected to the technique, among them children as young as four. It has been used for almost every diagnosis, but almost always to 'quieten down' the patient. Psychosurgery works by cutting cortical connections; in this manner, so as to obviate undesirable symptoms, brain function is disrupted and the whole human being is subdued. There is no adequate research to match the results of lobotomy against placebo or a control group; the little research there is indicates no overall improvement in the quality of life of lobotomised patients compared to patients with similar symptoms but not given a lobotomy. On the other hand, there is much anecdotal evidence of serious harm and mental deterioration; the latter, as 'quietening down', is the desired result of psychosurgery. Because of its highly disproportionate use on women and black people (in the USA), we might suspect the use of psychosurgery as a particularly brutal form of psychiatric oppression. Psychosurgical literature and research reports show no interest at all in psychodynamics or other aspects of patients' lives and relationships - the demography of the patients, what they think, what their mental disorders might signify, the possible genesis of their mental disorders, etc.

Anti-manic and anti-psychotic drugs and ECT all have a lobotomising effect similar to that of psychosurgery, but without such overt risks.

The development of electroconvulsive therapy

There is no disputing that the effect of ECT is trauma to an otherwise healthy brain. The damage is similar to that caused by a severe blow to the head. It seems that treatment is considered successful when the patient is so dazed, confused and disoriented that she no longer remembers her problems - or at least shows fewer signs of her malaise. It was once common to keep some patients on a 'maintenance dose', i.e., normally weekly and for as long as the psychiatrists thought desirable. Nowadays this is unlikely (but not unknown), and patients are usually treated once or twice a week, for a total of five to ten sessions. Note that brain-trauma is not a side-effect of ECT: it is *the desired effect*.

ECT was invented when several psychiatrists were already pursuing the idea of therapeutic shock. It had been observed that epileptic patients did not seem to show signs of schizophrenia; if the two ailments were mutually exclusive, perhaps schizophrenic patients might be relieved of the condition by inducing an epileptic fit - it might 'drive out' the schizophrenia. The first experiments in response to this idea were with drugs. Beginning in the late-1920s, and into the 1930s, there were enthusiastic advocates of insulin coma and shock therapy, metrazol or camphor shock (as well as narcosis by barbital, sodium amytal or carbon dioxide). In the aftermath of The Great War, none of these techniques seemed particularly barbaric, but neither did any of them regularly deliver much benefit. Besides, unacceptable death rates began to emerge, and patients tended to fear and resist the treatments.¹⁹

18 Remarkably, there was apparently only one death. See Berke, JH, op. cit. (n. 16), 183-184; also: Verkaik, R (1991) Please doctor, will you give me a lobotomy? *The Independent* 14 May.

19 Insulin coma has long since been abandoned, but narcosis therapy was popular during the 1960s and 1970s. By means of barbiturates, patients would be 'put to sleep' for perhaps three weeks; occasionally they would be woken up and asked to talk about their dreams or thoughts. Holding someone unconscious for such a long time is a difficult procedure which in other circumstances demands the services of an intensive-care ward, and so the average psychiatric ward was not able to manage the situation very well. It was also a dangerous treatment in which patients sometimes died.

From occasional reports of success, we know that since the 18th century there had been sporadic attempts to cure unwanted mental conditions by the shock from electric eels or camphor. Electricity had always been fascinating to physicians, and the modern apparatus was invented in 1938. By then, slaughterhouses were run as production lines in which high voltage electrodes were held to the animals' heads. In Italy, two psychiatrists happened to notice that the pigs fited before they died. In their first experiment, they therefore subjected the cranium of a schizophrenic patient to increasing amounts of shock until he fited. This experiment was considered a great success, and the technique spread rapidly. Initially, the use of ECT with diagnosed schizophrenics was viewed as effective because it exacted greater compliance. And then, during the Second World War, when the psychiatric services were suddenly inundated with shell-shocked and battle-fatigued personnel, the technique became very popular in the UK and USA for almost any condition.

At first, fully conscious patients subjected to electroconvulsive therapy were simply held down and shocked until they fited. This proved inconvenient - often, especially after their first shock, patients resisted vigorously. The induced *grand mal* fit also tended to cause fractures - before muscle-relaxants were introduced (during the 1950s) many patients suffered broken vertebrae, and there were also a questionable number of fatalities. Nevertheless, for years many facilities continued to simply tie patients down and apply unmodified shock. By 1960, however, electroshock was normally administered with a muscle relaxant and under a general anaesthetic.

Therapy as some kind of direct interference with the brain was very popular from the 1920s until the end of the 1960s. In the English-speaking world, William Sargant has to bear much of the blame - or take the credit, depending on one's point of view - for these unashamed assaults on the psychiatric population. Sargant was a pioneer in that period, and until the modern psychotropic drugs became widely available he was Britain's most famous and influential psychiatrist. His autobiography is a candid account of 'cost-effective', quick-fix, mass physical assault on the brains of psychologically traumatised soldiers, in order to 'get them back on their feet' and out of the wards. Sargant and his 'hard-nosed'²⁰ colleagues boasted of their 'armorium' - their armoury, the place where they kept their psychiatric weapons. This term, dignified and made to sound medical-scientific by the Latin, indicates that the doctors of his generation generally saw therapy in military terms, as a campaign against 'the diseased brain', just as general medicine 'attacked' physical diseases with chemicals or surgery. Because every undesirable thing that a psychiatric patient did or said was interpreted by Sargant and his colleagues as a symptom of a diseased brain, of course they took no interest in the thoughts and feelings consequent to a patient's *psychological* trauma. Having apparently worked very well in wartime, the techniques were carried over into peacetime. Sargant saw himself as pragmatic, unsentimental and unqueamish; he scorned psychological theory and would use whatever means necessary to get the outward compliance of his patients, which he viewed as cure enough.

Except for electroshock, the crude techniques of Sargant's day are now abandoned. ECT is carried out with a muscle-relaxant and general anaesthetic; there is little sign of the grand mal fit, but the brain still undergoes the same physical trauma. After the indiscriminate use of ECT during the early years, it appeared that the technique did little to relieve schizophrenia but it did seem to benefit cases of severe depression. By the 1950s it was 'the treatment of choice' for that diagnosis, especially for women and the elderly. In the end, ECT found more favour than the other kinds of shock treatment and psychosurgery because it was easier to administer and, especially in its modified form, less frightening.²¹ All the same, electroencephalographs (EEGs) measure greater disturbances for ECT than for any other technique of supposedly therapeutic interference with the brain.

Is there any evidence for the therapeutic value of an electrically-induced convulsion? Supporters of the technique claim there are uncontested research findings to show that it can sometimes relieve a deep, perhaps life-threatening depression or catatonic stupor. Moreover, the persistent popularity of ECT amongst some psychiatrists is based on a belief which, on the face of it, appears incontestable.

20 A self-appellation: Sargant and his colleagues celebrated their icy resolve (or lack of compassion); according to them, detachment was dictated by the medical need for objectivity. See Sargant, W, op. cit. (n. 7, Ch 2).

21 Berke, JH, op. cit. (n. 16); Chapter 3, 58-88, gives a brief history of ECT and precursor shock treatments.

They argue that there will always be a certain hard-core of patients who will never be amenable to anything other than such an extreme medical assault, and that there will never be enough healthcare staff to cope with critical problems of severe depression so effectively, so quickly and at such low cost. In one area of the UK, 65% of the consultants said that it was their treatment of choice when dealing with a depressive illness with a high risk of suicide, and 89% chose it for depressive illness when the patient refuses to eat or drink.²²

Advocates of ECT, including some on the liberal wing of psychiatry, argue that it might be a crude tool to use on such a complicated and delicate organ, but their main concern is that it does sometimes seem to work: it can jolt some patients out of a deep depression. These days, the argument runs, since it is performed under general anaesthetic by skilled medical and nursing staff, it is not such a terrible experience. When patients benefit from shock treatment, this seems to be by the loss of the memory of what originally ailed them; after treatment, when patients recover, the main problem they report is temporary loss of memory.²³ In which case, a psychiatrist (or psychiatric team) might resort to shock treatment 'when all else has failed' - for example, where a patient seems determined to kill herself, especially when she is elderly and seems to be starving and dehydrating herself and cannot or will not co-operate with her rescue, as well as with rarer cases of catatonia. Many psychiatrists also consider ECT the treatment of choice for puerperal depression (following child-birth), when the life of both the mother and the baby are at stake; patients with a schizophrenia diagnosis who are viewed as particularly troublesome are also candidates for shock treatment.

Champions of electroshock accept the mystery of its alleged efficacy without being able to account for it in terms of any demonstrable neuronal effects. The only thing that is certainly known about how it works, as discovered by autopsy, is that there is often haemorrhaging and some brain cells are destroyed. When the full context is taken into consideration, however, it becomes clear that it is difficult to disentangle the medical from the wider psychological and social considerations of this particularly controversial form of treatment. There is, besides, no research evidence to show that ECT is more effective than other forms of therapy, or even placebo. This ought to suggest that the possible benefits of electroshock might be achieved by altogether less violent means.

Furthermore, psychiatric officials really ought to be aware that the use of ECT is not based in any evidence of its efficacy: trials have indicated that *anaesthetic on its own is completely adequate for clinical benefit*. This was shown by research subsequent to the notorious discovery, in 1974, of a blunder at one psychiatric hospital. For two years, all the staff and patients had believed that their shiny new shock machine worked just like the old one it replaced. But the new machine was never properly switched on. This did not prevent the staff from continuing to register the same levels of improvement among the patients as before. This unwitting placebo experiment was only terminated by the arrival of a new doctor who realised what had been going on - which is to say, electrically speaking, precisely nothing.²⁴

This clearly indicates that the elaborate and awesome or reassuringly clinical rituals involved in administering ECT are sometimes psychiatrically beneficial simply because that is what is *expected* of them: electroshock may cause short-term memory loss and organ damage, but in terms of *therapy*

22 Benbow, SM et al (1998) Electroconvulsive therapy practice in North-West England. *Psychiatric Bulletin* 22 226-229.

23 However, it is indiscrete to mention that loss of memory probably *is* 'the cure' of the depression.

24 See Coffey, RR (1974) Hospital shocked by finding no shock in shock machine. *Chicago Daily News* 20 Sept; this news item reported an article in the journal *World Medicine*, and is quoted in Frank, LR, op. cit. (n. 15), 105. The discovery was made that year at a psychiatric facility in the North of England. For controlled testing of active vs. placebo ECT, see Johnstone, EC et al (1980) The Northwick Park electroconvulsive therapy trial. *The Lancet* 20-27 Dec, 1317-1320. Two equivalent groups of patients both improved at four weeks, and no differences between actual and placebo ECT were found at the six-month follow-up.

The RCP's current ECT information pamphlet, cited at footnote 3 (above), asserts that live ECT has been demonstrated more beneficial than placebo ECT; however, although there are a number of research references at the foot of the pamphlet, none is concerned with that issue, and neither can we find any such evidence in the literature.

it is essentially a kind of placebo.²⁵ In which case, why not run through the routine but not switch on the machine? This would prevent the well-authenticated brain damage and other ill-effects caused by electroshock.

The use of ECT has declined in recent years, but it remains an ever-present option - or threat. At least 15% of the UK's psychiatric patients are still subjected to the treatment. There is also no legal reason why it should not become more popular again. Like psychosurgery, ECT was also devised under the auspices of a dictatorship: fascist Italy. It is therefore interesting that the following papal argument was made against the old widespread use of electroshock as therapy for almost any kind of psychiatric malaise:

A man may not undertake or permit medical acts, physical or somatic, which doubtless eliminate serious physical or psychic stains or infirmities, but which at the same time involve permanent abolition, or a considerable or lasting diminution of liberty, that is to say, of the human personality in its typical or characteristic function. The result is the degradation of man to the level of a being sensitive only to acquired reflexes or of a living automaton.²⁶

The shocking symbol of psychiatric power

Along with the chronic resort to psychiatric drugs, electroshock medicalises problems of stress and psychological and social conflict: the psychiatrist claims he deals with a purely medical matter by means of a proven medical technique. The place where the patient is taken for electroconvulsive therapy is known as 'the ECT suite'. Bizarrely, this implies everyone's easy familiarity with an uncontroversial procedure carried out in a relaxing manner in comfortably furnished rooms.

But of course, there is nothing cosy and mundane about passing a powerful electrical current through someone's head. No need to be a doctor to know that the brain is a particularly vulnerable organ. Everyone understands that it is the most essential component of a person's humanity, of the active personality. It is the locus of one's executive agency: it is where the pilot sits. Consequently, it is difficult to conceive of a bolt of electricity through the brain as anything other than an attack on the person's humanity.

For this reason, electroshock is the most terrifying token of psychiatric power. Consciously or not, it is bound to figure as an element in any psychiatric transaction in which there might arise questions of power and dependency - which is to say: *continuously*. The use of shock treatment - or the threat of its use - also punishes, coerces or distracts the person whose emotional, mental, or motivational deviance called down psychiatric intervention in the first place.

However, psychiatrists are not known for recognising the disparity between their claims for the therapeutic value of ECT and the lack of research evidence, or for admitting the harmful and possibly punitive aspects of the procedure. There are now few advocates of lobotomy, but shock treatment still attracts a substantial minority of supporters. And yet it cannot simply be a technical matter to use such violently invasive methods; inevitably, it is also a question of the exercise of social power and of what the technique *represents* to everyone involved. In reality, the employment of *any* so-said medical means to alter what a person thinks and does is always a matter of signification and social power. As the most tangible and frightening form of invasive treatment, however, electroconvulsive therapy is the technique which in mental health carries the greatest symbolic weight.

ECT certainly does something to the patient, but it cannot guarantee to produce the desired therapeutic effect. As we mentioned, research shows that shock treatment does not appear to give even temporary relief from depression for more than about one-third of those treated, while the majority of patients report ill-effects, and the great majority would refuse it in the future. Besides, it has been known for forty years that placebo ECT is just as effective as active treatment.

²⁵ We discuss the real and important psychological effect of placebo, with respect to lobotomising drugs, ECT and the entire psychiatric effort, in Chapter 8 below.

²⁶ Pope Pius XII, quoted in Frank, LR, op. cit. (n. 15), 131.

Why, then, does shock treatment remain popular with a significant number of psychiatric professionals, and every other official seems happy enough to tolerate its use? It seems to us that the technique plays a crucial ideological role within the mental health scenario, and especially within psychiatry. For it appears to demonstrate the arcane, modern, scientific-technical, and undoubtedly *medical* nature of the service; at the same time it announces the arbitrary, absolute and implacable nature of psychiatric *power*. Drugging may be used callously and to control psychiatric patients rather than to help them (as we witnessed in Chapter 4, above), but if he is to prevent patients from automatically viewing him as most likely an agent of social repression rather than a carer or healer, the issue of *the irrational use* of electroshock has to be addressed by anyone working in psychiatry.

Thomas Szasz pointed out the political and legal liberties taken at the point of the invention of electroconvulsive therapy. The first subject was found wandering lost in Rome, obviously a stranger to the city. He was 'lucid and well-oriented' but 'described with neologisms, deliriant ideas of being telepathically influenced, with related sensorial disturbances'. The police handed this man over to a psychiatrist for care and observation. By chance, this doctor was ready to test his new idea about shock treatment. No-one knew the patient's identity, so nobody gave consent - and certainly not the unfortunate subject. Nevertheless, he was subjected to electroshock, without anaesthetic. The first attempt to induce a fit failed, and the man quite reasonably asked the psychiatrist to stop. He was ignored, and the voltage was increased for another attempt. This continued until finally a seizure occurred. The doctor reported that he felt himself 'under great emotional strain [since we] felt we had already taken quite a risk'. He did not mention the strain and risk to the prisoner-patient.

In short, the first person on whom electroshock therapy was tried was neither a volunteer nor a regular (voluntary or committed) mental patient, with whose history, personality and family the psychiatrists were familiar; nor a prisoner convicted of crime subsequently declared mentally ill and under the jurisdiction of a court...²⁷

This is significant. Had he wanted to use them, the psychiatrist had legitimate access to plenty of patients diagnosed with schizophrenia. Yet it seems he preferred to reduce the risks to himself by experimenting on an unknown man from out of town who, at that moment, conveniently existed in a sort of legal and psychiatric limbo. Advocates of ECT sometimes say it is hypocritical and anyway too late to express any moral qualms - of course the unethical origin of electroshock is unfortunate, but its history should not disqualify a procedure which might be very useful. After all, doctors and other officials are harassed daily by the immediate problems of the chronically over-stretched mental health services. Amongst other 'quick fixes' (i.e., drugs), isn't the use of shock treatment reasonable?

Even if we ignore the manner of its historic 'discovery', it remains the case that there is no evidence that shock treatment is beneficial to many patients, or that its apparent occasional value outweighs the harm and distress it causes to the majority of patients who do not benefit. But what is certain is that *electricity is a terrifying symbol of sudden, arbitrary, elemental, irresistible and annihilating force*. To say 'electroshock' is to evoke gothic images of Frankenstein's laboratory, in which a mad scientist calls down lightning to jolt life into a misshapen and ill-fated individual sewn together out of dead body parts. In our imaginations, and in an emotional sense, the very depressed or catatonic psychiatric patient is also 'not alive': psychologically and socially, she too is a kind of grotesque and hapless 'dead' creature. At the same time, 'electroconvulsion' conjures images of electrocution: it signifies dicing with serious injury or death. These meanings and associations are unavoidable for anyone faced with the prospect of shock treatment.

Neither can this symbolism be dismissed as simply an emotional reading of the situation. By definition, the psychiatric patient is ill-fated and psychologically misshapen, existing in limbo, socially more dead than alive. Due to her distress and confusion - or due to the 'side-effects' of psychiatric medicine - she may well be dishevelled and actually appear misshapen, while severe depression or catatonia is a kind of emotional death. Besides, the physiological risks of shock treatment are not wild imaginings - they are stark matters of fact. Finally, like Dr Frankenstein, a

²⁷ Szasz, TS (1971) From the slaughterhouse to the madhouse. *Psychotherapy: Theory, Research and Practice* 8 64-67.

psychiatrist has absolute power over his subject. Standing on the safe side of the electrodes, it is not enough for officials to argue that the risks are negligible and that a patient's fears of harm or annihilation are groundless. The patient is already at the end of her tether, and now she is compelled²⁸ to submit to the great and normally dangerous power of electricity. According to the medical evidence we rehearse later in this chapter, patients do well to be fearful.

Nor should psychiatric officials discount the fantasies and magical notions which accompany the technique, which might persuade some patients to invite its use. Everybody wishes mental illness could be obliterated, and in the imaginations of the patients, just as much in the minds of the doctors, electricity might work an annihilating magic: believers hope that ECT will fulfil the fantasy of electricity 'killing off the badness inside the patient's brain'. The ritual, apparatus and ambience of the technique together speak of a kind of surgery worked by doctors and nurses who are pleased, at last, to be 'really' (i.e., visibly) 'doing something' about mental illness. Some patients positively wish for shock treatment and others report feeling better for it: shock-induced amnesia does sometimes appear to blank-out previously preoccupying anxieties. Again, submitting to shock treatment may satisfy a wish to die and be reborn as a 'cured' person, which is to say, as a person whose overwhelming problems have magically vanished. Another possible motivation is provided by the guidelines recommending that as the patient recovers from the treatment she is to be particularly well attended by nursing staff: pleasurable cossetting may serve the patient's desire to regress.

As well as ideas of death and rebirth, and no matter how much the officials may deny it, with ECT there are unavoidable connotations of pain and punishment. A psychiatrist may wish to punish, and a patient's desire for shock treatment may be due to a wish for mutilation or mortification of the self as punishment for guilty impulses (usually of a sexual or murderous nature).

This punitive aspect of shock treatment should not be brushed aside; psychiatric officials ought to be aware that the technique does damage the brain and that many patients do fear it. Here is the recollection of a woman who spent the years 1947 to 1954 in mental hospitals, diagnosed with schizophrenia:

Every morning I woke in dread, waiting for the day-nurse to go on her rounds and announce from the list of names in her hand whether or not I was for shock treatment, the new and fashionable means of quietening people and of making them realise that orders are to be obeyed and floors to be polished without anyone protesting and faces are made to be fixed into smiles and weeping is a crime..²⁹

In the meantime, modified (sedated) ECT was introduced and is now standard practice, but widespread fear of the technique is still reported by patients and ex-patients..³⁰ That few patients openly resist shock treatment may be due to the fact that every psychiatrist has the power, in order to credit his own fantastic beliefs, to *compel* his victims to accept any treatment he wishes for them - and in order not to antagonise him, his patients learn 'to lie in harmony with him'..³¹ Added to which, amongst doctors, usually advised by nursing staff, a wish to punish or exact retribution from particularly annoying patients cannot be discounted: research indicated that those patients least liked by psychiatrists were more likely to be given shock treatment..³² Moreover, in terms of behaviourist theory - that reductive approach to psychology which is highly regarded amongst psychiatrists - ECT

28 Every psychiatric patient lives under compulsion: whether or not a patient gives formal assent to treatment, it is unlikely that she does not feel compelled or is allowed a genuine choice. We discuss this later in this section.

29 Frame, J (1962) *Faces in the Water*. London: WH Allen, Chapter 1.

30 E.g., Mike Lawson (one-time Vice-Chair of MIND, and for many years often an incarcerated psychiatric patient) asserts that in his experience very few patients were *not* intimidated by ECT, and that most *did* believe it was consciously used as a threat by those in authority to get patients to comply with their demands. Lawson, M (1986) Talk. York: Campaign Against Psychiatric Oppression, 15 September. Also see text to footnote 10, above, which discusses the findings of the Mind survey.

31 Rolin, J (1956) *Police Drugs*. New York: Philosophical Library, 163.

32 Rabiner, EL et al (1961) Method of assaying doctor-patient tensions: its application in assessing the role of these tensions in the choice of electroshock. *Archives of General Psychiatry* 4 553-60. Quoted by Frank, LR, op. cit. (n. 15), 77.

should work precisely as negative re-enforcement: few patients undergoing a course of shock treatment will be unaware that the required result is a certain change in their behaviour. Perhaps this explains at least some of the short-term relief from symptoms that the technique sometimes seems to deliver.

As well as these considerations, we ought to be uneasy that female patients are more than twice as likely as males to be given shock treatment. Taking into account demographic factors and diagnostic differences, this is so disproportionate that it gives the impression of habitual carelessness towards women as compared to men, if not outright misogyny. Neither should pathological hatred of women be discounted. Here we enter the territory of psychoanalytic speculation. We might nevertheless entertain the hypothesis that there could be a motivated response to the hordes of 'unreasonable' or 'troublesome' women who, each working day, beset the doctors (who are usually men). Psychiatrists are not without their own emotional insecurities.³³ When we consider ECT, we should not ignore its spectacularly virile operation, and the possibility it gives for expressing unconscious feelings of hatred and revenge - for example, on mothers or on women in general. If shock treatment is simply one more useful technique, why are patients disproportionately likely to be given it if they are: female, elderly, working class, less educated or not Caucasian? Also, why are there 'hotspots' of its employment, linked with specific psychiatrists? Are these doctors unconsciously pursuing their own neurotic agendas?³⁴ And if there are any doubts at all about the technique, why is it still sometimes used on children?³⁵

All of these considerations point to the use of ECT in response to the unacknowledged yet motivated wishes of those who hold psychiatric power, rather than purely depending on patients' needs for therapy. In general, it seems to us that shock treatment may still be in use because it sometimes seems to give short-term benefit to a doctor or a psychiatric team harassed by patients or relatives, and because the apparently surgical-technical apparatus and rituals appear to demonstrate to everybody that psychiatry is undoubtedly an efficacious medical-scientific enterprise.

On the other hand, given the emotional and mental vulnerability of the patients and the compulsory or dubiously voluntary nature of much psychiatric treatment, the availability of shock treatment also tends to blight the whole of the mental health services. Whether spoken or unspoken, there is always the threat that the official carers and therapists are able and often willing to resort to the fearsome bludgeon of electricity. Since, in some degree or other, every psychiatric worker participates in decision-making processes that might well lead any patient towards a course of ECT, the availability of the technique undermines the project of reassuring patients and gaining their trust: to the extent that a patient fears shock treatment, to that degree care and therapeutic trust is compromised. (Psychiatric officials might not recognise it, but to that degree the patient also exhibits her lucid rationality.) Until electroshock is finally and definitively banned, and however much he protests his humane and liberal principles, no psychiatric official will be able to argue his way around the ever-present threat of resort to shock treatment.

Psychiatry throws a smoke-screen over the issue when it defends electroshock. In default of a consistent and clearly patient-centred strategy for dealing with psychiatric crisis, this obfuscation tends to perpetuate a sort of low-level, grumbling barbarism throughout all the practices of mental health care. Therapies which well-meaning professionals feel that they have no option but to employ - drugs or ECT - might sometimes work, in terms of somewhat changing the behaviour of certain patients. But there is little evidence that they improve mental health, in the reasonable sense of

33 Amongst medics, psychiatrists are thought to be particularly prone to suicide; however there is no sound research. A meta-analysis of 25 reliable studies found that physicians are as prone to depression as anyone else, and compared to the general population, male doctors were nearly one-and-a-half times as likely to commit suicide, and female doctors more than twice as likely. Schernhammer, ES & Colditz, GA (2004) Suicide rates among physicians: A quantitative and gender assessment (meta-analysis). *American Journal of Psychiatry* 161 12 2295-2302.

34 See text to footnote 4, above.

35 See: ECT used on children (1997) September *Newssheet*. Survivors Speak Out, 5.

helping patients to become less confused and less miserable. Rather, there is too often a sense of what Pope Pius XII feared: psychiatric treatment simply creates cowed, dependent and diminished human beings.

ECT is the most notorious form of psychiatric coercion. The issue of its use is not simply one of establishing the trust of those patients who are required to submit to that particular treatment, but of the long shadow it casts over *every* transaction in mental health care. In order to recover, a patient needs to be able to openly express her innermost thoughts and feelings. Yet any doctor or mental health official is able to initiate processes leading to a patient being forced to submit to a technique which is well-known to be controversial, harmful and upsetting. In which case, psychiatric patients might be wise *not* to trust their carers and therapists. Under the present circumstances, it is doubtful that many psychiatric officials ever get to know their patients very well.

It seems that the therapeutic intent of electroconvulsive therapy is precisely to disable the patient, to an extent, by disrupting her memory. Sowing seeds of distrust throughout the field of mental health is only an unintended and unacknowledged effect. Unless a patient is in the best possession of her wits, however, and unless she feels confident enough to honestly talk things out, how can any mental health worker help her to discover what is wrong, and begin to address her real problems? As an ominous agency of social control which can easily resort to the electric cosh rather than offer positive therapy, it is likely that psychiatry helps to perpetuate whichever kind of misery each patient presents - whether it be depression, paranoia, psychosis, obsession-compulsion... Like psychiatric medication, shock treatment does not begin to address causes; if there is any benefit, it is only short-term symptom-relief. No doubt, staff and patients *can* and do build mutual trust - but only in spite of the justified fears and suspicions of those patients who are more or less aware of the threat of ECT or more or less incapacitated by its effects. Therapy will remain an uphill struggle as long as shock treatment is an option.

This might be less of an issue were there not also the questions of compulsory commitment and treatment, and the fictions of voluntary commitment and consent to treatment. It is a Kafkaesque misrepresentation that when patients agree to the wishes of their psychiatrists those agreements are voluntary: in practice, patients are most often only able to 'exercise their free choice' in the face of a clear or implied threat that if they will not go along with what the officials wish, the 'necessary' medical attentions will anyway be forced on them. One experienced ex-patient maintains that it is routine to coerce 'voluntary consent' to ECT by means of threats, especially for patients held 'under a section': the stick of enforced commitment or treatment is accompanied by the carrot of less severe and prolonged punishment (treatment) if the patient will submit quietly and 'voluntarily' to whatever the doctors want.³⁶

If nobody could be committed to psychiatric care and all mental health assistance were actually voluntary, so would all treatment be freely chosen. The threat of shock treatment would then disappear: patients would submit to it if they so wished, and not if they refused - and the oppressive atmosphere of psychiatry and mental health care might begin to lift. As things stand, there are few genuinely voluntary psychiatric patients and none able to refuse a doctor's wishes. Consequently, the atmosphere which pervades psychiatry remains threatening and fundamentally untherapeutic.³⁷

Shock treatment is not a cure

In the light of the evidence of the ill-effects, and what we suggest about its dreadful signification, we feel it is not true to say that ECT is not such a terrible experience because it is modified by muscle-relaxants and an anaesthetic. Terrible for whom? The modifications will make the experience less harrowing for staff who have to manhandle and hold-down patients far less often, and are no longer forced to witness violent seizures. Perhaps shock treatment is nowadays less terrifying for everyone involved, including the patients. But it is still hazardous. People still die from it - never mind that these days the immediate cause is likely to be coronary or respiratory failure under the

³⁶ This is affirmed by Lawson, M, op. cit. (n. 28).

³⁷ We return to the problem of compulsory psychiatric incarceration and treatment in Chapter 28 (Volume 2).

anaesthetic.³⁸ Increased death rates for older patients are probably due to the fact that shock treatment interferes with the autonomic nervous system and hence the general metabolism, particularly to upset sleep and appetite, and to increase susceptibility to hypothermia.³⁹

Aside from the fears of every patient who might be forced to submit to the experience, there is considerable evidence that the unwanted effects of 'successful' anaesthetised ECT are not just temporary.⁴⁰ All the same, it might be debatable that memory-loss is the main problem for most patients, who already suffer from a surfeit of other problems. For those who find themselves under the care of a psychiatrist who favours shock treatment, the main problem becomes avoiding the treatment, or if they have already been treated, avoiding more sessions. Besides, the presence of an ECT machine must surely tempt psychiatrists or staff to threaten or coerce uncooperative patients. The public might like to imagine that every psychiatric official is so utterly professional that he is incapable of responding to a patient except with benign objectivity - but that would be unrealistic. Undervalued, under-resourced, and perhaps under-trained, officials cannot be expected to be the paragons that the public might like to imagine. Additionally, by its nature, psychiatric work is personalised, emotionally affecting and stressful. Interacting day in and day out, perhaps for months at a time, personal likes and dislikes between staff and patients are bound to arise, and over time these are liable to erode what might have begun as an official's professional approach, such that his attitude towards some patients may be coloured by distaste, hostility or fear.

Shock treatment is not an uncontroversial medical-scientific technique of proven value. Rather, it carries and embodies the weight of everything that anyone ever feared about both the legal powers of psychiatry and naked electricity - and with good reason. It is a possibility that, before a person commits any crime, psychiatry is able to catch and lock her up indefinitely, and do with her what it will. It can make her condition worse, perhaps drive her deeper into madness, and perhaps damage and maim her; it may even kill her. Anyone finding herself made into a psychiatric patient is able to appease her managers by employing simple behavioural and verbal formulae - by getting up and dressed every morning, by eating, by acting 'normally', and by saying that she feels a little better. For anyone who cannot or will not perform those tricks, electroshock mimics God's wrathful thunderbolt.

Apart from these considerations, the value of any medical treatment is normally measured by the rate of remission. This is not good for those who receive ECT as their 'appropriate' therapy: in terms of patients no longer needing psychiatric help, the technique cures nobody - at best it sometimes provides 'a breathing space'.⁴¹ As for a patient's best interests, then, the most that can be said is that shock treatment is able sometimes, and temporarily, to obliterate her awareness of having certain problems. Clinical studies which ask patients about the efficacy of ECT are hard to find. In one study, when patients who reported feeling better for the treatment were asked what they thought it did for them, the highest number responded that it was the fear of repeat treatments which spurred them to try to change the way they behaved.⁴² In other words, for those patients shock treatment was a kind of punishment rather than a kind of medicine.

Many doctors claim that ECT does help some patients recover from certain kinds of severe mental illness. Yet who is it that runs the clinics, and whose criteria of the utility of the treatment we are to

38 Neither the USA nor the UK has a national audit of ECT, let alone harm or deaths. Frank cites 384 ECT-related deaths reported in the English-language psychiatric literature from 1942 to 1977. See Frank, LR, op. cit. (n. 15), 153-156. Since these represent only the deaths written-up in research papers, there have undoubtedly been more, and during the last fifty years no new procedures have been introduced to reduce the risks.

39 See the evidence cited in Mills, H (2000) ECT: suicide and mortality, the myths and the research. *Asylum 12* 2 10-13.

40 See Thomas, P, op. cit. (n. 75, Ch 1).

41 See Breggin, PR, op. cit. (n. 107, Ch 1), 206. In 1985 the American National Institute of Mental Health and the American National Institute of Health both accepted that the effectiveness of ECT never lasts longer than four weeks.

42 See Friedberg, J (1976) *Shock Treatment Is Not Good For Your Brain*. San Francisco: Glide. We discuss some surveys concerning patients' feelings about the usefulness of ECT in the text to footnotes 10 and 13, above.

depend upon? Why, the psychiatrists. The effectual, technical ‘work’ that electroshock performs on catatonia or profound depression is best seen as blasting the patient’s problems out of her memory. At the same time, it teaches the patient that she can expect more of the same if she does not change her ways.

Or else, as we already suggested, some patients may feel better for electroshock because the idea of it is incorporated into their fantasies. For example, patients commonly believe that shock treatment is a punishment they deserve for the awful sins they imagine they have committed. Sylvia Plath expressed this feeling:

...I wondered what terrible thing it was that I had done.

Again, an entry in her Journal, in 1959:

Why, after the ‘amazingly short’ three or so shock treatments, did I rocket uphill? *Why did I feel I needed to be punished, to punish myself?* Why do I feel now I should be guilty, unhappy: and feel guilty if I am not?⁴³

It seems clear that ECT routinely works to persuade patients to comply with the demands of the social order in which they became so upset and confused in the first place. The evidence to support the use of shock treatment is poor, and it seems to us that psychiatrists and their fellow workers who support its use also fail to appreciate its symbolic weight: shock treatment is a highly significant ritual which invokes a modern kind of magic. It is supposed to solve the problem of a patient’s deviance - her bad thoughts, bad feelings and bad behaviour - by means of electrical annihilation. It is unlikely that the symbolism of the technique does not engage whenever a patient is persuaded (or forced) to submit to the violence of a bolt of electricity through the head. If a patient does believe that electroshock is helpful, however, it is possible that a wish for punishment persuades her of its value; when they would do better to have someone help them with their real problems, shock treatment is likely to confirm the fantasies of those patients who wish to be punished.

As we have seen in preceding chapters, the medical model of mental disorder is profoundly mistaken. *Most* psychiatric diagnosis and treatment is not based in the sound methods and proofs of scientific medicine. Specifically, the signs of a mental disorder are *not* evidence for an illness, psychiatric drugs are *not* generally more effective than placebo, and neither has shock treatment proved very helpful to most patients who have experienced it. The best that can be said for the technique is that it may sometimes solve the administrative problem of a patient’s compliance with the psychiatric regime. At its worst, ECT harms and even kills patients. It cannot therefore be an answer for any patient, however much it might please the authorities: it is a brutal attack on the brain, and as such it degrades the humanity of both the patient and the psychiatric officials involved.

These days, some psychiatrists do seem to appreciate that electroshock is contentious. Apparently only a small minority are responsible for its use on so many patients. There are no figures for the UK, but in 1998 it was employed by only 7.3% of all psychiatrists in the USA.⁴⁴ This begs the questions: If it is such a valuable technique, why do so few doctors employ it? And why do those few doctors seem to have such disproportionate influence on therapeutic decision-making?

Harm to the brain and to the person

Perhaps the successes of psychiatry have always been no more than the results of humane care and placebo, *in spite of* whatever damage is wreaked by the allegedly medical techniques. Brain trauma from shock treatment is not superficial, but somehow psychiatry regards this harm as *directly therapeutic*.

The electrical activity of human brain nerve cells is described in millivolts, or one-thousandth of a volt (0.001 volt). Nerve firings are on the order of 50-100 millivolts (0.050-0.1 volt). It is now clear that other means of brain-cell communication (called

43 Stevenson, A, op. cit. (n. 23, Ch 2), 148, quoting from McCullough, F, op. cit. (n. 23, Ch 2): *Journal for 1958*. (Our emphasis.)

44 Hermann, RC et al (1998) Characteristics of psychiatrists who perform ECT. *American Journal of Psychiatry* 155:7.

'electronic communication' by some) operate on fractions of a millivolt or one-tenth of a millivolt (0.0001 volt). ECT consists of 'shooting' approximately 120 volts through a person's skull and brain. Other factors bearing on the electrical reaction are amperage, skull resistance, and duration and type of current used... All this supposes the ECT machine is working properly.

Comparing ECT's 120 [or more] volts to the brain's natural 0.0001-0.1 volts, and given the extraordinarily sensitive electro-chemical nature of the human brain, it is not difficult to realise the gross overkill of ECT...[which] is a form of electrical brain-burn and short-circuiting, and that electrical destruction and damage in some degree cannot be avoided...

Thus ECT damages, and most likely destroys, brain cells with every shock. These cells, unlike those in the skin, bone or liver, have a limited ability to repair and reconstruct themselves. Every electric shock treatment damages the blood-brain barrier, as the brain's blood vessels take the brunt of the electrical assault. This causes haemorrhaging in the brain and a massive release of natural brain neurotransmitter chemicals. These effects manifest themselves in the totally confused, disoriented, and 'wiped out' condition of the person after being shocked.

The personal testimony of many who have undergone shock treatment attests to the fact that it can and does cause permanent memory loss. Languages, special skills, recollections of personal experiences can be blotted out of the mind as if an eraser had swept across a blackboard.

Despite the psychiatric party-line, that ECT causes only temporary memory loss and no permanent memory or intellectual loss, there is no hard evidence to back up these claims.⁴⁵

In summary, even one or two ECT treatments risk limbic damage in the brain leading to retarded speed, co-ordination, handwriting, concentration, attention-span, memory, response flexibility, retention, and re-education. On the psychological side, fear of ECT has produced stress ulcers, renal disease, confusion, amnesic withdrawal, and resistance to re-educative or psychological therapy. The research thus indicated that ECT was a slower-acting lobotomy with the added complications of shock-induced terror. As with lobotomy, it facilitated custody, but it damaged therapy. For the sake of the patient's present (or the staff's) his future was sacrificed.⁴⁶

What is the underlying rationale for electroshock? How is it supposed to improve a person's mental health, or his character or personality? Someone diagnosed with schizophrenia and given a long course of ECT during the 1950s reported:

It was explained to me finally that 'You have a new personality now.' But this statement was no explanation at all. It puzzled me more than ever since I had no awareness at all of any 'old' personality. If they had said, 'You *are* a new personality', it would have been much clearer. That would have fitted. They had made the mistake of thinking of a personality as some sort of possession, like a suit of clothes, which a person wears. But apart from a personality, what is there? Some bones and flesh. A collection of legal statistics, perhaps, but surely no person. The bones and flesh and legal statistics are the garments worn by the personality, not the other way round.

But who was the *old* personality whom they had known and assumed I was a continuation of? This was my first inkling of the existence of Phaedrus [the name the writer gives his lost previous self] many years ago. In the days and weeks and years that have followed, I've learnt much more.

He was dead. Destroyed by order of the court, enforced by the transmission of high-voltage alternating current through the lobes of the brain. Approximately 800 mills of amperage at durations of 0.5 to 1.5 seconds had been applied on twenty-eight consecutive

45 Richman, DL (1978) Brain Burns. In Frank, LR, op. cit. (n. 15), 136.

46 Morgan, RF (1966/78) The isolation, description and treatment of the pathological behaviour of ECT-damaged patients. Unpublished thesis, quoted in Frank, LR, op. cit. (n. 15), 77.

occasions, in a process known technologically as ‘Annihilation ECS’. A whole personality had been liquidated without a trace in a technologically faultless act that had defined our relationship [his relationship to his former self] ever since. I have never met him. Never will.

And yet strange wisps of his memory suddenly match this road and desert bluffs and white-hot sand all around us and there is a bizarre concurrence and then I know he has seen all of this. He was here, otherwise I would not know it. He had to be. And in seeing these sudden coalescences of vision and in recall of some strange fragment of thought whose origin I have no idea of, I’m like a clairvoyant, a spirit medium receiving messages from another world. That is how it is. I see things with my own eyes, and I see things with his eyes too. He once owned them.

These EYES! That is the terror of it. These gloved hands I now look at, steering the motorcycle down the road, were once *his!* And if you can understand the feeling that comes from that, then you can understand real fear - the fear that comes from knowing there is nowhere you can possibly run.⁴⁷

We do not suggest that this should be the last word on what is intended by shock treatment, or on its effects. Still, it is unusual to find a first-person account of ECT in any of the orthodox psychiatric literature. This description of the rationale and the experienced aftermath is from a biographical novel. What is appalling, and indicative of the general attitude of psychiatrists towards their patients, is that very little research into ECT has ever solicited their responses to treatment, or treated the data seriously when it has done so.⁴⁸ But why would it? Psychiatrists believe that their profession is a branch of scientific medicine: naturally, the medical expert wields the knowledge and technology, and the patient’s role is simply to accept any appropriate treatment. Just as a general patient’s report on how he feels is not very relevant when he undergoes surgery - of course it might hurt afterwards, but it will do him good - how can a psychiatric patient make a significant contribution to his own therapy? There is supposed to be only an objective, behavioural outcome: Does the patient function better for the treatment? The medical model maintains that a defining characteristic of any mental illness is the patient’s inability to understand what is wrong with him. ‘Hard-nosed’ psychiatrists would have it that electroconvulsive therapy legitimately works to ‘bring the patient round’ (‘quieten him down’ or ‘liven him up’); if that is by impairing some of his ability to remember or by making him curb his deviance for fear of further treatment, so be it.

By contrast, we argue that if the main point of therapy is to help patients rescue their humanity, the so-said scientific, objective and medical view of the matter is self-defeating: it mainly produces damaged, reduced and disheartened human beings. And if the psychiatric project is conceived only as forcing patients to become compliant, then we are against it: it is a form of state-sanctioned violence and terror.

Consider the use of shock treatment for mothers who suffer from severe post-natal depression. From a perspective other than that of orthodox psychiatry, ECT might appear not as a benign scientific-medical technique but the callous use of a blunt instrument to shut her up and force her to perform a particular gender-role and economic function. The myth of ‘hormone-changes-cause-the-depression’ supports the myth of a technical cure. If a woman goes into childbirth with problems and fears - and what mother does not? - why is it a wonder that she may emerge not in a condition of bliss but instead exhausted, utterly desperate for lost sleep, apprehensive, depressed, and perhaps at her wits end? Surrounded by what might seem to her like the sentimental clucking of friends and relatives, a new mother is rarely given sufficient sympathy, understanding or - most importantly - material assistance. Unless there are obvious medical complications, she is expected to vacate the

47 Persig, RM (1975) *Zen and the Art of Motorcycle Maintenance*. New York: Bantam, 84-85.

48 For example, see Weeks, D, Freeman, CPL & Kendell, RE (1980) ECT: III: Enduring cognitive deficits? *British Journal of Psychiatry* 137 8-37. This study reports hitherto hidden evidence of deaths by ECT, solicited patients’ experiences and feelings about treatment, finds enduring cognitive impairment and patients in fear of treatment - and then proceeds to discount the patients’ responses as therapeutically irrelevant.

hospital bed as soon as possible and go home. Perhaps she is permitted to rest for a day or so, but she is soon expected to resume her domestic duties. And so, after quite likely a physically and emotionally exhausting pregnancy (in which she was probably expected to keep working as long as possible *and* still do all the usual domestic chores), after many hours or perhaps a day or more of the hard and painful labour of giving birth (and quite likely disorienting drugging and painful surgery), and in the face of this real dicing with death, the enormous seed-pod of her body finally unburdens itself, only for the mother to find herself assailed by the demands of an immense new responsibility. Abrupt entry into motherhood or into responsibility for another child is also likely to bring to the surface unresolved issues from the mother's own childhood, or to magnify any problems with her current relationships.

From this perspective, 'puerperal depression' may be seen as an understandable response by a mother to the circumstances: physical and mental exhaustion, a variety of likely emotional factors, and distress in the face of the bizarre and unsympathetic expectations of all the unhelpful persons who surround her. The cure would best be loving encouragement, a sympathetic ear and as much rest and domestic help as possible. In more civilised societies, a woman is encouraged to recuperate for forty days after giving birth. She is pampered and massaged, reassured of her desirability, and not expected to lift a finger except to attend to the baby's nutritional needs. This is considered essential for the prevention of organic and psychological complications and disease.⁴⁹ Not so in our busy and distracted modern societies, which would rather engage the mental health services to deal with all the mothers who collapse under the weight of everyone's normal lack of concern for the ordeal of childbirth and the immediate aftermath, the changes their bodies undergo, and the many other life-changing ramifications of the event.

The use of electroshock on the elderly is just as redundant and hazardous. Often living in lonely isolation and suffering from bereavement and waning powers, confused old people also face the possibility of assault by ECT. Prime targets are the catatonic and the very depressed - mostly demoralised and exhausted women.

Even when it does appear to work, this last-ditch, 'quick fix' technique sometimes shows no favourable results for many sessions. The best that the research can offer is that ECT may sometimes work as a short-term 'holding operation'. In fact, the risks of suicide and imminent death are statistically greater after ECT than they are with any other forms of psychiatric intervention.⁵⁰

Sylvia Plath says she tried to commit suicide so as to avoid further shock treatment for her depression. She was frightened of the effects on her long-term memory. She said that sometimes she could not tell whether she was awake or asleep and dreaming, and that it was as if she had lost events, people and years from her life.⁵¹

Another famous victim of ECT was the Nobel Prize-winning writer, Ernest Hemingway. Due to recurrent bouts of depression, in 1961 he was detained at the prestigious Mayo Clinic. In short order he was given more than twenty shocks. Writing to a friend, he said it had destroyed his creativity.

...What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient. It's a bum turn, Hotch, terrible...⁵²

Hemingway committed suicide shortly after his release from the clinic.

As long ago as 1940, Harry Stack Sullivan criticised lobotomy, metrazol and camphor convulsion therapies, and electroshock.

These sundry procedures produce 'beneficial' results by reducing the patient's capacity for being human. The philosophy is something to the effect that it is better to be a contented imbecile than a schizophrenic. If it were not for the fact that schizophrenics... can and do

49 The Spanish-American birth quarantine or *cuarenta* [forty]. See Trueba, G (1994) *The Traditional Midwives of Mexico. Midwifery Today* 32 27.

50 See Thomas, P, op. cit. (n. 75, Ch 1).

51 Wagner-Martin, L, op. cit. (n. 16, Ch 2), 112.

52 Hotchner, AE (1966) *Papa Hemingway*. New York: Bantam, 308.

recover and that some extraordinarily gifted and, therefore, socially significant people suffer schizophrenic episodes, I would not feel so bitter about the therapeutic situation in general and the decortication treatments in particular.⁵³

Defenders of ECT tend to pose a spurious alternative. They argue that it is irresponsible not to use it when a patient suffers from a life-threatening mental illness that fails to respond to other treatments: somebody has to make the difficult decision about treatment, and what are the options when a psychiatrist is faced with a patient in a deep depressive crisis?

All the same, the apologists ought to allow that a serious psychological crisis rarely 'descends out of the blue'. By the time someone is very depressed or catatonic there is generally a history of mental healthcare interventions. We contend that many of the crises referred for ECT would simply not arise with such force if the mental health services were better organised. That is, if good physical and mental health were positively encouraged, and if, rather than habitual resort to medication, sympathetic listening and helpful counselling were introduced as soon as possible whenever someone presents with a psychological problem. At best, psychiatric medicine only alleviates symptoms; it does not address causes. This basic shortcoming means that the medical attentions, in themselves, rarely contribute to the solution of a person's problems. Rather, they may only delay the onset of a crisis and make it deeper; in this manner, the mental health services' own practices help to cause the 'necessity' for the desperate measure of electroconvulsive therapy. It would also help if psychiatry did not conduct all its business under a cloud of compulsion and fearsome treatments, but was more truly accessible, democratic and psychotherapeutic.

Shock treatment continues to play a pivotal role in psychiatric ideology. Where would the erosion of the doctors' authority end if they were to give up their absolute power to treat patients as they see fit? Psychiatrists cling to their prerogative to use ECT even though the medical evidence is not good. Not only is there no clear evidence for the efficacy of electroshock but there are further questionable implications. Its use is *very often* unethical: patients and families are routinely deceived as to the benefits and risks. Patients are also habitually coerced into consent, which is therefore not genuinely by free choice. When shock treatment was unmodified by anaesthetics, patients would often be dragged to it by main force - in those days, its use as a threat or a punishment was undisguised. Many patients still resist ECT, and compulsory treatment or bogus consent remains an outrage to civil liberties.

During the recent past, psychiatric workers in the UK who wished to 'opt-out' of performing duties around the administration of ECT have been denied the right to do so: nurses have been sacked and trainee nurses failed their accreditation.⁵⁴ Others, of course, have not had the stomach for that kind of medicine, and have simply abandoned a career in psychiatry. Doctors could have used their authority to make changes which would give an option of not participating in the administration of ECT. However, it seems that collectively they view the prospects of a 'conscience clause' as the thin end of the wedge - an incursion into their absolute control of the management of mental disorder. Apart from which, making it possible for psychiatric workers to opt-out would draw attention to the dubious nature of the technique.

No patient or ex-patient has ever successfully sued a psychiatrist or a mental health authority for harm caused by the administration of ECT. But any experienced psychiatrist is always able to recall a patient who has thanked him for being given shock treatment. This leads us appropriately, in the next chapter, to consider the effect of placebo with respect to all of psychiatry's medical techniques.

53 HS Sullivan, quoted in Frank, LR, op. cit. (n. 15), 15.

54 The sacking of trainee nurse Les Parsons was a high profile case. At Conference in 1984, the mental health service union COHSE was mobilized around his and other cases. Conference endorsed a Conscience Clause, and pledged to support any nurse victimized for refusing to participate in the administration of ECT. We have no knowledge of this clause ever being invoked.

Summary: clear evidence of harm but little for benefit

The most recent review of the available literature on the efficacy of electroconvulsive therapy was published in 2010. Wishing to promote evidence-based practice, the authors trawled worldwide for data in an attempt to identify every study comparing active with simulated ECT. They accessed *PsycINFO*, *Medline* and previous reviews and meta-analyses. Their review comprehensively debunks the belief - still held by many psychiatrists - that ECT 'works'.

Read and Bentall found that placebo-controlled studies show minimal support for the idea of the effectiveness of shock treatment for either depression or schizophrenia: that is to say, only in some studies and for some patients, on some measures, and sometimes perceived only by psychiatrists but not by other raters (i.e., perhaps less partisan assessors). Beyond the period of treatment, for either diagnosis, there is no evidence of benefit. There are no placebo-controlled studies which evaluate the hypothesis that ECT prevents suicide, and no sound evidence from other kinds of studies to support that belief. In addition, these authors review strong evidence of persistent and permanent brain dysfunction for some patients, mainly in the form of retrograde and anterograde amnesia which relates to ECT, not to depression per se. They cite the only reliable study which found a range of cognitive deficits (memory and attention) immediately following ECT, and that the number of shocks administered was the strongest predictor of gaps in autobiographical memory (retrograde amnesia) six months after the end of the treatment; there was also a significant relationship between the number of treatments administered and cognitive ill-effects; and the relation between the number of treatments and memory-loss was particularly strong for bi-temporal electrode placements, as compared to unilateral. Also, the best predictor of long-term brain damage from shock treatment is the number administered, and there is evidence of a slight but significant increased risk of death.⁵⁵ There are always some patients glad to report relief of their symptoms by ECT,⁵⁶ but in the light of the findings, Read and Bentall conclude that the cost-benefit analysis for electroconvulsive therapy is so poor that using the technique cannot be scientifically justified.

Earlier in this chapter we quoted a Pope speaking about ECT. Bearing in mind the numbing, dumbing and harmful physiological effects of psychiatric drugging as well, consider the opinion of an eminent Protestant thinker:

Of all the tyrannies a tyranny sincerely exercised for the good of its victims may be the most oppressive. It may be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience. They may be more likely to go to Heaven, yet at the same time likelier to make a Hell on earth. Their very kindness stings with intolerable insult. To be 'cured' against one's will, and cured of states which we may not regard as disease, is to be put on a level with those who have not yet reached the age of reason or those who never will...

You start being 'kind' to people before you have considered their rights, and then force upon them supposed kindnesses which no-one but you will recognise as kindnesses and which the recipient will feel as abominable cruelties.⁵⁷

55 Read, J & Bentall, R (2010) The effectiveness of electroconvulsive therapy: A literature review. *Epidemiologia e Psichiatria Sociale* 19 4 344-347; this particularly refers to Sackeim, H et al (2007) The cognitive effects of electroconvulsive therapy in community settings. *Neuropsychopharmacology* 32 244-254.

56 E.g., Mayers, A (2017) Drugs didn't work for my brother. Electroconvulsive therapy did. *The Guardian* 24 April; and in Plath's experience, it 'amazingly' cleared a deep depression (text to n. 43, above).

57 Lewis, CS (1970) The humanitarian theory of punishment; in Hooper, W (Ed) *God in the Dock*. Grand Rapids: Eerdmans, 292 and 294. Quoted in Frank, LR, op. cit. (n. 15), 71.

Chapter 8: PLACEBO & FAITH HEALING

There met Him out of the tombs a man with an unclean spirit, who lived among the tombs, and no-one could bind him any more even with chains, but the chains he wrenched apart and the fetters he broke in pieces; and no-one had the strength to subdue him. Night and day among the tombs and on the mountains he was always crying out, and bruising himself with stones.

And when he saw Jesus from afar he ran and worshipped Him; and crying out with a loud voice said, 'What have you to do with me, Jesus, Son of the Most High God?' For He had said to him, 'Come out of the man, you unclean spirits!' And Jesus asked him, 'What is your name?' He replied, 'My name is Legion; for we are many.' And he begged Him eagerly not to send them out of the country. Now a great herd of swine was feeding there on the hillside and they begged Him, 'Send us to the swine, let us enter them.'

So He gave them leave. And the unclean spirits came out, and entered the swine; and the herd...rushed down the steep bank and...were drowned in the sea...

And people came to see what it was that had happened. And they came to Jesus, and saw the demoniac sitting there, clothed and in his right mind, the man who had had the legion [of demons]...

...And He said to him, 'Go home to your friends, and tell them how much the Lord has done for you, and how He has had mercy upon you.' And he went away and began to proclaim in the Decapolis how much Jesus had done for him; and all men marvelled.

The Gospel of St Mark¹

Trust plays a crucial role in the remedy or management of incapacitating irrationality and emotional distress. We argue that if psychiatry can claim any success at all, it has yet to demonstrate that this is due to the potency of its medical methods and is not essentially the effect of placebo or faith. Since mental health treatment is governed by the medical model, nearly every aspect of current practice, theory and research is therefore called into question.

Faith healing

Stories of Jesus curing the sick give us a sense of mental disorder, psychological understanding and healing in the Ancient World. The tale of the Gerasene demoniac is especially interesting due to the detail in the description of Christ's use of His reputation to heal someone in the throes of an acute mental disorder. According to the Gospels, Jesus apparently performed many other miracles simply by interacting with the sick, rather than by using specific remedies. In addition, when He healed what seemed like physical maladies - such as raising the dead or curing the blind or lame, or when someone was miraculously healed by touching His coat - we would nowadays understand those as probably psychosomatic conditions, i.e., catatonias and conversion hysterias. In short, the charismatic presence of Jesus was so compelling that He was able to persuade many disturbed individuals to substitute hope and joy for anxieties so overwhelming as to have issued in a critical psychological disorder.

¹ Mark 5: 2-20. *The Holy Bible: Revised standard version* (1963) Oxford: Oxford University Press.

In the story at the top of this chapter, Jesus had just crossed the Sea of Galilee with His disciples. It seems He had prevented their boat from sinking by commanding a storm to stop. Then, as soon as they stepped ashore, they met the man with 'an unclean spirit' (or 'many spirits'). St Luke reports that this man was from the city and that he had neither worn clothes nor lived in a house for a long time. The 'unclean spirit' had 'seized him' many times. He had been kept in chains and under guard but had broken free and 'been driven by the demon into the desert'.²

Jesus' response was spectacular yet simple, achieving the immediate cure of a profound disturbance by means of an imaginative and magnanimous response. The Gospels are clear that the demoniac was wary of human contact and had no faith in normal rationality or the official powers respected by the sane. A modern psychiatrist would probably react to a similar situation with the attitude: 'This person is irrational. Science and experience tells me the best course of action. He will have to accept my solution or continue to suffer.' That sort of approach confronts head-on - and only with *asserted* rationality - the greater opposing force of desperate irrationality. As an attempted cure, it is unlikely to succeed. Instead of confrontation, Jesus used psychological acumen to take advantage of the logic of the situation, which included the demoniac's willingness to believe in the high authority of the Christ.

In this case, the possessed man does not appear to have been ill, in the organic sense. Rather, by all accounts he was fit and strong. Two thousand years later, though, orthodox psychiatry still believes in a somatic cause for every kind of worrying individual irrationality. We argue that this is a modern folly, the result of wishful thinking and blind faith in reductionist imitations of genuine scientific medicine. For, on the face of it, this demoniac was plagued by relentless and agonising self-conversations. The evidence for this - as with many contemporary psychotics - is that he frightened witnesses by shouting at his demons, his 'voices'. Since he was healed simply by conversation, we must assume that this man was possessed and beset *not* by an actual illness but by words - by self-conversations, by his own incantations, by what he imagined.

Of course, the demoniac's insanity was conditioned by the consensus of the society from which he was fugitive. It seems that he had sufficient possession of mind to understand who Jesus was - that He was a successful and popular healer and a holy man - and was provisionally willing to believe in Him. Any kind of faith is a compelling set of symbols of self-integrating purpose, a type of willing obedience: strong faith 'superintends the self-organisation of the personality and secures a sense of well-being'.³ Powerful symbolic systems are often based in magical thinking. By 'magic' we mean the real power which words and other symbols work on consciousness: magic is a form of persuasion based in a wish, and it incites emotional commitment by employing evocative postures, ceremonies, formulae, incantations, spells and charms - including the embodied charm of charismatic presence. The strength of belief in a purported remedy - whether traditional, magical or apparently scientific - responds to the urgency of the wish for a cure. Magic can only work by going with the grain of whatever the person is already willing to believe. Hence, Jesus' miraculous cure could work only in terms of the shared understandings of the time, which is to say, in terms of the rhetoric of the greater power of the Son of God over possessing demons.

Nowadays, of course, when faced with problems which seem to be internal to the person, most of us put our trust in Medicine. This lays us open to seduction by the arcane jargon and magical rituals of the mental health services. Naturally, this is said to be a technical discourse and routines necessarily developed from medical-science: the rhetoric and rituals serve to persuade everybody that psychiatric medicine must surely be appropriate because it is derived from Scientific Evidence. As we will see, however, rather than emotional and mental distress being ameliorated by medically active treatments, the evidence points as much or more towards magical relief by means of faith.

Charisma is only established and maintained by astute performance. Reputed participation in Godhead was not enough, in itself, to cure the Gerasene demoniac. Given that Jesus' reputation preceded Him, and that the man did believe that He was the Son of God, Jesus still had to convince

² Luke 8: 27-29. *The Holy Bible*, op. cit. (n. 1).

³ See Rieff, P (1966) *The Triumph of the Therapeutic*. Harmondsworth: Penguin, 4 and 13.

him to let go of his demons. The problem must have been that the multiple voices or multiple personalities which possessed the demoniac and caused him to suffer constituted a fearful power. Perhaps, in a way, they were also faithful old friends, the composers of a certain reliable sense in his world - they were what he knew. With the benefit of the psychoanalytic idea, we may understand the man's demons as a fantastic bulwark against whatever overwhelming original hurt he had been forced to repress from awareness: terrible though they seemed, the demons were fantastic protectors against a deeper terror. Even in the presence of such hope as the great Jesus, Son of God, the demoniac still felt that he could not afford to harm or offend his demons, and he was reluctant to have them banished - which modern 'scientific' psychiatry would invariably attempt head-on, but rarely with much success. The demoniac's voices begged not to be exiled, but to inhabit other bodies. Jesus humoured this request, and the herd of pigs which received the man's demons promptly stamped over a cliff and were killed.

This was a neat solution to the problem of the persecuting voices or personalities. Had they not asked to enter the swine? Was it anyone's fault if the demons/pigs then decided to commit suicide? Now the demons were gone, not just away, but for good. This was a weight off the man's mind. Simultaneously, and in place of his previous psychotic belief in the reality of the voices (demons) which had inhabited him, the cured man was able to substitute a powerful but socially acceptable faith - a 'reasonable faith', belief in the Messiah. Beyond this rescue of the man's imagination from his tormentors, Jesus also gave him something with which to occupy himself and help reintegrate him with the community - a positive and socially approved role, as witness and proselytiser of His power: '...And he went away and began to proclaim in the Decapolis how much Jesus had done for him...'

Until the rise of Science, it was generally believed that the soul could suddenly be possessed by God, by demons, by an ancestor or by the spirit of an enemy. Today, people like to think that they have outgrown that kind of superstition. Most of us believe there is a scientific explanation for every human event or process, ordinary or extraordinary, which - if ever we think about it - we imagine must finally be reducible to some or other purely material process. And yet, for most of us, scientific medicine is itself essentially a mystery, a kind of magic. Few of us really understand the workings of science, and few scientists know much of anything outside their own narrow field of expertise. It is therefore no surprise that few people dispute an allegedly medical explanation for the cause of mental disorder, and that most conceive of bizarre, agitated or depressed conditions of the person as the symptoms of *actual* diseases, i.e., as 'mental illnesses'. Most doctors and mental health workers certainly seem to believe it, *even though there is no evidence for an organic illness causing the symptoms of any functional mental disorder*. This lack of evidence does not prevent anyone from imagining that a person's spiralling euphoria or crash into depression - his emotional distress and confusion - 'must be' a medical event. In this view, *any* mental disorder 'must be an illness', i.e., the development of a disease or a genetic glitch. Yet, since it lacks proof, the belief that every functional mental disorder (mental illness) must have an organic cause is no less irrational and dependent on magical remedies than the idea of possession by demons. No matter how people may imagine the cause of mental disorder, and whether in times past or today, blind belief in unproven explanations and remedies can only be understood as due to an urgent desire for 'a greater power' to work the miracle of ending painful confusion and distress.

Authority is augmented by an aura of competence and calm assurance. Along with his technical training, an expert learns to adopt this kind of 'front'. The idea that effective help is at hand is already likely to encourage and lift the spirits of anyone he tries to heal, and the healer increases his chances of success if he *appears* self-assured and knowledgeable. Faith-healing, however, is a boot-strap operation in which the healer is his own authority and the agent of no technical or causal effect other than his own demeanour: healing is achieved *only* by means of persuading the afflicted to have faith in the power of the healer. A healer's reputation and his performances feedback in a re-enforcing cycle to build greater faith: as long as the faith-healer appears successful, his reputation and his powers can only increase. Where there is faith, there miracles may be wrought.

To the extent that medical science cannot cure every ill, there remain those who look to healers who claim the authority of a connection with God (or spirits or demons). These days, however, most

healers advertise themselves as trained in a scientific technique. Even so, natural and technical processes are hardly less mysterious to most of us today than they would have been to people two thousand years ago. We cannot tell what herbal remedies Jesus may have employed, but the impression from the Gospels is that He was able to perform miracles simply by way of His psychological acumen, His unwavering courage and self-belief, and the innocence of His ambitions. Taken at face value, the canny cure of the man possessed by demons demonstrates that the high degree of His virtue was matched by that of His intelligence: Jesus was a pure and compassionate magician.

Placebo

Placebo translates as 'I shall please'. A medical meaning was introduced towards the end of the 18th century. For a time, rather than denoting the production of a genuine remedy, it took the negative sense of any device (potion, ritual, formula, etc.) ostentatiously employed so as to trick the patient into keeping him satisfied with the physician's services. Now it means a kind of beneficial magic that accompanies the practice of medicine.

The medical utility of credulity and suggestion was recognised by some observers a long time ago. In 380 BC, Plato understood that 'the great error of the physicians...was the separation of the soul from the body. Despite any doctor's best efforts, curing the body is impossible without flattering the mind...'

If the head and body are to be well, you must begin by curing the soul... And the cure...has to be effected by the use of certain charms, and these charms are fair words; and by them temperance is implanted in the soul, and where temperance is, there health is speedily imparted, not only to the head, but to the whole body.⁴

By now many trials have shown that a physical illness or a psychological condition may often be remedied, to some extent or even completely, simply by the patient *expecting* to benefit from a medical procedure. Patrick Lemoine maintains that this is easily achieved by uttering what he and his colleagues call *the incantation*. For example, magnesium deficiency produces symptoms similar to those of anxiety, but magnesium is not licensed as a psychological remedy. Yet Lemoine reports that, like many other doctors, he often tells patients that he is going to prescribe magnesium for their anxiety. He finds that the patients are not only satisfied by this but they also get better; and if the dummy treatment is interrupted, they relapse.⁵

Brain-imaging for pain and some organic illnesses reveals electrical and chemical correlates to the placebo effect. In 1978 it was reported that placebo analgesia (pain relief) is a result of the release of endogenous opioids in the brain, and it has since been discovered there are also marked increases in dopamine and endorphin activity. We now know that the placebo response is also influenced by various cues. It is higher when subjects are given big colourful capsules rather than little white pills; pain is relieved more by red pills or capsules, but depression by blue ones; and placebo increases significantly in response to manifestly careful and sympathetic attention given to the patient during the clinical encounter, rather than a minimal, rapid, impersonal and purely technical exchange. Surprisingly, Feinberg also reports a significant placebo effect for irritable bowel syndrome even when subjects are told that they are being given a placebo. This seems to indicate that medical authority, in itself, has a significant placebo effect: so long as he does not bring bad news, contact with a sympathetic medical professional may already be remedial.⁶

4 From Plato's *Charmides*; quoted in Brooks, M (2010) *Thirteen Things That Don't Make Sense*. London: Profile Books, 166.

5 Brooks, M, op. cit. (n. 4), 167. This kind of deception is of course a hot topic for ethics committees. Unfortunately, Dr Lemoine's books are not translated from the French.

6 Levine, JD et al (1978) The mechanism of placebo analgesia. *Lancet* 2 8091 654-657; Lieberman, MD et al (2004) The neural correlates of placebo effects: a disruption account. *MayerNeuroImage* 22 447-455; Feinberg, C (2013) The placebo phenomenon. *Harvard Magazine* Jan-Feb.

It was during the 19th century that physicians began to use the term 'placebo' in a positive sense, to mean the amelioration or remedy of an individual's malaise by means of faith, persuasion or deception, i.e., by any device that the patient believes is medically active but is actually inert. Probably most doctors feel it is sometimes beneficial to deceive a patient by prescribing an inert device - a 'sugar pill' or some other procedure that looks impressive but is not medically active. For instance, a placebo may be used when the doctor can find no physical cause for a condition and thinks that it may well have developed due to the beliefs and emotional condition of the patient; the doctor wishes to raise the patient's morale and thereby aid recovery by persuading him that he is indeed being given all due medical care and attention, as indicated by the prescription of what looks like a regular remedy.

It seems to us that placebo is the effect of a medical kind of charisma. The Greek word 'charis' means 'a favour freely given' or 'gift of grace'. The notion of charisma was crystallised by St Paul, by way of the hero cults of Greece and Rome, in which the presence of past heroes and the gods was experienced as vibrantly real. Paul assured members of the early Church that the Holy Spirit would bestow on each believer one of a number of 'gifts for the common good': wisdom, knowledge, faith, healing, working miracles, prophecy, 'the ability to distinguish between [good and evil] spirits', 'various kinds of tongues', or 'the interpretation of tongues'.⁷ The Gospels tell us that Jesus exercised all but the last two of those facilities. By the Middle Ages, along with connotations of spiritual leadership, the notion of 'grace' that attached to certain heroes was close to our idea of charisma: 'compelling attractiveness or charm that can inspire devotion in others', and also 'divinely conferred power or talent'.⁸ The modern, secular meaning was introduced by Max Weber, when he identified three ways by which those who wield power over others are able to claim legitimacy: according to legal-rational-bureaucratic authority, achieved by election (or appointment by elected representatives) to an office with limited and well-defined powers; by traditional authority (normally inherited), such as the powers of tribal chiefs and kings; and by charismatic authority, where

[c]harisma is a certain quality of an individual personality by virtue of which he is set apart from ordinary men and treated as endowed with supernatural, superhuman, or at least specifically exceptional powers or qualities. These are such as are not accessible to the ordinary person, but are regarded as of divine origin or as exemplary, and on the basis of them the individual concerned is treated as a leader.⁹

Charisma is a relationship in which the hero is believed to possess an extraordinary gift. Those who are open to charismatic influence are gripped by powerful emotion and belief; these days, we might say that they are devoted fans - their faith in the hero is fanatic. A charismatic figure usually has a compelling 'back story', but every believer will agree that he has a powerful 'presence' - he is easily identified, has an irresistible aura of authority and self-possession, and often an intense and penetrating gaze. He appears strong-willed yet sensitive, powerful yet deferential - he often seems to take great interest in the concerns of any member of the public he meets, and since his time is obviously precious, this is flattering. At the same time, since any ordinary person permitted to get too close to the hero might discern a human weakness, meetings with members of the general public must be kept brief and otherwise offset by distance: charisma is constructed, and the hero's encounters with the public need to be stage-managed. Charismatic suggestibility is obviously due to the power of the imagination, but endorphins are bound to flow due to the excitement caused by the presence of the hero, or better, touching or being touched by him. Consequently, charismatic presence often seems to be healing: the adoring faithful certainly always *feel* better for it.

⁷ *The Holy Bible*, op. cit. (n.1), 1 Corinthians, 12: 1-11.

⁸ *Oxford English Dictionary* (1989) Oxford: Oxford University Press. 'Charisma' is not listed in the 1960 edition since the concept had not by then escaped from sociology into the general vocabulary.

⁹ Weber, M (1924/47) *The Theory of Social and Economic Organization* (Trans Henderson, AM & Parsons, T) Glencoe, Ill: Free Press, 328 and 358. 'Authority' denotes a social power to which people willingly acquiesce because they accept its legitimacy.

Charisma only exists in the eyes of the beholder; it is a kind of hero-worship. Whereas Mussolini and Hitler may have always seemed ludicrous but brutal megalomaniacs to all but a small minority outside their own countries, it is clear that they were genuinely idolised by millions at home. The charismatic leader embodies the ideals of his public. He emanates a kind of inner authority which followers readily acknowledge; he formulates and confirms their aspirations and tells them how to live, and is therefore perceived as a kind of saviour. Inhabiting the flatlands of our humdrum, compromised and careworn lives, we crave intensity and create these demigods: we idealise and make an idol of someone who appears to be able to satisfy a great need. The charismatic individual is often physically imposing, and always appears glamorous, charming, strong-willed and supremely talented; he is perceived as single-minded and full of self-belief, and no true believer is excluded from his vision. He is gifted at 'reading' people and getting them to acquiesce to his wishes; he woos his public by appearing to offer what they desire; he is articulate, highly committed, and exerts a moral authority - he is on a mission to solve a very difficult problem. The charismatic leader offers certainties where there is uncertainty, clear and simple answers to people's insecurities, to their fears, anxieties and wishes; he is perceived as active, expert and wise, with a firm and powerful vision. Charismatic political leaders emerge at times of apparently intractable social crisis, times of widespread need and anxiety. Although charisma must be achieved, it appears innate or God-given. A hero must regularly appear in public and, as the centre of attention, he is subjected to close scrutiny; charisma is therefore unlikely to succeed as a purely cynical construction, since any hint of inauthenticity immediately destroys the spell. The charismatic hero is a living icon: he is the representative symbol of a highly valued project.¹⁰

If he did not achieve pre-eminence by means of his intrinsic charisma, nevertheless it is likely to attach to the leader of any significant institution - for example, to kings, religious leaders, very successful businessmen - and celebrated healers. Medieval monarchs used to practice 'the King's touch', that is, healing by 'laying on of hands'. This illustrates the charisma of office. 'The royal touch' is documented from the 11th century, and in England it reached its peak during the reign of Charles II, when thousands received it every year. During the winter months (when there was a helpful reduction of the chances for cross-infection), any subject who was sick was permitted to offer himself to be cured by being touched or stroked. A monarch is God's anointed, so this kind of miraculous healing was by the grace of Christ. The royal touch had its own religious ritual, and was most often delivered to subjects suffering from *tuberculous cervical lymphadenitis*, known as scrofula or 'the King's Evil'. From the time of the Tudors it was used only for scrofula, which was not usually fatal and often went into spontaneous remission, so an apparent miracle was more likely. This practice demonstrated the legitimacy of the monarch's reign.¹¹ Under the sway of the Enlightenment, with the introduction of inoculation, and in opposition to all things Catholic, the royal touch was abandoned by the Protestant monarchs.

Charisma is often explained by reference to hypnosis. In 1774, when successfully treating a hysteric patient, Franz Mesmer thought he had discovered 'animal magnetism'. He was persuaded that some kind of invisible, magnetic-like natural energy flowed between objects, and maintained that he could channel this energy to effect cures (mainly of the blind and the lame). Mesmerism was a long-running sensation. Mesmer was known for being at pains to show great attentiveness to the patient, and for his intense and penetrating gaze. His method was to sit facing the patient, with their knees touching, and stare steadily into the subject's eyes. He would also hold the patient's thumbs, make 'passes' over her body with his hands, and touch or hold her head and thorax. This was more than a particularly good bedside manner, and there often seemed to be a scandalously erotic response from the patient - it was noted that most patients were women. Mesmer could not always work a cure,

10 Modern technologies multiply reputation by broadcasting, and thereby they multiply charisma. Obviously, there are different publics for different charismatic figures, but each embodies a certain principle in which many people take a great interest; the principle is likely to answer to some or other great anxiety, whether concerning adolescent identity (e.g., fashion, and Lady Gaga) or oppression (freedom, and Nelson Mandela).

11 See Krieger, D (2002) *Therapeutic Touch as Transpersonal Healing*. New York: Lantern Books.

and a French royal commission decided that he had not discovered a new 'physical fluid' but rather that any benefits were 'due to the imagination'. Meanwhile, JC de Faria concluded that mesmerism worked by the power of suggestion. His contemporary experiments seemed to indicate that 'animal magnetism' is 'an event taking place in the moral order', a mixture of suggestibility and authority, often aided by physiological means such as fatigue and 'a fixed look'; 'it is a kind of sleep, nothing comes from the magnetiser, and everything comes from the imagination of the subject'.¹²

Anyone who is seriously ill is also bound to suffer from uncertainty and anxiety. Under the auspices of modern scientific medicine, healing is very likely to benefit from the charisma of the medical office as well as from any purely medical effects: a patient already feels reassured, is 'in a better frame of mind' and is consequently physiologically better set-up for healing when he knows he is about to receive a reputable treatment. In other words, other things being equal, so great are our fears concerning illness and such is our blind faith in the benefits of medicine that a degree of charisma attaches to every doctor simply by the fact that he is certified medically competent, and presents himself as such. Beyond that, a doctor who is apparently exceptional - who is considered a great expert, or is particularly solicitous and reassuring, who exhibits a self-assured demeanour that matches patients' preconceptions of what a successful doctor should be like - such a doctor adds his own personal charisma to the project of healing the patient.

If a patient is given a placebo and his medical condition improves (or he perceives that it does), this is known as 'the placebo effect'. When someone seeks relief from a healer, exactly what he believes is unimportant so long it causes him to have faith in the healing: it is immaterial whether the patient believes in the efficacy of the intervention of God, spirits or Scientific Medicine. If placebo or faith healing is to work, it simply matters that the patient believes in the agent to whom he has turned.

Nowadays, in order to pre-empt deception, observer bias and placebo or nocebo effects, a standardised placebo is also required for 'double-blind' testing of any current or potential pharmaceutical agent, in any branch of medicine. (Nocebo - 'I shall harm' - refers to any apparently harmful effect from an intervention known to be medically inert.) So as to reliably calculate the effectiveness of a medical technique, until all the results are collected and processed, nobody involved in a trial - subjects, researchers or commissioning agent (e.g., a drug company) - must know which subjects received the active intervention and which the placebo.

It is therefore now well established that belief in the power of medicine influences healing. This can only be against the background of universal awareness of the proven efficacy of medical procedures which, in turn, are generally based in sound scientific evidence concerning the causes of illness. Obviously, the spectacular general medical successes of the last century-and-a-half are the basis for the belief in the benefits of medical psychiatry. Therefore it seems to us that if the charisma of medicine does very often work, and can be used as a successful psychological ploy when treating organic conditions, it must surely play *at least* as significant a role in psychiatry, where the problem is not the patient's physical condition but precisely his *psychological* condition - which includes the patient's perceptions and his attitude towards his world, including his malaise and its remedy.

Advocates of the psychiatric medical model have appropriated the appearance of the hypotheses, methodology and general style or 'tone' of medical science, and spuriously incorporated all of that into their ideology. Nevertheless, in matters of emotional or psychological crisis, the realities are quite different from those of the natural sciences. Furthermore, as we saw in Chapters 5 and 6, there is *no evidence* that the so-said medical techniques of psychiatry ever cure 'sick minds', in the same way that general medicine has proved that it can cure sick bodies. Instead, it seems clear enough that psychiatric healing - if and when it seems to occur - might well be exactly the same kind of healing as that performed by any religious charismatic. That is to say, it is faith healing. Psychiatry attaches its reputation to that of general medicine quite illegitimately - but also most persuasively. Therefore, since there is scant evidence for the efficacy of the standard treatments, where healing appears to be

¹² Franz Mesmer (2015) Wikipedia 24 July; Abbé Faria (2015) Wikipedia 20 May.

brought about by psychiatric medicine this might well be due to some other factor,¹³ very possibly the patient's blind belief that psychiatry's so-said scientific medicine can, will or does cure him.

Of course, anyone who believes in psychiatric medicine will find this argument shocking. All the same, the truth of the efficacy of medicine for mental disorders is hardly guaranteed by how many people *believe* that it works. As we saw in the two previous chapters, *there is no evidence that any functional mental disorder is the result of an organic cause,*¹⁴ *or that any kind of medical treatment for a functional mental disorder is significantly more effective than placebo or no treatment at all.* Instead, the lack of evidence for the utility of psychiatric medicine urges us to consider two other entirely plausible hypotheses: that, in the field of mental health, so-said medical remedies are simply persuasive devices employed in a wider process of *conversion* brought about by patients' blind faith in medicine; or that patients often recover anyway, for a whole variety of reasons, but the doctors (and everybody else) simply *assume* that it was the medical treatment which worked the cure.

Before discussing psychiatric placebo in more detail, we should emphasise that whether he is understood to be holy, a spiritualist, a magician or a physician who practices scientific medicine, faith healing is only achieved through the convincing performance of the healer. In this respect, there would seem to be two essential requirements of any faith healer (or doctor who successfully prescribes placebos). First, the would-be healer must seem to have a special talent, i.e., he must appear medically adept, or holy, or otherwise in possession of arcane or magical powers. Then, by dint of his own psychological acumen, he must keep persuading audiences that his powers work much more often than not; obviously, this is not achieved without apparently consistent evidence for the successful performance of feats of medicine, miracles or magic, or by offering plausible excuses for any failures.

Placebo and psychiatric remedy

We have seen that it is not at all certain that any of the psychotropic drugs work better than placebo.¹⁵ But unless proven by rigorous randomised double-blind tests, *any* psychiatric therapy is surely called into question by the placebo effect. One meta-study of 39 research papers found that the placebo effect for anti-depressants - the most widely prescribed type of psychiatric drug - is at least 50%. In other words, placebo is *more effective* than the active pharmaceutical agents, which on average only appear to account for 27% of any benefit.¹⁶ We also referred to evidence that administering an anaesthetic and simply giving everyone the impression that a patient is given electroconvulsive therapy is as effective as carrying out the active procedure; in other words, *it is just as convincing* to all involved.¹⁷ However, this research is unusually transparent. Historically, few psychiatric research studies have systematically incorporated adequate controls for the placebo effect; they seldom used a double-blind procedure, whereby neither the administrators nor the subjects knew whether treatment was active or inert.

Without recourse to divine or other colourful explanations, it is now generally accepted that placebo is a common phenomenon which works psychosomatically through the patient's belief that he is being given active medical treatment. This relieves his anxiety, in turn causing hormonal changes which facilitate the processes by which the body begins to heal (or the person to feel better). There are many studies indicating that in general medicine the power of suggestion is profound: belief alone appears to cure or alleviate various ills for between 30% and 70% of the cases researched. It is also well-known that the placebo effect increases if the device seems particularly

13 There may be any number of reasons why a psychiatric patient might recover his emotional and mental equilibrium, whether or not he undergoes a specific treatment, and perhaps despite the deleterious effects of treatment. According to orthodox psychiatrists, if a patient seems to 'get better' without treatment (or otherwise contrary to expectations), that is 'a spontaneous remission of the illness': i.e., they cannot account for it.

14 This lack of evidence is further explored in Chapter 12, below.

15 See text to footnotes 11, 12 and 28 in Chapter 6 above.

16 The Placebo Effect (1998) *What Doctors Don't Tell You* 9 6 6-7. This cites various studies.

17 See footnote 21, and the accompanying text, and footnote 22 in Chapter 7, above.

impressive, e.g., according to the size or colour of an inert pill or capsule. Again, patients in one study had exploratory operations while believing they had been subjected to actual surgery: 40% reported 'feeling much better'. Research also indicates that the more compliant the patient - the greater his faith in the competence of the medical authorities - the more he is likely to believe in the benefit of a placebo.¹⁸

In 1985 it was estimated that 35%-45% of all medical prescriptions were actually placebo, or at such a low dose that they amounted to placebo. Twenty years later, studies of large samples found that nearly half of all Danish doctors prescribed a placebo (or placebo dosage) ten or more times in a year, while a clear majority of Israeli doctors also did so, with 30% doing so at least once a month. Of the Israeli doctors who regularly prescribed a placebo, 94% found them effective.¹⁹

Most placebo research is in general medicine, often post-surgery and comparing placebo with pain relief by morphine or other painkillers. It now seems fairly certain that a positive play of the imagination (i.e., hope or expectation of benefit) has the power to release opioids and other painkillers which the body produces naturally. As regards a wide spectrum of diseases, however, recent meta-analysis disputes whether the placebo effect has any measurable existence. After inspecting more than 200 trials, which together included many thousands of patients and sixty different clinical conditions, the authors conclude that there is no evidence that placebo has a significant effect on health: objective measures, such as blood pressure or cholesterol levels, showed no placebo response. Although the evidence is not clear, the only area in which there might be an effect is pain relief - but of course pain is measured subjectively. On the other hand, PET brain scans do show a definite activation of the endorphin system after placebo injection, which means that, amongst other possible effects, patients certainly tend to *feel* better.²⁰

Meanwhile, in 2003, questions of the existence, potency and complexity of the placebo effect took an interesting turn with the publication of a study of the anxiolytic diazepam (Valium). Diazepam is used in both general medicine and for mental health. Introduced in 1963, throughout the 1970s it was the best-selling pharmaceutical in the USA, and it is on the World Health Organisation's short-list of essential ('core') medicines. The study reported a newly discovered placebo effect in relation to the use of diazepam in general medicine (after surgery). Patients' anxieties failed to abate when they were given the drug without their knowledge, and so it follows that diazepam is beneficial only when the patient is specifically told he is being given medication to help with his anxiety. This suggests that diazepam becomes active only when triggered or augmented by chemicals secreted in the brain due to the patient's *expectation* of benefit. This finding clearly calls into question every other kind of successful mental health medical treatment: how many others require placebo - expectation of benefit - in order to become effective?²¹

Whatever the problems of subjectivity with the many studies in which patients are asked to report their condition before and after treatment - for example their pain and its relief - evidence from PET brain scans seems to confirm that a patient's state of mind does matter: his *belief* that he is receiving active medical treatment triggers neurological and hormonal changes which form the optimal organic basis for recovery. Moreover, a functional mental disorder (mental illness) is precisely *not* a physical, objective condition; on the contrary, someone is diagnosed with a mental disorder when he displays worryingly aberrant behaviour, feelings and ideation *in the absence of any objective measures of disease*. And since mental disorder is precisely a subjective condition, why would placebo play a

18 The Placebo Effect, op. cit. (n. 16), 7. The article cites the relevant studies for this paragraph.

19 Brooks, M, op. cit. (n. 4), 167-168. In these cases, due to the ethical 'grey area' of lying to the patient, the placebos contained active ingredients, but well below levels recognised as providing any genuine benefit.

20 Hróbjartsson, A & Gøtzsche, PC (2010) Placebo interventions for all clinical conditions. *Cochrane Database Systematic Review* Jan 20 (This study included two previous placebo meta-analyses by the same authors.); Zubieta, JK et al (2005) Placebo effects mediated by endogenous opioid activity on μ -opioid receptors. *The Journal of Neuroscience* 25 34 7754-62.

21 Benedetti, F, et al (2003) Open versus hidden medical treatments: The patient's knowledge about a therapy affects the therapy outcome. *Prevention & Treatment* 6 1 DOI: 10.1037/1522-3736.6.0001a

lesser role in psychiatry than in general medicine (e.g., with respect to pain relief)? Rather, as we will demonstrate, it is likely that the general belief that worrying irrationality is a kind of illness (a mental illness) and everybody's faith in remedy by medicine combine to make it likely that placebo plays a major part in *any* kind of apparently successful mental health intervention.

And yet orthodox psychiatry insists on operating by reference to the crude reductionist notion that a person is essentially nothing but a physical body which happens to interact with other bodies and the rest of the environment - that he is the product of strings of unmediated stimuli and responses, purely chemico-physical causes and effects. This is an inadequate theory which ignores the evidence staring everyone in the face. Rather, a person is a wilful centre of a structure and dynamic of signification, imagination and intention, and cannot be understood without recognising how he is embedded in the social matrix: this is the terrain on which causes and remedies should be sought. To begin with, any mental state (mental disorder or otherwise) can only be inferred from symbolic interactions. A person does not exist only autonomically: he lives in consciousness and through purposive activity, and often in opposition to the direct reflexes of the organism's somatic or metabolic processes. Hence, any mental state (e.g., psychological disorder) might persist however much the organism is assailed by chemicals or electricity. In large part, a person is *constituted* in his attitudes and beliefs. As likely as his mind will be changed as a result of chemical or physical psychiatric interventions, *the person* may stubbornly persist, through organic damage and sometimes unto death. If psychiatry has an impact on any particular mental disorder, to the extent of appreciably *changing the person's mind*, this will always involve persuasion or coercion. Persuasion may be facilitated by respite and sympathetic care, and by medical treatment that everyone agrees is beneficial (and is not experienced as distressing); coercion may proceed by threatening or restraining the patient, by subjecting him to painful or distressing treatment, or by depleting his organic resources by means of drugs or electricity.

In the two previous chapters we saw that the medical techniques of psychiatry are by no means directly effective as chemical or physical agents. In which case, perhaps a major defining aspect of the psychiatric encounter is rather its symbolism: what is important is not what psychiatric medicine actually does to the brain so much as what everybody *believes* that it does.

After working with children for many years, the psychoanalyst Melanie Klein was persuaded that everyone's primal anxiety is for his own integrity. She argues that when the infant is deprived of the mother or breast

...[he] reacts with a temper tantrum and the fantasy that goes with the tantrum is to tear everything out of the mother's body... The child then fears retaliation for these impulses, i.e., that everything will be scooped out of its own inside.²²

Thereafter the child (and later the neurotic or psychotic adult) not only fears and is frustrated by the loss of succour but is also anxious for the integrity of his body. He begins to fantasise restitution, expressing a potent wish for protection and for his own indestructibility from the 'bad forces' that he imagines exist within him or around him.

This psychoanalytic perception throws light on the symbolic import of the routines - or rather, rituals - of psychiatry. All of us may suffer from anxiety for our integrity, but psychiatric patients are likely to be very much more troubled. Meanwhile, a psychiatrist is expected to operate with scientific medicine on what is 'in' the patient and 'causes' his mental dysfunction. In the logic of wish and myth, it is self-evident that a technical operation on a 'bad', 'malfunctioning' or 'deficient' brain cannot be performed successfully by an agent who might not be trustworthy due to unfitness, fallibility or any other imperfection. The apparently objective, scientific and medical demeanour of the physician - indicated by his confident self-presentation (and classically by the clinician's white coat and stethoscope) - speaks of the incorrupt, altruistic, highly-trained and technical work that he performs: at work, the doctor is an efficient healing-machine. It is as if, by means of long and exhaustive medical training, he is special amongst men for having purged himself of his self-

22 Klein, M (1937) The psychoanalysis of children. *The International Psychoanalytic Library* 27. We discuss psychoanalytic theory in Chapters 21 and 22 (Volume 2).

interested and fallible humanity; it appears that he has divested himself of his 'bad' insides - his ignorance, his fallibility and his all-too-human biases and motives - and filled himself up with pure, objective, technical expertise.

This interpretation of what a reputable doctor appears to bring to the encounters with his patients is confirmed by anthropological evidence.

The profession...of the medicine man, this nucleus of all primitive societies, 'originates...on the basis of the infantile body-destruction fantasies ...'.²³

For example, Australian aborigines used to believe that a healer's insides were special by being incorruptible - that instead of corruption and faeces, the healer was full of certain valued objects. They believed that during a medicine man's training, the spirits removed his intestines and replaced them with pebbles, crystals and rope, and sometimes a little snake endowed with power.²⁴ They imagined that foreign sorcerers shot diseases into people, and so the healer - a benign sorcerer - had to act differently and must not penetrate a sick body. Rather, the primal fantasy element of the valuable-body-contents-torn-out-of-the-mother returned in the healing technique: the patient could only be restored to health by the medicine-man sucking, pulling, or rubbing the badness out of him.²⁵

Modern folk, of course, imagine that effective treatment for any alleged constitutional or invasive disease - such as a so-called mental illness - must take the form of scientifically precise chemical concoctions, surgery, or the action of some kind of shiny machine. As long as a technique *appears* medical, we are willing to believe it can attack and destroy, or cut out or overwhelm and drive out the badness inside the patient, and in its place insert goodness - good medicine, succour (mother's milk). However, we have seen that there is no evidence that psychiatric medicine is based in sound science, or that it is *actually* beneficial. In which case, encounters between doctors and people said to 'have a mental illness' are essentially neither medical nor scientific. Like relations between medicine-men and sick or disturbed aborigines, mental health relations are mediated by myth and magic. And what is known as 'psychiatric help' is a kind of micro-politics around the management of individuals who go into psychological crisis. By preference, this management is conducted by way of a persuasive rhetoric which asserts the objective truth of the various mental health myths; failing that, psychiatric management is imposed by force.

None of this is very novel. More than fifty years ago the psychiatrist Jerome Frank recognised that every functional mental disorder is a kind of demoralization, the expression of conflicts within the person, and between him and society. Someone who is desperate is more likely to be open to suggestion: if psychiatric medicine works, it is because the patient, as well as everybody around him, wishes and believes that it will work. Frank suggests that if the placebo effect is the main factor in all psychiatric remedy - and he thinks it is - then the psychiatrist is no more than a latter-day witchdoctor or shaman. The same applies to any other kind of supposedly scientific therapist or healer - Frank points out the shamanistic elements common to the various schools of psychotherapy. Moreover, as well as being barely distinguishable from the spirit-healing rituals of primitive societies, the routines employed by psychiatry and the various kinds of psychotherapy are little different from the methods of religious revivalism or totalitarian 'thought reform'. Whether carried out by a psychiatrist, a behaviourist psychologist, a psychoanalyst, a shaman, a Christian Scientist or anyone else who heals

23 Campbell, J (1949/1993) *The Hero With A Thousand Faces*. London: Fontana, 174; Campbell quotes from Roheim, G (1943) *The origin and function of culture. Nervous and Mental Disease: Monograph 69*.

24 It is interesting that a popular medical logo is the ancient Greek symbol for medicine - a snake entwining the Rod of Asclepius. A rod, staff or wand is an obvious symbol of power, but a serpent is ambiguous: it emerges from 'the underworld' as an elemental, mobile digestive tract; by shedding and renewing its skin, it symbolises rejuvenation; and its venom reflects the ambiguity of drugs, which may heal or harm - as reflected in the Greek word *pharmakon*, which equally means 'drug', 'medicine' and 'poison'. In earlier times, products derived from the bodies of snakes were thought to have medicinal properties. The Greeks knew that snake venom can be fatal if it enters the bloodstream but could often be safely imbibed, and was sometimes used medicinally.

25 See Roheim, G, op. cit. (n. 23), 48-50.

by persuasion and ‘smoke and mirrors’, the person is reintegrated into the life of the group by means of faith rather than through procedures based in science and reason.²⁶

Implications for treatment, theory and research

Since placebo or faith plays a major role in both general medicine and psychiatry, we ought to seriously consider the following questions and propositions:

- Any apparent improvement in a mental disorder could be either a placebo effect or that inexplicable kind of recovery which doctors call ‘spontaneous remission’. Regarding any psychological condition diagnosed as a mental illness, amelioration or cure could never be *only* or *directly* the effect of medicine; it cannot avoid the vital influence of emotional, cognitive and social factors which medical psychiatry fails to acknowledge and incorporate into theory and practice. ‘Spontaneous remission’, for example, simply means that the patient recovers but without treatment, and no-one can imagine how or why that could be. This does not mean that reasons for recovery could not be discerned if only officials would admit the decisive significance of extra-medical factors - for example, events or changed circumstances in the patient’s life.
- We have seen that there is no evidence that any psychiatric technique is more effective than placebo; rather, there is evidence that the more spectacularly ‘medical’ its appearance, the greater the therapeutic effect of a placebo.²⁷ We reviewed the example of electroshock: since *the full effect* is apparently achieved when the machine is inactive,²⁸ it must be that the combination of apparatus, ritual and rhetoric impresses everyone with the *appearance* of medicine; in which case, it is likely that patients who seem to improve after active ECT may do so *in spite of* being caused brain damage and cognitive impairment. It therefore seems likely that, as long as they were assured by officials that they would certainly feel a benefit, patients would show just as much improvement if they were routinely subjected to any other very convincing medical charade.
- What should be well-known about the placebo effect ought to have far-reaching consequences for psychiatric theory and research. If faith and placebo are so powerful, how can research into the comparative efficacy of the various psychiatric treatments meaningfully separate out the experimental variables? Until very recently, few researchers seem to have adequately taken this into account: it seems that most psychiatric drugs studies have little scientific value because they fail to provide proper control groups, or test against placebo.²⁹ Besides, at a critical moment in a patient’s life, kind and wise or encouraging words from some or other sympathetic person might effect a crucial alteration of his mind and attitude, thereby catalysing a ‘spontaneous remission’. As regards any kind of statistical research, psychiatric experts have yet to face up to the difficulties of weighing this kind of informal and unquantifiable sympathy, solidarity and understanding against specific quantities of medication, so many sessions of ECT, or (say) a series of six 50-minute counselling sessions given to the patient when he may not be receptive to change, or with a therapist lacking in sympathy or empathy.
- If the placebo effect is not only real but often *more powerful* than active treatments, then the whole range of psychiatric medicine is mainly *the appearance* of remedy. Since this is indicated by studies in the field, every doctor should know it; it is only wishful thinking and blind faith in medicine which prevents them from recognising the implications of the research. Of course, acknowledgement of the redundancy of much of the treatment would call into question the status of physicians as unquestionably the leading experts of every kind of mental disorder.
- A disturbing consequence of the medical monopoly of the management of mental disorder is that drugs and shock treatment are routinely administered *even though* they are known to be potentially distressing, harmful and disabling. Psychotropic drugs and ECT have real neurological

26 Frank, J (1963/73) *Persuasion and Healing: A comparative study of psychotherapy*. Baltimore: Johns Hopkins University Press.

27 See the previous section: Placebo; and also text to footnotes and 11, 12 and 74 in Chapter 6, above.

28 See text to footnote 21 in Chapter 7, above.

29 For example, see text to footnote 28 in Chapter 6, above.

and other organic effects, and this may help to make them convincing placebos even though their impacts on the organism are hazardous. They are often addictive and frequently cause long-term organic harm, and, at best, provide only short-term psychological benefits to a minority of those receiving treatment. Furthermore, they do nothing to address or change patients' underlying psychological, social or material problems, but much to divert attention from them.

- All this implies that the techniques of orthodox psychiatry are administered not to help or cure the individual but rather to alter his mood and persuade or compel him to change his beliefs and behaviour. At the same time, so-said medical-scientific techniques act magically to reassure not only the patient but also psychiatric workers and other interested parties, such as family members and neighbours. And while everybody is persuaded that medicine is the necessary response to the alleged illness, the problems which triggered the patient's crisis tend to remain unaddressed.
- Recognition of the part played by faith in the amelioration of mental disorder ought to have profound implications for the distribution and employment of the powers to manage very worrying mental disorder. It might seem politic for doctors to ignore research findings about the dubious efficacy of the standard treatments, as well as for other officials to ignore the systematic dissimulation of medical expertise: all parties might continue to exploit the willingness of patients to respond positively to the advice and ministrations of anyone they take for a genuine medical authority. On the other hand, a psychiatric patient is already alienated and confused, and it might be better not to lie to him and instead offer an alternative and more useful, non-medical response. This option would involve the doctor forfeiting his role as ultimate arbiter of every decision concerning care and treatment: he would become simply another member of the mental health team, albeit an important one.
- There is also a darker side to the trust a psychiatric patient (and anyone else) might place in those who organise his care and treatment: when dependence and blind faith are intrinsic features of mental health processing, conditions are ripe for the exploitation or abuse of patients by ignorant or unscrupulous professionals. The profession has not always proved it is prepared to prevent or remedy abuse, whether deliberate or simply casual, thoughtless and routine.³⁰
- This leads us to pose the question: To the point of phobia, why is psychiatry so incurious about *the person*, and only wishes to work on his brain with chemicals or electricity? Why the fanatic urge to measure aspects of the organism in the most minute detail, and yet such outright refusal to allow significance to important aspects of the person and his social context? (We discuss this mental disorder of the psychiatrists in detail in Chapters 11 to 14, below.)

Placebo works where there is faith in medicine. It is not only gullible patients and the lay-public who subscribe to an irrational belief in the efficacy of psychiatric medicine. So do the professionals: due to his commitment to his role, a mental health official is likely to have as great and as blind a faith in medicine as anyone else. As long as the medical model dominates everyone's thinking, knowledge and research in the field will continue to be based in false premises and flawed logic.

The main thrust of psychiatry is an assault on the patient's brain. This only impedes his connection to the very resources he might otherwise call upon in order to pursue a more appropriate remedy for his wayward thoughts and feelings. Of all the psychiatric medicines, the most certain in their action are those which induce sleep - the vacancy and inactivity of the person; many psychiatric patients also find sedation the most welcome immediate intervention. When they do 'work', anti-psychotic drugs seem to do so by poisoning the body and invading the brain's receptors and transmitters, thereby inducing lethargy and sluggishness; like alcohol and cannabis, the anti-depressants lower inhibitions and raise the person's mood; electroshock burns out brain cells and impairs the memory, and this may temporarily relieve the patient of the weight of his preoccupations.

30 See footnotes 10, 25 and 26 in Chapter 10, below (and the text to them), the discussion to footnotes 76-87 in Chapter 14, and also note 50 to Chapter 15, below.

But none of these treatments, in itself, can cure a profoundly disturbing emotional or psychological condition.

In any branch of medicine, the application of an apparently scientific technique tends to alleviate anxieties and calm everyone down.³¹ If, as seems to be the case, a positive attitude often plays an important part in remedying physical illness, faith and placebo are factors which should not be ignored. And yet whatever a patient who has a real illness thinks or feels - about his body, the illness and the treatment to which he submits - it is by no means always decisive to the course taken by the illness. When a patient with a real illness *feels* better or more optimistic, his positive attitude might assist healing by triggering beneficial hormonal effects - but just as likely it might not. General medicine responds to processes which are indisputably organic and follow their own course relatively (or often completely) independent of the emotional disposition or attitude of the patient. For any physical illness there is also generally a high degree of medical consensus concerning the cause and any possible remedy.

This does not apply to the functional mental disorders (mental illnesses), for which, by definition, no organic cause is apparent. The precise and defining feature of such a disorder is that no indication is to be found anywhere in the brain or metabolism: each is no more than *a particular deviant behaviour and reputed or reported irrationality*. The great majority of psychiatric patients suffer from a functional mental disorder. As distinct from true illness, what is known as mental illness is not a diseased condition of the brain or body; it is an undesirable disposition of *the person*. This sort of disorder is therefore not a matter which may be discovered by any physiological test, but only by *psychological* analysis.

In which case, a mental health condition is not determined by any kind of physiological test: it is diagnosed only according to whatever the person suffering from the mental disorder *feels* and *thinks*. After getting pills from a doctor - or shock treatment, or a placebo, or after simply visiting a doctor and getting a sympathetic hearing and some encouraging advice - if a patient then feels better, or seems more coherent or in more competent command of himself and less detached from reality, *to that extent his diagnosed mental disorder is already in remission*. All that is then required is that this better feeling and improvement in his mental state should not then evaporate; and that can only be a matter of 'keeping up the good work' - whatever that work may be - thereby hopefully preventing a relapse. In the last few chapters of Volume 2 we enlarge on the idea that therapy is best achieved by helping the person to help himself to understand and cope with whatever causes him overwhelming anxiety.

A case of placebo or psychiatric faith healing?

It seems to us that confirmation of the power of faith is found in Kay Jamison's narrative of her resort to psychiatric medicine for relief from appalling manias and depressions.

Jamison says that for a long time she resisted seeing a doctor, preferring to cope with the distress on her own. Of course, she did not relish the stigma that comes with a mental illness diagnosis, but she worked in psychiatry and was well acquainted with the claims of the dominant medical model. Accordingly, after years of suffering, and having been caught-up once again by an extreme and terrifying mania, she went to see a particular psychiatrist who had already impressed her when she was a student.

My psychiatrist opened the door and, taking one long look at me, sat me down and said something reassuring. I have completely forgotten what it was - and I am sure it was as much the manner in which it was said as the actual words - but slowly a tiny, very tiny, bit of light drifted into my dark and frightened mind...

31 Apart from the evidence cited in this chapter, also see John Modrow's claim: text to footnote 1 in Chapter 6, above.

...I answered yes to virtually all his questions [checking off the symptoms of mania], including a long series of additional ones about depression, and found myself gaining a new respect for psychiatry and professionalism.³²

Jamison was much affected by the calm and careful certainties of this esteemed colleague.

Gradually, his experience as a physician, and self-confidence as a person, began to take effect *much in the same way that medications gradually begin to take hold and calm the turmoil of mania* [our emphasis]. He made it unambivalently clear that he thought I had manic-depressive illness and that I was going to need to be on lithium, probably indefinitely. The thought was very frightening to me...but all the same I was relieved: relieved to hear a diagnosis that I knew in my mind of minds to be true. Still, I flailed against the sentence I felt he had handed me. He listened patiently...to all of my convoluted, alternative explanations for my breakdown - the stress of a stressed marriage, the stress of [a new job], the stress of overwork - and he remained firm in his diagnosis and recommendations for treatment. I was bitterly resentful, but somehow greatly relieved. And I respected him enormously for his clarity of thought, his obvious caring, and his unwillingness to equivocate in delivering bad news.³³

Here we must pause to comment that whatever Jamison thinks that she 'knew in her mind of minds', the diagnosis of an *illness* called manic-depression (bipolar disorder) which requires lithium medication is not supported by any scientific evidence: along with most people, she only subscribes to an unfounded belief. Having trained in psychology and then worked in psychiatry, and though for years she resisted the label 'mad' or 'mentally ill', she was primed to believe that she was simply so unfortunate as to 'have an illness' called manic-depression, which can only be contained by a certain powerful medication. We can guess that Jamison wished to believe this since, as well as giving her hope for medical respite or cure, belief in an organic cause for her malaise relieved her of the awful responsibility for it.

We must also point out that, although it was misinformation, so long as she was disposed to believe in the efficacy of psychiatric medicine, and all the accompanying rationalisations, the doctor did not bring 'bad news' at all. Actually, it was the kind of news she wished to hear: it relieved her of a major anxiety, that is, responsibility for her uncontrollable thoughts and behaviour.

The doctor then proceeded to provide her with regular emotional or moral support.

Over the next many years...I saw [the psychiatrist] at least once a week... He kept me alive a thousand times over. He saw me through madness, despair, wonderful and terrible love affairs, disillusionments and triumphs, recurrences of illness, an almost fatal suicide attempt, the death of a man I greatly loved, and the enormous pleasures and aggravations of my professional life... [H]e saw me through the beginnings and endings of virtually every aspect of my psychological and emotional life.³⁴

Jamison informs us that she will be on lithium permanently. We must be blunt: in spite of what the psychiatrist declared and she wishes to believe, her account makes it clear that lithium was a poor remedy. She is explicit about the recurrence of her manias and depressions over the years, and yet apparently she took this hazardous medication almost continuously. Lithium salts are dangerously toxic; Jamison is clear about the seriously debilitating and incapacitating effects on her body and her intellectual functioning.³⁵

But she is also thankful to have met a sympathetic psychiatrist who provided her with a plausible story about her aberrant mental states and behaviour - a story she would prefer to believe. He became

32 Jamison, KR, op. cit. (n. 6, Ch 2), 85-86.

33 Jamison, KR, op. cit. (n. 6, Ch 2), 87.

34 Jamison, KR, op. cit. (n. 6, Ch 2), 87; also see 93-95 and 153 for a comprehensive and vivid account of the unrelieved and overpoweringly deleterious effects of lithium on her somatic and intellectual functioning. We discuss Jamison's case in Chapter 6 above, in the section: Patients' experiences of psychiatric drugs.

35 Jamison, KR, op. cit. (n. 6, Ch 2), 93-95 and 153.

her regular psychiatrist, and she became emotionally dependent on him. This was not just any old shrink, however. He was the chief resident of a psychiatric institute, and she describes him as

...tall, good-looking, and a man of strong opinions, he had a steel-trap mind, a quick wit, and an easy laugh that softened an otherwise formidable presence. He was tough, disciplined, knew what he was doing, and cared very much about how he did it. He genuinely loved being a doctor, and was a superb teacher... an island of rational thought, rigorous diagnosis, and compassion in a...situation where...vapid speculation about intra-psychic and sexual conflicts prevailed.³⁶

This reveals that Jamison is aware that her malaise might pose questions of psychodynamics and sexuality, and yet simultaneously she evades this recognition by means of a romantic fantasy. Lucky lady! - her doctor was charisma incarnate, the archetypal protective father-substitute. This paragon of medical expertise authorised the belief that she was not at all responsible for her 'illness'. Before continuing with her adoration of such a profound thinker and tutor, Jamison further describes the doctor as 'very tough, as well as kind, and...understood more than anyone how I felt...'.³⁷ In short, she sees in him all the attributes of that indisputable authority which is required, when a subject believes in the magic of medicine, to work a faith healing.

Meanwhile, it is unevidenced nonsense that her 'exquisitely vulnerable genes given her by her father' are what caused her recurrent emotional and mental disorders.³⁸ This kind of belief is based in a popular fantasy of what genes are and how they operate. In fact, genes make protein, not behaviour. Besides, no evidence is offered about the father's genetic role. Why blame him and not the mother? And yet, without so much as a blood test, her charismatic doctor was glad to support this psychiatric delusion: he declared that her genes were indeed the cause of her psychological problems.

At the risk of labouring the point, we repeat that a *functional* mental disorder is defined by the lack of a discernible organic cause: there is no test for a genetic cause of any functional mental disorder. The belief that 'there must be' such a cause is simply wishful thinking and a misconception of what science really is and what it really knows. Like many others, however, Jamison is eager to believe this delusion: she is ready to submit to medical-looking treatment - in fact, poisoning - so as to counteract '...whatever witches brew of neurotransmitters God had programmed into my genes'.³⁹

The rationalisation that her manias and depressions are due to a real illness with a genetic cause finds expansion in the chapter headed: 'The Troubled Helix'. Here Jamison again asserts 'the fact that manic-depressive illness is a genetic disease' - but still offers no evidence or argument. Like so many people, she is dazzled by the glamour of the natural sciences, with their statistical-causal certainties, all the flashing lights and digital read-outs of their sparkly technical apparatus, and the promise of the predictive control of events. Like the rest of us, she does not really understand any of it. This she freely admits: she simply has faith. More than that, she recognises that the purposes of psychiatric neurological research are unclear, that it just 'shoots into the dark' (her phrase). Nonetheless, she is '...more reassured and less frightened [by its existence]... glad that first-class researchers were studying [the most up-to-date brain scans]. Without science, there would be no such hope.'⁴⁰

There is no evidence to support the idea of a genetic basis to the functional mental disorders. What is certain is that, like most of us, rather than confront whatever terrors fuel her runaway anxieties, Jamison would blame someone or something else (God, her father, genetics) and blindly put her trust in a modern kind of magic - Scientific Medicine. And her faith, tested against an astute latter-day medicine-man, does not go wanting.

36 Jamison, KR, op. cit. (n. 6, Ch 2), 83-84.

37 Jamison, KR, op. cit. (n. 6, Ch 2), 88.

38 Jamison, KR, op. cit. (n. 6, Ch 2), 70 and 119.

39 Jamison, KR, op. cit. (n. 6, Ch 2), 46.

40 Jamison, KR, op. cit. (n. 6, Ch 2), 198. For the full exposition of Jameson's irrational belief in 'genetics', her views on neuropsychiatry (for which she offers no evidence, and which she willingly admits are completely untheorised), and the comfort those beliefs provide her, see 185-198.

Nowhere does Jamison offer evidence that lithium really does work as an agent of *organic* cure. Rather the opposite: she felt awful and miserable during all the years she was taking it, and it seriously impaired her intellectual and general somatic functioning.⁴¹ Even so, her morale is clearly lifted by taking the drug. The ‘medication’ - a ritual poisoning - reassures her that ‘something is being done’ about her manias and depressions. This belief enables her to tolerate the misery of chronic emotional and mental turmoil. Jamison’s biography fails to convince us that lithium really is a remedy for bipolar disorder, but it does much to persuade us that amongst those who subscribe to a popular fantasy which associates mental disorder with genetics and psychiatric medicine, lithium serves as a potent occult or alchemical talisman. We can only guess that this must be due both to the extreme nature of the mental disorder for which lithium is prescribed and the dangerous toxicity of the so-said remedy. Jamison’s account provides no evidence for a cure by psychiatric medicine, but it is wholly consistent for the solace to be found in blind faith.

Unfortunately, at no point does Jamison reveal the nature of the psychotherapy that she says is a necessary complement to lithium medication. Perhaps it was delivered during her weekly meetings with the wonderful doctor? Since she is a professional who abhors interpretative psychology and purposely joined the camp of ‘hard-nosed’ medical psychiatry, neglecting to speak about her own psychotherapy seems a significant omission. There is no doubt that she needs to talk-out the problems of her life - as who does not? But we are left wondering exactly how, in this case, the conversations might have proceeded. Was she only encouraged to ‘let-off steam’? Did the therapist offer only (or mainly) uncritical, fatherly, apparently authoritative reassurances? Jamison was anxious about her manias and depressions and, especially since he practiced a branch of medicine not known for high rates of successful treatment, the doctor must have been anxious about his competence with regard to that difficult case. This makes us wonder: was her psychotherapy anything more than doctor and patient ensconced in their cosy credulity, and engaging in mutual admiration and flattery before the patient collected her repeat-prescription for a poison that certainly produced metabolic effects - pernicious ones which psychiatry glosses as ‘side effects’ - but which, given their shared belief in the benefits of psychiatric medicine, also acts *psychologically* as a placebo to *both* of their anxieties?

Jamison’s book does not read as if she ever gave serious thought to the personal conflicts which might lie behind her anxieties - the ‘convoluted, alternative explanations for [her] breakdown’ - the stresses of marriage, a new job, overwork, etc., back into any childhood traumas which might underlie her predisposition, under stress, to panic, mania and depression. On the contrary, she positively avoids considering those factors, and hints that she cannot tolerate having her malaise correlated with any terrors in her childhood or adolescence. (About which, by the way, since she writes a candid and colourful biography, we are inevitably given a number of clues.) A psychoanalyst would recognise that a strong resistance like Jamison’s indicates awareness of a problem which the patient does not wish to have explored, and that this is exactly why the analysis must pursue that line of inquiry. What is mania if not a kind of flight? Jamison never discusses the signification of her manias and the consequent crashes into depression - except to maintain that they have a genetic cause. It seems unlikely that her psychotherapy ever developed to the point of becoming particularly expansive, expressive or analytic, since she fiercely resists such an approach. Specifically, she waxes angrily and derisively about Rorschach blots and psychoanalysis - but again without developing a coherent argument.⁴² The text leads us to suppose that the psychotherapy to which she alludes would probably amount to a kind of emotional support consisting of flattery and moral exhortation.

Kay Jamison would rather get relief by means of medicine. The charismatic medicine-man offers her that relief in the shape of a reassuring medical fantasy with three key elements: an indisputable diagnosis, an undoubted genetic cause and a definite remedy. And yet still she suffers. Jamison is unable to account for her pain except in terms of a genetic curse delivered either by God or her father. (She offers neither proof nor argument for her belief in ‘genetics’.) Her torment is nevertheless

41 See footnote 34, above.

42 Jamison, KR, op. cit. (n. 6, Ch 2), 60-61.

reduced, she presumes by the lithium, to a 'low-grade, fitful instability...an integral part of [her] life'.⁴³ In the meantime, however, she undergoes a new kind of suffering: lithium poisoning.⁴⁴

There is no evidence of medical remedy in any of this, yet many indications of the suppression of her energies by lithium overload. At the same time, however, she is given hope: the malaise is contained by means of her faith in medicine and the encouragement of a reassuring psychiatric authority-figure. In her case, the healing does finally seem to bring such emotional and mental relief that the patient goes on to become a proselytiser for the wonders of lithium.

In short, Jamison's account is more consistent with amelioration by faith and placebo than by healing through the action of the medication; whereas there is no research evidence to support the idea that her condition was cured or improved by lithium, Jamison provides much evidence that the medication was harmful and incapacitating. In the light of her blind faith in medical authority and her irrational belief in a genetic cause, it is likely that there was an *emotional-cognitive* holding-operation and eventual partial recovery by way of this patient's faith in the fantasy of a magically-conceived medical science, as well as by her life becoming less stressful and more meaningful and optimistic in a variety of ways (as is indicated in her book).

It is interesting that Kay Jamison's narrative parallels the story of the demoniac cured by Jesus. True, one charismatic apparently worked a spectacular and immediate cure, while the other was only able to exert his charm to the full after a decade or so of weekly meetings. Still, the similarities are striking: in both cases the high repute of the healer preceded the personal encounter; both healers were impressive figures who displayed compassion and implacable certainty in the face of suffering that others were unable to assist and feared to approach; one healer offered the authority of God and the other Scientific Medicine, but both suffering individuals were predisposed to believe in their respective healers; although both demoniacs initially offered forthright verbal resistance, each quickly found relief in the solution on offer; and both 'born again' individuals became proselytisers for their healers and the respective kinds of magic.

Kay Jamison's good doctor adopted an attitude typical of today's psychiatrists. He ignored the research evidence and was pleased to reiterate and elaborate the prevailing folk belief - 'the obvious fact' - which is, in reality, a collective fantasy based in a wish: that any serious psychological problem must be an illness (a so-said mental illness) for which there is always a medical remedy. Jamison's charismatic psychiatrist graciously accepted the suffering patient's adoration, and proceeded to placate, reassure and encourage her. He found a ready audience when he spoke in the fantastic terms of the myth of mental illness and its medical remedy. As a doctor, he was bound to employ a tangible, apparently authentic medical technique - a 'nasty medicine that nevertheless does you good' - or else the illusion of his magic would not have worked. In the modern alchemy of psychiatric medicine, painful and distressing poisoning is conceived by all true believers as tangible evidence for the potency of the treatment, and hence of its efficacy.

The truth of the matter is that Jamison's psychiatrist employed the plodding but allegedly sure procedures of a 'medical science' which is in reality ill-conceived, unproven and fantastic - it is an ideology. Yet by means of a dogma (the medical model) and a magic potion (lithium), and with much effort and difficulty, he finally managed to bring the patient's terrifying manic and depressive episodes under a kind of control. As well they might have been, both the man in the Bible possessed by demons and the modern woman afflicted by the 'genetic illness' known as bipolar disorder were grateful to be relieved of their sufferings. In their tremendous relief, they were happy to go forth and spread the good news.

There is nothing in Kay Jamison's account to persuade us that these days we live in an age of enlightened psychiatry based in sound scientific evidence. On the contrary, there is much to suggest that she was cured by a combination of placebo - her willingness to believe in the magic of psychiatric medicine - and 'spontaneous remission'.

43 Jamison, KR, op. cit. (n. 6, Ch 2), 169.

44 See text to footnotes 37 to 39 in Chapter 6, above.

Summary: faith, placebo and effective psychiatric treatment

An exploration of faith and the placebo effect suggests that the best aid to psychiatric care and cure is whatever encourages the patient to feel better and be more able to take up the threads of his life. Love is a form of faith-healing if ever there was one, and Kay Jamison readily admits it worked the best remission in her case, even if she cannot bring herself to believe it could work completely without lithium, her talisman of the power of medicine.⁴⁵

The truth about faith-healing and the placebo effect might cause consternation amongst doctors who have a position to defend. All the same, the rest of us might only wish that those who suffer from unbearable emotional distress and mental turmoil could find some relief: whatever substantially reduces a person's anxieties is surely therapeutic. In which case, placebo is a powerful form of therapy that in many cases is likely to work, at least temporarily. It may provide the respite from panic and despair that a distraught person needs before he is able to recoup some reasonable self-composure. Of course, as the fiction of medical cure, placebo depends on unqualified belief in the power of medicine. We should not be dismayed by the fact that faith in medicine is often misplaced - that medicine does not always perform the miracles we think it does. We are all anxious for our mental and physical integrity. We all wish medicine could cure us, and who does not live in hope? Placebo or faith ought to be recognised as a powerful force in mental health treatment. Of all the psychiatric methods, it seems to deliver the most regular therapeutic effect.

In general medicine the placebo-effect is acknowledged and doctors often intentionally employ it. Psychiatric textbooks make little reference to its deliberate use, and they do not situate faith and placebo within a general theory of mental disorder and its remedy. However, if placebo and faith play a *central* role in mental health therapy - as appears to be the case - the implications for treatment are profound. Those psychiatric treatments which have real but harmful physical effects (so-called 'side effects') are revealed as obsolete weapons which only cause organic harm to those who are supposed to be relieved of their distress and confusion. Tardive dyskinesia is only the most spectacular kind of aetiological harm, and the clearly deleterious effect of so much of the medicine persuades many patients that the psychiatrists not only fail to help them recover but are positively destructive of their well-being; these patients and ex-patients have lost whatever faith in psychiatric medicine they may once have had.

There is no evidence that psychiatric medicine is more effective than placebo. Together, because they are dressed up as the products of medical science, the various kinds of mental health treatments constitute a more or less persuasive kind of modern magic. As long as people need hope and medicine provides it, it is likely that all those allegedly scientific techniques will continue to be employed enthusiastically by mental health officials and received gratefully by many patients - at least initially - and the placebo effect will remain powerful.

45 Part 3 of Jamison's book is headed: This medicine, love. There she describes how remission of her bipolar symptoms correlated with the establishment of a loving sexual relationship. See especially Jamison, KR, op. cit. (n. 6, Ch 2), 139-151, 159-161, and 175.

Chapter 9: WORKING AS A PSYCHIATRIST

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First, do no harm.
Hippocrates²

After an introduction, this chapter consists of the reminiscence of a doctor who spent nearly fifty years as a practising psychiatrist, academic and manager; he also conducted significant biochemical and drugs research. Alec Jenner discusses the impact of the introduction of the kind of psychoactive drugs still relied on today, as well as more recent developments such as the reorganisation of psychiatry as Care in the Community. He also reflects on the utility of the psychiatric medical model and its diagnostic categories, on modern routines and treatments, and on the problems of organisational politics and a senior psychiatrist's busy schedule.

At the beginning of his career, and as a newly-qualified chemist, Professor Jenner believed in bio-psychiatry. However, when the accumulating research failed to provide evidence to support that hypothesis, he became increasingly convinced of the truth and efficacy of social-psychiatry.

Introduction: Working in psychiatry³

Tuberculosis was a mysterious and dreaded disease before there was a cure - the diagnosis was tantamount to a death sentence. For the last sixty years, cancer has been viewed in much the same way. Susan Sontag suggests that the metaphors attached to those two terrifying illnesses 'imply living processes of a particularly resonant and horrid kind'. This means that whoever contracts such a disease finds that he also has to cope with everyone else's moral and psychological judgements.⁴

Much of what Sontag says about those illnesses seems to apply equally to the field of mental health. Since medical experts are unable to offer a certain cure, anyone afflicted by a mental disorder so serious as to warrant psychiatric treatment is delivered a kind of social-death sentence: the diagnosis marks him off from 'normal' people as suffering from an incurable affliction of the mind; he is then under suspicion for almost anything he might do, say or think. Moreover,

...[a]ny disease that is treated as a mystery and acutely enough feared will be felt morally, if not literally, contagious. Thus, [people with the malaise] find themselves being shunned by relatives and friends and are the object of practices of decontamination by members of the household...as if infectious. Contact with someone afflicted with a disease regarded as a mysterious malevolency inevitably feels like a trespass; worse, like the violation of a taboo. The very names of such diseases are felt to have a magic power... [and] conventions of concealment [of the diseased] are...strenuous.⁵

1 From interviews with Peter Speedwell and Phil Virden.

2 Jones, WHS (1868) *Hippocrates Collected Works I*. Cambridge: Harvard University Press. Recent scholarship suggests this aphorism was not coined by Hippocrates (c. 460-377 BC) but it was long imagined to be part of the Hippocratic Oath.

3 Introduction by Phil Virden.

4 Sontag, S (1978) *Illness as Metaphor*. Harmondsworth: Penguin, 43.

5 Sontag, S, op. cit. (n. 4), 10-11.

Most people who become psychiatric patients do so not because they are actually ill but because they seem to have become seriously deficient in the ability or will to act with conventional competence and sociability. Nonetheless, the stigmatisation and rejection which accompany the diagnosis of a serious mental disorder go a long way to explain why the psychiatric intervention itself is so often a crucial part of a process which locks the person deeper into his confusion and misery, rather than helps him to recover emotional and mental balance. Not only due to his apparent incapacity and isolation but also to his medically authorised stigmatisation - as 'having a serious mental illness' - and debilitating treatments, it is often extraordinarily difficult for a psychiatric patient to 'get better'.

Mindful of the popular conception of mental disorder amongst those who have little experience of it - because of the great fear of personal irrationality, and consequently its sequestration - Sontag goes on to suggest that we

...consider our own era's...act of distortion, under the pressure of the need to express romantic attitudes about the self... In the twentieth century, the repellent, harrowing disease that is made the index of a superior sensitivity, the vehicle of 'spiritual' feelings and 'critical' discontent, is insanity.

The fancies associated with tuberculosis and insanity have many parallels. With both illnesses, there is confinement. Sufferers are sent to a sanatorium, (...the most common euphemism for an insane asylum). Once put away, the patient enters a duplicate world with special rules. Like TB, insanity is a kind of exile. The metaphor of the psychic voyage is an extension of the romantic idea of travel that was associated with tuberculosis. To be cured, the patient has to be taken out of his or her daily routine...

In the twentieth century the cluster of metaphors and attitudes formerly attached to TB are split up and are parcelled out to two diseases. Some features of TB go to insanity: the notion of the sufferer as a hectic, reckless creature of passionate extremes, someone too sensitive to bear the horrors of the vulgar, everyday world. Other features of TB go to cancer - the agonies that cannot be romanticised. Not TB but insanity is the current vehicle of our secular myth of self-transcendence. The romantic view is that illness exacerbates consciousness. Once that illness was TB; now it is insanity that is thought to bring consciousness to a state of paroxysmic enlightenment. The romanticising of madness reflects in the most vehement way the contemporary prestige of irrational or rude (spontaneous) behaviour (acting out), of that very passionateness whose repression was once imagined to cause TB, and is now thought to cause cancer.⁶

Sontag's essay is interesting since it recognises that the response to unaccountable but frightening disease or mental disorder is based more in everybody's avoidance of anxiety and in what they wish rather than in what is reasonable or recommended by the scientific evidence.

In that last quotation, Sontag criticises the romantic idea of madness which found its fullest expression in the 1960s and 1970s. Yet this view was only ever proposed by a minority of woolly-headed idealists,⁷ and it has never had more than an extremely marginal influence on psychiatric practice. Most people believe that, by definition, madness is the absence of reason and the very inverse of enlightenment - and most psychiatrists would heartily endorse that view. Which is why, except for a small number of patients who find themselves referred to heretic, psychologically-inclined doctors, anyone who is diagnosed with a mental illness almost always has to submit to some kind of medical treatment so as to *subdue or eradicate* their irrationality. This is because psychiatrists have always seen themselves as highly trained experts in medical science, much wiser than the layman, who is too emotionally involved and clearly admits his perplexity in the face of individual irrationality whenever he calls for medical help. An orthodox psychiatrist celebrates his 'emotional

6 Sontag, S, op. cit. (n. 4), 39-40.

7 Sontag is wrong if she thinks she criticises 'the anti-psychiatrists'. Although her characterisation of a dewy-eyed view of madness might fit some idealists with no experience of psychiatric work, it is not a fair representation of the subtle and compassionate ideas of Drs Laing and Cooper.

detachment' and 'no-nonsense, hard-nosed, scientific approach'. He has little or no interest in possibilities of the patient's exceptional sensitivity, spiritual feelings, critical discontent or potential for moving through the crisis and out the other end towards self-transcendence. Amongst the medical authorities and behaviourist psychologists who have dominated the management of madness for the last hundred years, 'sensitivity', 'spiritual feeling' and 'critical discontent' is so much irrelevant gibberish which only glosses all that ideational and behavioural deviance which, no doubt about it, is *devoid* of reason and therefore 'must be' due to genetic error or chemical imbalance ('must be' a fault in the brain).

And yet the medical model of mental illness and its treatment is as much based in fears and wishes as any romanticised notion of madness. This book demonstrates the fallacies of both 'romanticised' and 'hard-nosed, scientific' conceptions of functional mental disorder, but it is the medical model which governs the official provision of mental health care and treatment. In which case, we pay particular attention to the ruling psychiatric beliefs which, despite the lack of evidence, nevertheless insist that they are authentically rational, scientific and medical.

Of course, as long as they remain unquestioned, generally agreed psychiatric beliefs and attitudes are bound to dictate the standard forms of care and treatment. So how exactly are the beliefs and rationalisations which define irrationality and its appropriate management translated into daily practice? In this and the next two chapters, we try to give a sense of psychiatric actuality by turning to a psychiatrist and two nurses for accounts of their experiences. In the thick of care and therapy, they are not inclined to romanticise incapacitating emotional distress and mental disorder. Instead, they had to accommodate themselves to a psychiatric system which they found already up and running, and supposedly justified by a medical model which they feel is wholly inappropriate.

Working with subjects is not like working with objects. To work with a person - with his ideas and emotions, his constructions of reality, his hopes and fears - is to work *along with* him. The 'object' to which psychiatric work (care and treatment) is supposed to add value, i.e., the patient, is in fact *the person*, not his brain. Obviously, there are a multitude of organic changes which a medical expert may be able to measure. Most importantly, however, the psychiatric patient always reacts *emotionally* and *psychologically* to whatever is done with him - and the desired effect of *any* form of psychiatric care or therapy is exactly a beneficial change in the patient's beliefs and behaviour.

As the argument of this book unfolds we will see that, with respect to any functional mental disorder, it is not that the organic vehicle - the body, the brain, or any other organ - is faulty or broken-down, but that the vehicle is *being operated* in an undesirable manner. To anticipate our argument, this means that it is unlikely that genuinely productive or remedial psychiatry will ever consist of interfering physically or chemically with perfectly good brains which happen to produce undesirable beliefs and behaviours. Rather - and in spite of whatever it thinks it does - when it is not simply coercion, psychiatry can only be psychological work intended to change the patient's *mind*: it is a form of persuasion or education.⁸

When the nature of the work is to alter persons (or their beliefs and attitudes) there is often much disagreement and much to negotiate with fellow workers. Psychiatric care and therapy is teamwork; it is bound to generate differences of opinion. Doctors, managers, and the various nurses, social workers, psychologists and therapists often have quite separate responsibilities and agendas, and all of them have to negotiate not only with the patients but also with each other. A major source of conflict is between care and the supposedly medical cure. Psychiatric care is primarily a sort of normal nursing compassion and attentiveness; it is the attempt to alleviate the patient's symptoms by bringing him emotional and material comfort. On the other hand, cure is conventionally supposed to be a sort of cold and dispassionate intervention by means of some or other medical technique which attacks or eradicates the source of the disease, thereby creating the organic conditions necessary for

⁸ Neither do we suppose that it is always, or even usually, the patient who has to learn from the psychiatric workers. As we make clear later in the book, it seems to us that psychiatric officials only genuinely help to remedy someone's mental disorder when they act not as dictators claiming superior medical knowledge but as facilitators in a project in which worker and patient inform each other.

recovery. Certainly there is perennial conflict between those officials who have absolute faith in the medical alleviation of symptoms and those who view psychiatry's almost exclusive focus on symptom-management as often ineffectual and ultimately counter-productive. In our account of the mental health project, we are concerned not to over-simplify the various responses of the staff. Nevertheless, amongst psychiatrists there are those who are even more medically aggressive. They imagine or hope that their interventions might one day bring about unequivocal cures. In diametrical opposition are others who are dissident to the medical tradition and favour quite different forms of care and attempted cure, such as protecting patients by resisting many of the medical interventions, and by facilitating counselling, psychotherapy and the management of patients' personal problems.

An effective psychiatric worker has to be responsive to constantly changing situations and personalities. Each patient is unique, with his own specific problems, overt and private. As we argued in the chapters above, and will demonstrate with further argument and evidence throughout the book, it is neither true nor helpful to consider a mental health patient's behaviour or personality as nothing but the outcome of a disease. At the moment he may be overwhelmed by his problems, but he remains a unique and sensitive centre of experience and sociability. Aside from the routine medical care of those patients who also have a real illness (or may have deteriorated physically due to their emotional and mental distress), it seems clear that however else it is conceived, psychiatry always works with *communication*. At the very least, each patient has to be persuaded to co-operate with a minimal regime of symptom management and socially acceptable routines. Besides, if a fundamental moment of the remedy of any patient's problems is talking things out, dialogue is the very essence of care and cure: listening and a sort of psychoanalytic, persuasive or educational effort then take centre stage in the psychiatric project.

There is no evidence that there is an organic cause underlying any functional mental illness.⁹ Most psychiatric patients' symptoms are not caused by an organic problem - they have problems with their lives. Negotiations around problems of living are in fact basic to psychiatric care and cure. This means that it is impossible to represent psychiatry as a neat and tidy set of organised routines arranged around diagnostic categories and medical responses about which every psychiatric worker is agreed. Learning how to become an effective psychiatric official is not like learning about an industrial process which allocates measured technical inputs to a flow of inanimate objects. Nor is it like many normal processes of managing persons, in which the technical means are not contentious and the utilitarian rationality of the managed may be taken for granted. This makes psychiatry quite different from working in general medicine, but not (as many psychiatrists would have it) more like controlling disobedient children. Of course, each new psychiatric official is faced with established routines of care and the management of symptoms. Even so, these are always established by more or less tentative negotiations, they differ according to local variations in policy or ethos, and there are often fairly rapid intended and unintended changes due to shifts in the relations between the various groups of professionals involved, or due to changing intellectual and technical fashions. This is an unending process - each day there are new situations, new problems, new patients.

Meanwhile, the absolute authority of the medical model of mental illness remains unquestioned by the standard psychiatric textbooks.¹⁰ And just as those texts devote little or no space to the social or psychodynamic aspects of the patient's malaise, if they mention them at all they do not adequately discuss the informal routines and taken-for-granted understandings which constitute the milieu within which all the formal psychiatric procedures are carried out. But it seems obvious that these ambiances, constituted in myriad intimate contacts between officials and officials, and officials and patients, are crucial to the mental and emotional wellbeing of each patient precisely because his malaise *consists in* a breakdown in his persona and sociability. The psychiatric workers who contribute to this book are quite clear that since officials are likely to hold a variety of often contradictory views about the problems that arise and what should be done, what actually happens to

9 The notion that there is (or 'might be') an organic (bio-chemical or genetic) cause for functional mental disorder is laid to rest in Chapter 12 and its Appendix, below.

10 See text to footnotes 19 and 20 in Chapter 1, and 8 to 11 in Chapter 3, above.

any particular patient is in fact much more ad hoc than is represented in textbooks as the agreed and appropriate response.

In this and the following two chapters, three very experienced psychiatric workers offer a realistic sense of the constantly changing, negotiated, provisional and uncertain nature of treatment and care; they illustrate its pitfalls as well as its successes. Of course, it is in the nature of reminiscence to speak of how things were as much as how they are. Yet however much arrangements for care and treatment may have changed during their careers - due to changes in funding and organisation, in policy directives, and in mental health legislation - relations between any psychiatric patient and any official remain influenced by two factors far more than by any others: the medical model of mental illness and psychiatry's statutory powers of coercion.

We begin with Professor Jenner's narrative.

The route into psychiatry via medical and bio-chemical research

I was always interested in psychiatry. Even as a schoolboy I'd read quite a bit of Freud, because the English teacher I had was very interested in psychoanalysis. He was W F Spenser, and curiously enough he wrote a book called *The Divided Self*, which is the same title as the book by Ronnie Laing.¹¹ My teacher's book wasn't exactly about the same thing, but he was very interested in the literature. He was rather Jungian and mystical, but a nice guy who helped me a great deal at school.

So I started with that sort of interest and I was the sort of kid that read more than some, and converted easily to idioms such as psychoanalysis, Freud and Marx, Wittgenstein and AJ Ayer, Julian Huxley and HG Wells, Bernard Shaw, and so on. I'd also had quite a religious background, but I'd become by then a sort of scientist. I was very interested in psychoanalysis, but equally or more so in physics, chemistry and mathematics. I actually went into the Navy instead of doing maths, but a chap told me I'd make more money being a medic, so I decided to do that when I left.

I came to Sheffield and did the medical course, and a PhD in a chemical subject, and I thought I knew the explanation of manic-depressive illness. I had a general sort of ongoing interest in psychiatry, and held the intensely 'scientific' view that in the end the mind could be explained away chemically. This was, I think, influenced by Krebs who had won the Nobel Prize and was at the time in Sheffield, working on intermediary biometabolism in biochemistry. Also, a man called Gjessing, a Norwegian psychiatrist who had invited himself to Sheffield to see Krebs - a long time before he won the Nobel Prize - because he recognised the importance of Krebs' work as a biochemist. This was quite an insightful move on his part, and it interested me very much.

Gjessing was interested in the biological 'clock' in the brain, and was studying patients with schizophrenia who became ill predictably, to a timetable. This fascinated me, and it certainly fascinated Krebs. This guy wanted Krebs to turn his interest to mental diseases but he was really only studying yeast at a very fundamental chemical level and wasn't going to give up what was going to give him the Nobel Prize to do that. Krebs was very interested in Gjessing, though, and thought him a very able scientist. Gjessing was also the Medical Superintendent of a large mental hospital just outside Oslo, so the two of them went to Littlewood Hospital. In those days it was the mental hospital just outside Sheffield, and at the time it had more patients than all of Sheffield's other hospitals put together.

The fact that Krebs thought a lot of him, and my interest in his work, added to my interest in such matters anyway, put me on the road to psychiatry. At the time I also thought a newly discovered hormone, aldosterone, would explain manic-depressive illness. So it all came together and made me decide I would tell the new Professor of Psychiatry in Sheffield - a chap called Stengel, who had known Freud - about my idea. I was the secretary of the University's Philosophical Society, and we

11 Laing, RD (1959/65) *The Divided Self: An existential study in sanity and madness*. Harmondsworth: Penguin. Laing's first book, which he declares '...is to make madness, and the process of going mad, comprehensible.' Although Laing denied he was an 'anti-psychiatrist', his writings were seminal to the development of that movement since they opposed the so-called medical orthodoxy with a kind of interactional psychodynamic that Laing dubbed 'existential-phenomenology'.

had invited Stengel to give a talk, and I told him about my idea. I don't think he knew what on earth I was talking about, but he said: 'Oh, come and prove it'. He was probably short of staff. All the same, after getting a PhD in a purely physical subject (chemistry), without any training in psychiatry, overnight I became a lecturer in the field! This was a time when a telephone call from the Vice Chancellor could get you a job. A very different situation from what it is today.

I thought that the 'clocks' that Gjessing was talking about necessarily had a metaphorical pendulum, and that was the feedback chemical circuit from this hormone which had only just been discovered. It was not thought to be controlled by the pituitary parts of the brain, therefore what I was thinking, which was sacrilege to classical physiology at the time, was that somewhere that hormone could be shown to have a negative feedback. In other words, when it built-up it turned the thing down and turned itself down, and if that hormone was in some way associated with the control of mood in the brain you would have a clock which kept time and made the person go mad to a pattern. All I had to do then was to show it was true. It took me several years to show it was *not* true. And I got promoted in psychiatry for it! That's how I came into psychiatry: as a bio-chemical researcher.

I was involved in the translation of Gjessing's book, so I went to Oslo. What's remarkable about it is that what he said was absolutely true. At Oslo he had a collection of people all of whom did become mad to a timetable. This seemed to me the ideal thing for a chemist to study because you could know that halfway through next week this guy here would go psychotic. The records are all there, and this is a real phenomenon. It has been described in psychiatric literature for centuries. Peculiarly enough, when I started my study it was a disappearing phenomenon. Though you can find it in any textbook written before about 1950, and you'll find it in Kraepelin, the classics of psychiatry: 'the periodic psychoses' are given various names - in French the *double form, folie circulaire*, and so on. It is an interesting phenomenon and it still requires some explanation.

Gjessing kept the patients on an absolutely rigid diet - which was perhaps cruel - but they lived on a liquid diet for months on end, and every day everything that went in and came out of the patients was measured, in the hope that if you knew exactly what was going in and coming out you could analyse it chemically. This would show that the biochemical cycles that appeared against the controlled and measured inputs must be the cause of the madness. It ought to be said in his favour that Gjessing was not only a great scientist but also a very nice man. He had worked throughout the Nazi occupation of Norway, so although the diets he was giving the patients were terrible, they weren't worse than what the general population was getting, and he did make something happen in a very difficult context. The other thing that was important to me, however, was that what happened to the patients would be thought to be unethical today but at the time it was thought perfectly fine because, after all, they were mad and their lives were ruined. Therefore anything was justified. If the patients wouldn't take the diet a tube was put down them - otherwise the measurements and balance of the experiments would all be lost, and there would be no hope of a cure. Lithium was introduced into psychiatry soon after this. The recently invented phenothiazines and the anti-psychotic drugs already seemed to disrupt the rhythms in these patients, and made them difficult to study. At the time, it was considered a responsible position. As long as nothing could be done for these people it wasn't so unethical to do the things that were done to them, really, because we were trying to find a cure.

It was all very interesting. But when I finally got to Oslo, the elder Gjessing had died and I only worked with his son. This gives an idea of the international nature of psychiatric research. The son and I translated the book - which was actually written in German, with Danish translation instructions, Danish being a high form of Norwegian!

The fact that psychosis can be rhythmic is true. It's well established. I will come later to why I think this is so. At that time, though, there was a context to the research in biochemistry. People had claimed that sodium retention occurred in mania and in depression, but more in mania. The particular hormone that I thought should be causing this, controlled sodium in the body. This hormone was very difficult to estimate at that time. It took three days of very intensive work per specimen. Even then the accuracies were poor. And so on. In a nutshell, the hormone didn't go up and down as it should, in terms of my theory. But it took several years to get good ways of estimating this, and also a long time to collect the urine from these pretty outrageous and difficult psychiatric patients. Consequently,

it took several years to show that whatever the clock was, my idea about it was not right!

Remember, this was about the time that the anti-psychotic drugs were coming in. It became fairly obvious that, when given such drugs, these people changed and the cycles became obliterated or much more difficult to see. Gjessing did show that the nitrogen cycle - the relationship between the amount of nitrogen that went in and the amount that came out - showed the same cycle as the psychosis. Nitrogen is a part of the protein molecule, and though he didn't specifically point to that, Gjessing had the view that a toxic substance, which was like LSD or something and which contained nitrogen, was retained in one phase of the illness and washed out in another. That was the feedback circuit I was looking for - the pendulum for the clock. Because the phase relationship of the nitrogen to the mental state was different in different patients but was constant for each patient, Gjessing claimed - I think mistakenly, but at that time the world accepted it - that it couldn't be secondary. I think one of the contributions I made was to remember that in mathematics you can make any phase relationship as long as you've got two sine waves. The formula is quite simple for a sine wave and a cosine wave ninety degrees out of phase. So if there was one factor causing you to burn more protein and another factor that did the opposite, and they were to some extent out of phase, you could soon explain why the phase relationship would vary, why they would still be secondary. That was my personal contribution to the biochemical disaster zone that was our research project!

What struck me was that these patients were pretty wild in one phase and pretty dormant in another. Now, if you lie still your muscles break down, so that's one cause of negative nitrogen balance - you're getting rid of the protein in your muscles. If, on the other hand, you take a constant diet and you rush around, as long as you are using more energy than the carbohydrates and fats you take in, you will break down protein. So here were the two factors that you could put together to explain the phase relationship, and would at least destroy to some extent Gjessing's hypothesis that it couldn't be secondary to the mood. It took another five years to think about that.

The introduction of psychoactive drugs and my move towards social psychiatry

I then tried to find patients for the project in Sheffield. I got very good support from the Medical Research Council. I looked round the country for patients who displayed this rhythmicity very well - for research purposes that was what we needed. We imported people from all over the UK, and we flew a chap to Norway in order to get classical cases so we could look further. Because, even if I had punched a bit of a hole in the argument about the primary or secondary nature of the nitrogen, there was still the biological clock to explain. What I noticed, however, was that some of them, when they were moved around, had their clocks going wrong. Subsequently, when an American film company went to make a film of the patients in Norway *all* the clocks went wrong. What made a big impact on me was the number of psychiatric researchers sitting around saying what bad luck this was, rather than: 'Isn't this exciting?' Had it been a chemical that had been given causing it to 'all go wrong' they would have been excited. Instead, because it was a film crew coming along that had upset the clocks everybody was saying: 'How unlucky for us scientists that this happens when we're trying to publish our work!'

Then I did some experiments, very complicated, imitating the movement proactively - taking patients with this phenomenon and moving them. Moderately to my satisfaction, in a limited number of cases, I found that if you move a person, along with his social environment, the breaking of the cycle didn't occur. But if you moved him right out of his usual environment, it did. I found this an extremely interesting phenomenon: patients had a period of remission if you changed their social routine by moving them. This all started because we moved one chap from Birmingham to Sheffield, and his cycle, which was remarkably regular, immediately stopped. This had been infuriating. At the time I went back to the old literature and thought it was because he had the flu. But when the ward was clear, and nobody had flu, the same effect still persisted - and the penny began to drop.

As you can see, I came to psychiatry from a strong biochemical background. Piece by piece, though, chinks of light appeared through the biochemical approach. It struck me then, with this particular patient that we had moved, that you could either change the cycle by giving him a simple

chemical, i.e., lithium, or by moving him, by changing his social context. Really, I think then a long-term interest in philosophy raised in my mind the problem of defining what is fundamental. In other words, *the condition is context-related as well as chemically based*. Of course, by working in Sheffield, where Vitamin D was discovered, I couldn't but draw the analogy between that discovery and the treatment of rickets, which was rife in the city. Everyone knew that rickets was due to industrialism and smoke. What happened was that mothers took their children to the out-patients department and got Vitamin D for them so their bones didn't bend, and then took them off out into the smoke and smog again. It struck me that prescribing Vitamin D for rickets had held up smoke abatement and the natural improvement of children's health for a very long time. This idea raised for me the issue of what one means by 'fundamental'. After all, Vitamin D as a treatment of rickets did not constitute an attack on the *fundamental* causes but only ameliorated the condition. In Sheffield it wouldn't have been very important to distinguish rickets from tuberculosis; they were both products of the industry. I worked on TB wards and was covered in the bacteria, and yet I didn't suffer at all. You could do a graph of Sheffield where the kids who had rickets and TB lived and where the doctors lived, and they barely overlapped. These sorts of things had a big influence on me. All the same, you'll notice I'm not denying the reality of Gjessing's work, nor of pharmacology.

The other thing that occurred to me came from my interest in music. The note of a violin string depends on its thickness but also on its tension. I began to think that the onset of psychosis bore a relation to the tension of the situations the person lived through, and that this might have an effect on the rhythm. Then it struck me that in the old-style mental hospitals the patients lived in pretty grim and isolated circumstances, existing on an unvaried diet and with not much to look forward to, really - until this film crew turned up, and the cycles broke down.

This had some impact on my thinking. If the Vitamin D equivalent works - in the case of the 'disease' of psychosis, chlorpromazine, of course - it must be economically interesting. If there is a drug to stop a child's knees bending with rickets, it's going to be used. Now perhaps a similar effect can be made on people called schizophrenic. You could say, with Ronnie Laing - who by this time I had met - that it's all to do with the family structure, but you aren't going to change that very easily. On the other hand, if you give the son or daughter chlorpromazine, everybody finds to their delight that a lot of the mad ideas disappear!

Obviously, living and working through the period of the introduction of the new psychoactive drugs and the run-down of the big old psychiatric hospitals, nothing was so clear-cut and uncomplicated as I might have made it sound here. There never was one moment when I suddenly switched from a bio-chemical bias to realising the importance of the environment in psychopathology. My interest in psychoanalysis and philosophy always persisted. I was involved with leftist politics through this time, and very interested in psychodynamics, and yet at the same time had a sort of view that nevertheless everything was really all biochemistry. In other words I wasn't a totally consistent individual! And I haven't become one, either. There were two sides to the problem all the time, really. Even Gjessing, who was a very well read man, shows this. He was very well informed about Freud and so on. Still, it's very difficult to resist the biochemical ideology or the hope that we can find some simple, 'magic bullet' answer to every problem.

I suppose I wasn't very clear about this. I suppose like many other intellectuals I was, am and shall be bedevilled by the problem of the true relationship between the body and the mind. Of course, in the bio-chemical work that I did I was playing for the chance of my own fame. There had been all sorts of biochemical relations we thought we had discovered at various times, most of which didn't work out as we expected.

At that time, though, I was picking very unusual patients who did, and still do, exist, and doing experiments on them, not to show that one in several million patients showed a particular pattern but in order to show something that was true in general. I think it's Jung who says you only find out what you're looking for. It struck me that, in a way, the very design of the experiment (which wasn't scientifically wrong) was backing all the odds in order to get a physiological answer. That seemed a reasonable enough strategy at the time, though.

And then, of course, I'd got a lot of money from the Medical Research Council (MRC), and had

been made the Director of a Medical Research Council Unit, and there was pressure on me not to give up the experiments, although I had in the meantime become Sheffield's Professor of Psychiatry. Quite a number of other people depended on the research for their livelihoods, though, and to abandon the experiments would have ruined them. I was responsible for them, but tiring of it, not because I didn't think there was still something to explain but because I could see that there was a contextual, social dimension and that this research wasn't going to open any biochemical 'golden gate'. The upshot was that we went on doing the research until the MRC decided we weren't going to open the golden gate, either, and closed it down.

I was very lucky, because I was already the professor, and was in fact saved from what was an impossibly large job. When I was the Professor of Psychiatry there was only one for the whole of the Trent region. Now professors are ten a penny! I was on every appointments committee from Leicester to Lincoln to Nottingham, Derby, Barnsley - everywhere. As well as running this quite large MRC Unit. I'm afraid I had great enthusiasms but not great consistencies. I did the world's first studies on the benzodiazapines, Librium and Valium, and I got tied up with the business of Russian dissidents being locked up and treated as mentally ill. The amount I took on was silly, but that's how it was.

At the same time I had this interest in the contextual effect on patients' behaviour, and was meeting people like Laing, and of course I was interested in that sort of approach. Ronnie Laing once said he wasn't an anti-psychiatrist - it was the others who were. He and I did meet and chatted together. I found him fascinating, and was very keen to interact with him. I think partly because the patients had often already read *The Divided Self*, and they used to say: 'This chap understands me'. Naturally, I took that as them saying: 'He does, but you don't'! So I thought I'd better see what that was all about. Peculiarly enough, considering that I was heavily involved in bio-chemical research, he and I got on fairly well. I met him both professionally and informally, and we used to chat. He invited me to his house occasionally, which wasn't all that useful. He showed me the patients' houses he was running. At that time he was infinitely famous and I was comparatively unknown.

About this time a patient that impressed me was a young lad whose father had died and his mother had married someone else and the step-father didn't have a lot of time for him. This lad never said anything except: 'You bastard psychiatrists!' Then he'd attacked a nurse with a knife, pretty viciously. Some time later he said: 'Can I go to the cinema? I want to go and see *One Flew Over the Cuckoo's Nest*'.¹² He was quite isolated, and I was frightened of what he might do. I decided this was my chance, because this was really his first communication with anybody since we had taken him in. So I said: 'OK, but you'll have to be careful and behave.' He went with some nurses, and when he came back he said: 'I can tell you now what's wrong.' So I said: 'Why don't you discuss it with one of the nurses who went with you to the film, and write it all down?' He said: 'I'll do that. I'll bloody well show you.' The great document never appeared, but we became friends and spent quite a lot of time talking together, and the story emerged about him being pushed aside in the family as his mother struggled to know how to cope in her relationship with a rather horrible husband. We then began to sort things out realistically, and by and large his previous behaviour disappeared.

In this way it struck me that another big mistake I had originally made was to discuss psychopathology with the patients rather than discuss life with them. I was always interested in what sort of hallucination they had, and whether it fitted in with Schneider's classification, and things of that sort. I didn't bother with that with this particular lad, however. We talked about what he wanted to talk about. I also thought that the patient had as much right to an ego as a Professor of Psychiatry. Because the professional situation was such that my ego was being pumped up. Wherever I went everybody thought I was The Great Expert and the patients were the riff-raff.

This patient did quite well, and it struck me that part of the success was due to there being a future for him, and because he began to see that the way he was playing his cards in the real society was mistaken. If you're in any sort of social set-up, the art of politics is not just to indulge in protest and kick about but to do something positive, and it's a matter of how you show yourself in society.

12 Kesey, K (1962/76) *One Flew Over the Cuckoo Nest*. Harmondsworth: Penguin. This novel about the inmates of a locked psychiatric ward was made into a popular film, released in 1975.

He might have been a special case - but there are a lot of them. Another one was an artist who had the same intense need to be heard, to be accepted. Without judging the quality of his art, the psychodynamic was his need to be seen as a great artist; this stood against the impossible task of persuading his family of this priority when they wanted him to get a paying job to keep his wife and several children. He had religious inspiration for his great paintings. I asked other people who were better able to judge than me, who said he did have ability, and it was a shame. He also had a story about being thwarted in his childhood in his desire to be an artist, and had gone to art school where they told him he wasn't any good. Now he was living on very limited means, short of food - almost the classic artist's life. The psychodynamics of his need to be recognised interested me.

What also impressed me was that many patients could be surprisingly normal in many situations. It became clear to me that the way you handled the patient was very important. One patient comes to mind immediately: a black Jamaican guy was brought in absolutely raving. People phoned me up and wanted him compulsory ECT-ed. They'd got him locked in a room, shouting and so on, banging around. By a sheer stroke of luck someone mentioned that he went to a West Indian church. So I phoned up the minister in charge of the place and she said - it was a woman, actually - she would come round with the big choirboys. I thought that was a good idea! They came along and sat round the bed and prayed and so on, and he came round and apologised for his behaviour. That had a profound effect on me. And when I spoke to the minister it turned out that this happened to the man from time to time, after he had been to big congresses of their religious group. It was all tied up with his special role in the group, and she was able to tell him that God did have a special role for him, but not acting in such a wild way as he had.

I suppose that this idea of a special role in life is central to the problems of a lot of people. Everybody needs to feel special in some way. At that time I was trying to become a famous scientist - I knew quite a lot about ego really, so I could understand that! We became friendly and chatted about life. I'm afraid I didn't chat very much about his culture, but obviously it had some importance for the way he thought about things.

It's difficult for people today to understand that our generation was brought up in a tradition that separated physical illnesses from any sort of psychological problems, which were seen as a visitation upon the brain. It was thought that you must rush in and give treatment to the schizophrenic quickly, otherwise the chances were that he would rapidly get a lot worse. The treatment, of course, was when they discovered the phenothiazines. Talking to people took a back seat, really.

I remember a man once who was shouting and screaming, taking off his clothes and acting very threateningly. His family and the neighbours were all frightened of him, so we took him into hospital. He was an academic chap who mainly suffered from a horrible mother who interfered with his life. For example, she was horrible to his wife, who had been adopted when a child, alluding nastily in front of the grandchildren to her lack of parents. The man was ambitious but not very successful. He suffered, too, from an overwrought conscience. It appears that in Amsterdam he had once used a prostitute, and, though he had paid her of course, he felt compelled to go back and find her and ask forgiveness. People were scared of him when we brought him into hospital, and he got wilder and wilder. We fell into the trap of deciding that the only thing we could do was to lock him into a room. There was a Portuguese student with us - one of our best PhD students - and he said we were all making a big mistake. He said this was the time to give him more freedom, not less. I was very scared and didn't know what on earth to do with the man, he was so outrageous. Anyway, with a lot of trepidation, we let him out and asked him what he wanted to do. He sobered up, went home and acted rather well!

I couldn't really account for the sudden transformation. Except it did illustrate that responding violently or with more oppression increases the violence that is already the problem. In that situation, giving the man his freedom and respecting his wishes, instead of trying to stifle him by locking him up, led to a way out of the situation. In terms of what had caused him to act so crazy, there was this sort of ego thing with him and the failure of his ambitions. Egoism and sexuality tied up with the whole problem. When I talked to him, I concentrated more on ego and the power struggles in people's lives, although I'm sure someone who knew Freudian theory better could have explained the

sexual problems involved.

Both those last two examples were probably the most frighteningly violent patients I had to deal with, and both resolved quite remarkably. Of course, I can't say I was able to help resolve everybody's problems so easily. By the time of those instances I had already lost faith in the possibility of any outright biochemical cure. Those cases just confirmed my loss of belief. So then I became rather frightened: without the medical certainties, what the hell would I do now?

Practical problems of time, the medical prejudice and organisational politics

If only we had had the time to deal with such people and be able to deal with the immensely complicated conflicts and patterns of people's lives. A modern academic psychiatrist doesn't have a lot of time to give to patients. His assistants tend to be more trouble than assistance, because they have to be given a lot of time and patience to learn the ropes and to get on with their careers. Added to this, patients wouldn't be convinced that they would do as well to talk to the nurses, that they could do as much good as I could. The whole structure of the psychiatric set-up was unhelpful.

I think I probably failed in many ways, but I was always conscious of the repercussions of trying to change things too much, because there were a lot of reactionary forces in the system - a lot of forces who were against any change, and out to make things impossible for anybody trying to change things. You wouldn't achieve what you wished by going at them head-on. The other thing was that every day I was always busy with a mapped-out and tight schedule - which might sound like an excuse, but at the time it felt real enough.

I was very lucky in my early career in psychiatry. All the people I worked for treated me as their blue-eyed boy. It's rather embarrassing, really. Others were pushed onto one side. Stengel, who was my boss, thought I was a promising biochemist, which was very good for my ego. My contemporaries, I think, thought I was a bit out on a limb, especially with my ideas on schizophrenia. They were very supportive when the MRC dissolved our unit, but they would always want to discuss whether a patient displayed the symptoms of schizophrenia when I wanted to discuss: Why is he mad? Clearly there was a degree of conflict there, and I'm not sure I handled the conflict all that well, especially between the academic department and the NHS. I think that's true in every academic department. There are always political jealousies and so on, which emerge as gripes about people not pulling their weight, and all that sort of nasty backbiting. I'm not sure I didn't take those things too seriously, and didn't become a bit too much of an isolated recluse because of it. I felt quite lonely, in a way.

Managing psychiatry, and problems in its conception, practice and politics

The life of a Professor of Psychiatry was extremely busy in those days. Apart from sitting on many committees for the University and for the National Health Service, running the department and being available to all my more junior colleagues, I was involved with research, set up a Drug Unit, and also established the geriatric psychiatric services for Sheffield. That meant a lot more work, and a bit foolishly, I did it all myself. I saw the geriatric patients and the drugs patients myself at the out-patients department. I was aware that holding the title of Professor was a silly thing, making people think that I was something special and could offer things others couldn't, but I wanted to keep touch with what was going on with peoples' lives. I didn't delegate very well. It's a dilemma. If you want to understand people you have to interact with them, and at the same time you have people coming to you, not because of any ability you might have, but because of the label you wear: Doctor, Psychiatrist, Professor. I think I should have delegated more, because I would tell people that they would do just as well talking to the nurses who were there with them and were readily available.

I enjoyed the life, of course. There was nothing much to worry about for me. I was very well paid, I liked the money, and I could go here and there, I organised all sorts of meetings and so on. Though all of that distracted me from looking after the patients at hand, listening to them, and so on.

The psychogeriatrics was a big chunk of time, simply because the elderly were treated appallingly if they had dementia. I was opposed to there being a psychogeriatric specialism until I saw what

actually happened. If a doctor was generous to the over-65s, he got the lot - and then you had your wards blocked for ever. And if you weren't generous, what happened to them? So the only way to do it was to make sure they had a ration of the budget. Those sort of political decisions were being made all the time, as well as actually practising any psychiatry. It was a matter of balancing all sorts of forces and pressures.

I don't think I was a wonderful lecturer to the students. I was too contemplative. I tended to think out loud in front of them and they wanted didactic teaching. They mostly thought I was pretty strange. They twigged that I didn't myself know quite what I believed! For the peculiar fact is that because drugs are effective in some ways in relieving all sorts of psychiatric conditions - and that's true of illicit drugs as well as legal ones - there is something very like a medical component in psychiatry. The medicalisation of people's problems is a very confusing area.

Still, I always thought it wise - and I was never forgiven much for it - to admit that psychiatry has a policing function. Society requires some sort of thought police, in some sense. That's putting it rather crudely, but I think that much of mental illness is that which is not approved of, but for which the society's concepts of justice just don't work. This is largely because the whole notion of agency, the whole idea that there is a self that actually chooses, is problematic. I think we have an everyday way of working which might make good sense, but if you enquire too closely into problems of freedom and choice, things become less clear. I can't see that a society can operate without the assumption that people are responsible for their actions, or largely so, unless you make a special category that people can enter into - something like an illness which means they are not any longer responsible. Of course, this is where psychiatry comes into it, dealing with that special case.

If this is so (which it seems to be), psychiatry does then have a function of controlling that which must be dealt with irrespective of justice. This is nicely (but unfortunately) illustrated right now by national political interest in the concept of 'the psychopathic personality'. No-one can say it's just to lock a man up before he's committed the crime. Yet here we have a series of Home Secretaries discussing exactly that possibility.

The concept of Thought Police is a bit chilling, though I never took the totally radical view that it's wicked to be a policeman. I think society needs sophisticated and responsible policemen, and I spent a lot of time trying to work out how to be a self-respecting policeman, amongst the other jobs in psychiatry. There it is. What do you do with the big problems that do arise?

I can't help thinking that what is needed in the discussion of psychiatry is a greater sense of reality. I would see psychiatry and mental illness in terms of vested interests and struggles between people and groups, and the false gods that are made by the linguistic control of people. I don't think that biochemical research should stop. There are certainly differences between the reactions of different nervous systems which can be explained best by neurophysiology. People display great differences in heart-rates in response to stimuli, and so on. Some people live as if they are in a jungle full of wild animals, and other people don't notice that at all. And this is tied up with neurophysiological differences.

I also think, though, that there is a whole area in which medical or technical discourses are convenient kinds of gobbledegook. I suspect that people have a great need to all speak the same gobbledegook together. Then the question becomes: what gobbledegook do we have for what reason? What shall we make sacred? Not: what *is* sacred? But: What shall we *make* important?

I think psychiatrists should be increasingly aware of the treachery of the words they use. We can't escape the words, but we should deal with the treachery in as mutually respectful ways as possible. We should accept, too, that utopias are impossible. There is no absolutely 'best way' to deal with things. I think, philosophically, that the self is an illusion, but the struggle is for the self, and this is a struggle to become a self able to live in an adult way with other selves. I think psychiatry should put that sort of emphasis or attitude into the game.

After the radicalism of the 1960s and 1970s, there's been a tendency towards conformity. Just the same, I think Laing and others went too far. I think what they failed to see is that it isn't wicked to have a police force. They had some idea that if you 'let it all hang out' it would all be all right. I don't think things are as simple as that. It was utopian. They were against planning anything for the future,

and just wanted to smash the bad reality they saw around them, and would think later about what should replace it. I think there was something infantile and adolescent about that sort of attitude. I would rather be an adult who recognises that you can't be nowhere in history and society, the same as you can't be nowhere geographically. You are here. And here has everything from a given language to a given politics. To some extent I thought the confusion of the schizophrenic was that he thought he could have an accurate language of his own. That is not possible, however, without depending on the language he was given. Even if he uses metaphors, they are based on the common language. It's like wanting to kick a football with two feet - very original, but disastrous! By the way, I think the cultural revolution of the 1960s, in a wave of excitement, tried to kick a football with two feet. Of course I was made a professor in the '60s, which was a mixture of excitement and fear because the students were always occupying something or other, and psychiatry wasn't that popular!

I had an interesting experience of trans-cultural psychiatry and of the role of politics in psychiatry. I was moderately well-known professionally for the translation of Gjessing and my work on biological clocks and psychiatry - I think that's why I was made a Fellow of the Royal Society of Physicians, which was very gratifying. Because I had a bit of a name, I was invited by the World Psychiatric Association to a small and very well-organised meeting in Leningrad. There I met some people who spoke about abuses in psychiatry in the Soviet Union, and some of them wanted it brought up at this meeting. As a guest of the Government I didn't have the courage for that - I didn't understand the situation, I didn't speak Russian - but I went to see the mental hospitals. When I was there you could get three years in prison for having a Solzhenitzyn novel in your pocket - except for *One Day in the Life of Ivan Denisovitch*, because Khrushchev [the Soviet leader] had read that. His other books were forbidden, so you knew what you were doing if you protested.

I came back and talked to a number of people. Then someone sent me the papers of Vladimir Bukovsky, who was an artist in the Soviet Union who was always protesting. (By the end of the 20th century he was in the Department of Zoology at Cambridge.) His papers were translated into English, a great bundle, and I was asked to comment on the papers, whether they were true reports of what was going on. When I read them I thought I had to say something. I'd already been primed to some extent by talking to various people. I wrote to a couple of dozen leading psychiatrists in several countries and informed them, and they all agreed. So we wrote a letter to *The Times* which was published, so that campaign began and I got more and more involved. I never got invited by Moscow again! I say Moscow, because we went on from Leningrad to Moscow and celebrated May Day eating caviar and drinking champagne, looking out from the Kremlin onto the workers and soldiers parading in Red Square.

Here's an example of how psychiatry was used against dissidents in Russia in those days. Medvediev was a Russian geriatrician who I was less involved with. He was asked to come to Sheffield for a meeting on geriatrics, and said he'd be delighted. Next, an official letter arrived saying it was impossible to find the travel money. Then the people in Sheffield wrote back saying we would pay. And a reply came back: 'Oh, what a shame, now he has made other commitments.' 'Well, can he break them?' 'Well, he'd like to, but...' And it went on like that. There was a party in Sheffield at the time of the meeting, and people were there who knew that Medvediev was locked up in a provincial mental hospital for 'having grandiose ideas'. A big protest was set going, mainly by the geneticists, who had been involved after the fiasco of Lysenko's forged genetics. In the end Medvediev was let out, and the excuse was made that some silly little village psychiatrist didn't know what he was doing: they admitted in his case that he shouldn't have been psychiatrically committed. He came here afterwards, in the late 1960s, and told us how psychiatry was being abused by the powers in Russia. He ended up at the Medical Research Council in London - these people all got out in the end.

I got more and more information from people getting out of the USSR, and people sent me more and more zamizdat material, which became overwhelming. I couldn't deal with it all. Then, by and large, the Zionist organisations took it all over. To some extent I didn't like that. Although I was sympathetic to the protests of the Jews who were getting shut up in the USSR, I thought the Zionist element in it was at least questionable. Then, of course, a Palestinian Arab girl came and told me that the Zionists had taken her house and her uncle's house - and there we were allied to people

recommending Jewish emigration, which the Soviets were against because they'd paid a lot for the education of these people. So the abuse of psychiatry issue became tied into this Zionist issue. It taught me a lot of the politics of how psychiatry can be used, and how making a protest could serve other ends.

That whole matter made me more aware of the thought-police function of psychiatry. One could easily see how deviance from the party line could get close to being called madness. It's only a short step for authorities who take exception to a person's ideas to convince themselves that it's so bizarre to disagree with their wisdom that the ideas must be clinically mad. This tendency should always be considered in any psychiatric work in any country. It is interesting that international psychiatry does have a definition of delusion, which is 'any belief held by less than six people'; more than six people makes it a sub-culture. When leading psychiatrists define things like that there must be an element of coercive abuse. Some delusions are acceptable and some aren't. And the ones that are acceptable are those held by people powerful enough to be a nuisance if you try to say they are mad.

The development of Care in the Community

Closing down the big old hospitals and the movement towards community care is best seen as three stages. When I worked at Littlewood, the vast hospital just outside Sheffield, I thought it really had to go. Its rundown was initiated by the movement that insisted that mental illness was really a type of physical illness and shouldn't be stigmatised, and that the move should be to the general hospital. But that didn't work out very well. All the low-rise housing and gardens and fields of the fairly human-scale old accommodation were lost for the sake of gaining a great deal more respectability. Many consultants were very much opposed to moving to the general hospital. After we moved into the general hospital I could see that didn't work either, so I became an advocate for the move further into the community. Again there was conflict with some of the consultants, but Care in the Community would be OK so long as we could make the community care.

This is where the Italian example, led by Basaglia, was important. We never managed to do it properly - we never got the press and the public on our side like they did in Italy. In a way it was easier in Italy because things had been far more appalling before the change in Italy than they had here. Something had to happen in Italy - the Communist Party and the Catholic Church agreed, and nothing could have stopped that coalition achieving something. Over here we didn't play the media well enough - one of the problems with democracy is that the media controls it!

I think that community care has worked, though, on the whole. Obviously, more money would make it work a lot better but, for example, the amount of violence from schizophrenics has not increased at all since community care was introduced. The newspapers liked to give everybody the feeling that something dreadful has happened. The murder rate from schizophrenics is slightly higher than that of the general population, but not much, and we are all far more likely to be killed by a relative at home than by a random schizophrenic. I think care in the community has worked on the whole, but most people haven't noticed it. I think that lives are better - often still not good, but better - for such people.

It seems to me there will always have to be some way of taking people out of circulation when they don't fit in very well. Such people get rejected and the tensions increase and a vicious cycle sets up leading to worse behaviour and greater rejection. This means that work should be done on the tensions. The question of stigma is also important. To call someone 'mentally ill' disenfranchises him. Thomas Szasz talked about 'cruel compassion'¹³ - the idea that when someone is 'ill' he doesn't have to be listened to. That takes away from the person all of his agency.

One of the jobs of psychiatry, you could say, is 'to keep society tidy'. I can't see there ever not being a problem of people wishing to exclude those who are causing the rest problems. Even so, I think intelligent criticism can cast some light on what's happening - that there are two sides to the argument, that the psychiatric patient has a case, and a right to be heard. I don't think progress is

¹³ Szasz, TS (1973) *Ideology and Insanity: Essays on the psychiatric dehumanisation of man*. London: Calder & Boyars.

inevitable but still I think that with education we can gradually win the argument and show what's going on, that everybody needs to sustain an ego, everybody has a right to be heard. And, as much as possible, we should do this within the community

Recent practice, and the problem of the diagnostic categories

Compulsory detention for up to 28 days for the assessment and treatment of people whose mental disorder is considered dangerous to themselves or others is usually carried out under sections 2 and 3 of the 1983 Mental Health Act, and on the authority of two medical practitioners. Of course, it can then be renewed. A 72-hour emergency admission can be had on the application of a social worker or a relative and with the authority of a doctor, preferably one who knows the case.¹⁴ My attitude is that it's unrealistic to think that we could possibly deal with every instance without resorting to coercion. I'm not a dogmatic libertarian. I do think, however, that sectioning is quite often overdone. Not only is it overdone, it's also kept on for too long.

Undoubtedly, the problem is that often the psychiatrist is frightened, and you can see why: he will be held responsible for whatever the patient might do. He has to protect his professional reputation, as well as all the staff and public around the case, so the tendency is to err on the side of safety rather than risk. This has also become more pronounced because of the recent trend towards litigation against doctors for some of their unfortunate decisions. So the interests of the patient's liberty and health can become compromised.

The language we use, too, can be very treacherous. The words 'psychosis' and 'schizophrenia' appear to represent clear things when in fact they are just fairly useful, with a sort of halo, diffuse meaning. I don't take the view that those words have no meaning. I have a great respect for the early workers in the field who used such terms as they struggled to define the problems: you can only approach matters with the terms you've got, and from the ideological context which you inhabit. I think the categories are semblances, descriptions of real events. In the case of schizophrenia, I do think that Kraepelin discovered that the types of symptoms that he talks about have the statistical prediction of a difficult future. The trouble is that matters are not simple or concrete or by any means 100% predictive.

Any sharp line between reactive and endogenous depression has long since gone from psychiatry - the idea of endogenous depression being that it is somehow constitutional. I do still think that perhaps neurophysiology might be able to deliver psychiatry quite a lot of useful information, but there is no sign of that for the foreseeable future. The trouble is that today it is greatly over-rated: too many people think neurophysiology understands much more than it actually does. It's not much good conceiving of the mind as completely separate from physical processes. On the other hand, though, psychiatry's tendency to believe everything psychological can be reduced to something physiological - which is what I believed when I began my career - is far too simple.

Perhaps we try to solve this conundrum of the relationship between body and mind in the wrong way. Usually we all try to figure out: what is mind? We should perhaps focus on: what is matter? What we conceive of as matter itself depends on our concepts, our language. We won't solve the problem of mind-body dualism, the 17th century concern of Descartes, and which we usually think about in relationship to 19th century chemistry and physics, until we become a lot more sophisticated in our conception of matter.

There are social causes for depression, of course. There's no question about that. Freud wrote a wonderful paper, 'Mourning and melancholia',¹⁵ showing the similarity between bereavement and clinical depression, in which he gives us the whole idea of the loss of the loved object (person). Certainly, there are the extremely important questions about recurrent depression and puerperal depression (that starting after giving birth). There's no clear evidence for endocrine causes for either. Nonetheless, there is no doubt about the enormous physiological and psychological impact of

14 See *The Mental Health Act (1983)*, op. cit. (n. 70, Ch 1), 2-6.

15 Freud, S (1914-16/1964) Mourning and melancholia. *The Complete Psychological Works of Sigmund Freud: Standard Edition XIV* (Ed and trans Strachey, J) London: Hogarth, 243-258.

pregnancy, childbirth and the consequent new responsibilities and changes in established family relationships. Also, there can often be recurrences after the event.

I would preach a certain humility before such things. We ought to be running a type of psychiatry which is aware of our ignorance rather than one falsely confident in its answers. My original research work was in the belief that there must be organic causes. And I still wonder why it was that certain psychotic patients would manifest extraordinarily regular cyclic patterns of good and distressing behaviour, which, on the face of it, would indicate a physical basis. That sort of evidence can't be ignored.

Though I don't think we can talk about people 'sharing similar situations', and then be surprised that their responses are quite different. Everybody is born into different circumstances and lives a different life. The concepts 'similar' and 'different' are always used politically, according to the conveniences of our own interests. I don't think the meaning of experience can ever be quite the same for any two people. We don't know why one person should retreat into depression and another plunge into hyper-activity in response to what seem to us to be 'similar' sorts of precipitating events. In their balance, people are a little like computers. Modern chaos theory might be able to help: anything in some sort of extremely complicated equilibrium can be tipped out of balance by quite small 'errors', which can then multiply their effect fairly rapidly up to a point of breakdown. You can never know absolutely the conditions from which a person starts to enter disequilibrium, and therefore prediction is impossible.

Phobias seem to require some previous experience of a threat that recurs later as a psychological problem. Hysteria is at some level a cerebral representation of a feeling of paralysis in response to the life the person suffers. I wouldn't say there is a categorical difference between pathological anxiety - meaning severe anxiety - and any other. Anxiety is a normal response to threat. If people are susceptible to specific anxieties this must be understood by trying to find out what happened in their lives. The outlook and beliefs you have will be relevant to your anxieties. Obviously, in certain circumstances strongly held religious beliefs can cause people deep anxieties, as well as provide reassurance.

I think obsession is an extremely interesting phenomenon. Freud sees obsession as similar to religious ceremony or ritual: it entails atonement for sin, real or imagined. The obsessional person always has to perform his own rituals to a rigid pattern, and feels that if he gets it wrong some enormous disaster will befall. I remember a very obsessional woman who had a husband who I thought was quite a nice man, but she despised him because he had gone to a grammar school but only worked at a menial job. She lived a ritualised life, checking whatever she did according to certain rules. I thought she was dealing that way with the aggression she felt for him. This was confirmed when she got better immediately after he died. Another woman was obsessive about washing the vegetables three times before she cooked or served a meal. Her husband was a despicable individual. I thought her behaviour could be explained by her determination to resist her desire to poison him. The police get driven quite scatty by people going to them and falsely confessing that they have committed murders reported in the media. Obsessionals seem to have a fair amount of heavily censored aggression. Stengel, my one-time boss, wrote quite an interesting paper arguing that obsessional neurosis was a defence against schizophrenia.

The concept of personality disorder is just a catch-all for any behaviour that doesn't fit into any of the other categories. As far as I can see, the idea of the psychopathic personality is really just a label for a recurrent criminal. The concept implies a lack of responsibility, but this begs so many questions of free will and causality which routine psychiatry simply ignores. It is true that you can group a number of people together as very difficult socially - they lie, they steal, they're violent, and so on - and you can't say that they fit under any psychiatric category. Hence the label of psychopathic personality.

I think all these categories used in psychiatry are as good an attempt as can be made in order to deal with the people that present psychiatrically. There are characteristic differences that can be grouped together. For example, manic-depression is sometimes dealt with miraculously by lithium. Perhaps this is something much more like a physical illness. If you give them lithium they get better,

they go back to work and the thing seems to be all over. Some of those called schizophrenic, in terms of the criteria - even though they are shaky - by and large do respond to the phenothiazines. In that sense, the drugs do work, as tranquillisers, in order to calm the person down and give him time to reflect. The categories are poor and the drugs blanket, but they do have some use.

As my career progressed, though, I looked less and less to the category 'madness' or to *how* people were mad, but more to *what* was driving them mad. I became increasingly committed to understanding the person in humanistic terms. When I was younger I was all for explaining, but as I got older I was all for *understanding*. In order to grasp what it's like to be the patient, a life history must be ascertained. I think you have to accept that an understanding is always more precarious than any natural scientific explanation. You can't measure understanding statistically, as you can measure bacteriological processes. Still, understanding is the most relevant process for human activity.

A mental illness is only what society defines as such. For instance, is drug dependence a mental illness or not? I think the concept of mental illness is invoked to deal with things when the person is a nuisance in some way or another and yet the concept of justice can't deal with them. I don't believe many patients are truly voluntary: they enter psychiatry by doctors getting involved and they find themselves entering a social process which can't easily be stopped. Psychiatry has to accept that it is, to a degree, a sort of police force. It is inevitable that someone will perform that kind of function, and the more sophisticated and mature the police officers the better.

Psychiatry is ambivalent about drug or alcohol dependency. It isn't clear about whether it is a mental illness. This illustrates well the fact that psychiatry is really used to mop up a social problem. Society says people shouldn't take some substances, and it's a crime, but if a person goes to a doctor and registers as an addict he gets it free and he becomes ill, not criminal. This shows the rather ludicrous nature of the language. Drug dependency is certainly incapacity and dis-ease, but is it an illness?

There are no simple answers to why one person will sink into a depression when knocked back by events in his life, while another will become alcoholic or drug-dependent. The proscribed substances are physically addictive, and heroin particularly so - although it is medically safer than alcohol - and all of them create withdrawal problems. Getting involved in the first place has social motivations. If you live in an area of deprivation surrounded by a drug culture there are strong social pressures and you'd be abnormal not to get involved. The real question is why some fall by the wayside and others come through and survive quite well. Nobody knows the answer.

These are genuine problems that psychiatry is asked to deal with. Whether you call it mental illness or not doesn't really matter. Szasz says there are real problems, but he wants the judicial system to deal with all of them.¹⁶ I feel that isn't entirely realistic. If the term 'mental illness' is used, that immediately implies primarily a medical response. I would be quite willing to get rid of the phrase 'mental illness' and call it 'psychological disturbance', 'upset person' or any other term that suits. Once the word 'ill' is used, the medic is given a special role in things. This is attractive to him and perhaps to many other people because a medical response seems a lot easier than a political or moral response. As Thomas Szasz points out, though, if the term 'mental illness' is employed you get cruel compassion: the person is held not responsible and becomes completely disenfranchised.

All the same, much improvement since mid-20th century

I would say that things did get continually better in psychiatry throughout my career. When I first went into psychiatry the beds were side by side on huge wards, people didn't have their own clothes, there was crowding. The whole place suddenly became quiet when the phenothiazines came in, the shouting stopped and you could hear yourself think. They also gave everyone a sense of enthusiasm, the feeling that at last something could really be done. There was no hope in psychiatry until just before World War I. The great authorities who wrote about mental illness had no reason for optimism until GPI began to be cured. And then the optimism that arrived with the phenothiazines, in mid-century, led people to believe that psychiatric wards could be reduced to just a rump attached to the

¹⁶ For example, see Szasz, TS, op. cit. (n. 13).

general hospitals. This was a bit misplaced, but still, things did improve dramatically.

Relations between doctors, nurses and the other professions have changed so much for the better. When I started, and did the rounds, I had to see *hundreds* of people, and the nurses stood to attention, with the patient, next to the bed. Of course, the nurses then weren't necessarily very well educated, and there could be good reasons for the doctor being so powerful. Even though, of course, if there is time enough, anybody can be as good as anyone else at helping a patient if they just take an interest in him. I'm sure people wanted to see me and not a nurse because they felt I could do something miraculous, although there wasn't much evidence that this was true! I still feel that the deference given to some expert, or The Top Expert, is a major factor impeding progress in psychiatric care and help. Things have become far more democratic as between the various psychiatric professions. I favour that. All the same, efficient decision-making demands some sort of hierarchy of responsibility - there has to be a desk at which the buck stops. What is needed is balance.

Freud was aware that sexuality presents a great problem to any honest person. I believe he underrated power in relation to sexuality - I'm rather an Adlerian.¹⁷ It's interesting that in an era of so much more sexual freedom, sexuality hasn't stopped being a fundamental concern for everybody. And yet sexuality is not consciously incorporated into psychiatry, except marginally. Psychoanalysis was emphatically rejected at first, by everybody. I think psychiatry is like Hinduism - at first it rejects ideas, but in the end it incorporates them.

The role of medicine in psychiatry, first and foremost, is understanding drug-use. Asylums could have fallen into the hands of psychologists or could have been in the hands of the churches, or educationalists. There's no absolute reason why psychiatry should be dominated by medically-trained doctors. I think that, historically, drugs did improve the situation somewhat. I know that there is evidence that the big old hospitals were beginning to empty a little before the phenothiazines came on the scene, but I lived through the introduction of the new drugs, and they certainly added a very important new dimension to things. Peculiarly, that was the time when people began to question medicine - just when it started to do something relevant. Even so, drugs and their interactions and side effects and so on are, of course, an important medical issue.

There have been noticeable differences in the types and proportions of presenting psychiatric conditions over the last fifty years. When I came into the field you would see a lot of posturing, catatonic patients. Gjessing, with whom I worked on what I thought might be a chemical cure for manic-depression, was studying periodic catatonia. It all looked very physical, and some patients did perform to a timetable. This has disappeared. It's made a fantastic difference. In 1913, Kraepelin reckoned that 10% of all presenting cases were catatonic. Nowadays, though, I should think most doctors, even psychiatrists, would never have seen a case.

I came to believe that that sort of catatonia was partly a product of the hospital. Catatonia is a final stage of impasse. It was really the end of the road when a patient reached a back ward in one of the old hospitals. Catatonia doesn't occur if you give people phenothiazines. Most people who get to a general practitioner will get some or other drug and not reach that end-state. But perhaps it was a virus disease and the virus has disappeared. There's not much doubt that the world epidemic of

17 Alfred Adler was interested in the dynamics of power and compensation; he believed that social factors such as gender and politics are just as psychically important as libido. Although Freud did not share Adler's socialist beliefs, he invited him into his discussion-group very early on (in 1901), and they remained colleagues until 1911. Adler was an optimist and often wrote for the lay public in an accessible manner. It seemed to him that a person's behaviour depends very much on the way he construes reality. While still a member of the Vienna Psychoanalytic Society, Adler developed a theory of 'organic inferiority and compensation'; this was the prototype for his later concept, the Inferiority Complex. Adler supported feminism; it seemed to him that feelings of superiority and inferiority were often gendered and expressed symptomatically in a characteristic masculine or feminine style. He understood neurotic behaviour and 'safe-guarding tendencies' well before Anna Freud wrote about them in her famous book, *The Ego and the Mechanisms of Defense*. Adler recommended pre-empting mental health problems by encouraging and promoting social interest in children, and by avoiding pampering, neglect and corporal punishment. See Adler, A (1964) *The Individual Psychology of Alfred Adler* (Eds Ansbacher, HL & Ansbacher, RR) New York: Harper Torchbooks.

encephalitis lethargica in 1919 - the sleeping sickness which was also associated with so-called psychopathic disorders and with a wave of criminality - was due to a virus. Still, I suspect catatonia was not caused by a virus, but that the condition was a reflection of what happened to those people in the society and the mental hospitals at the time.

Schizophrenia, in general, is not as wild as it used to be, and hysteria is not as gross. Hysterical blindness or deafness or lameness, or aphasia (inability to speak) all seem to have abated. Psychiatric conditions seem to have become less gross. This change is due to the fact that nobody is left to get so bad any more, at least anywhere where there are modern psychiatric facilities. Consequently, anxiety and depression have become the more common forms of problems, and they are of course rather less spectacular forms of malaise.

The psychiatric system became a lot more liberal from the 1960s. A 'revolving door' intake of patients has replaced the old sort of terminal hospitalisation. People are having much longer periods outside. I'm quite optimistic about the progress that has been made in psychiatry during my time. It all comes about through the constant pressure of various interest groups, but positive things have been achieved by people pushing for changes. The more educated people become about psychiatry the better they can negotiate with the hierarchy, which used to concentrate nearly all power into its own hands.

When I first started as a junior psychiatrist I had 500 patients. What could you do but play golf in the afternoon? When I was appointed Professor I was the only one in the Trent region - which took in a population bigger than that of Scotland. Now power has been spread to all sorts of places and there are half a dozen Professors of Psychiatry in Sheffield alone. Also, the other psychiatric professions and Mind and patients' groups have all taken bites out of that once nearly absolute power.

As far as treatment goes, the big change of course was the introduction of the new drugs. I also came to the conclusion that in a limited way ECT does work, but only in very special circumstances. Of course, there have been campaigns against its use and it is given far less often now. I didn't use it once in the last five years of my clinical practice, because I didn't feel it was needed. I avoided it like the plague because I thought it was a very crude solution to a human problem. Nevertheless, I did occasionally see an old lady who wouldn't eat and wouldn't drink and was going to die, and if you gave her ECT it worked. I never knew in my own heart of hearts that if she wanted to die she was entitled to, but since she wouldn't communicate you couldn't tell if she knew what she was doing. Whether she should have been brought back to a condition where she began to eat and drink again, I don't know. No matter how crude and damaging it may be, ECT seemed to have worked.

I do not think ECT should be rushed into. When I began in psychiatry ECT would be given routinely, and if it didn't work - *then* we would speak to the patient! Its use has been moderated, but I do think it's still far too much over-used. I was opposed to a total ban, though. During the last five years when I didn't use it at all, a woman was in a dreadful state and all the staff wanted her to be given ECT. They said I was just letting my ideology stand in the way of treating the patient, so it was democratically agreed that she should be given ECT. But she couldn't sign the forms and her relations wouldn't sign them, and we had to wait to get a second opinion from outside Sheffield. That was going to take a week or so. Then, the day before the other psychiatrist was due to arrive, she suddenly got better!

This also illustrates the great difficulty in making confident decisions. I strongly advise humility in the face of a psychiatric disorder. Years ago I had a doctor as a patient and I arranged for her to have a leucotomy because her life had become so impossible. She then recovered and went on to get higher qualifications in medicine, and sent me a gift thanking me, with the message: "Why didn't you do it eight years earlier?" I wouldn't say she became very well, but the difference was quite remarkable. Unfortunately, I'm afraid that after that success I agreed to a few other patients undergoing the surgery. They were all complete disasters, so I quickly stopped. It isn't easy to decide what to do with people who have come to some sort of desperate impasse.

I came from a background in chemistry, so I was very interested in the possibilities of drugs. I did the world's first double-blind studies on Librium and Valium. (In double-blind tests, neither subjects nor researchers know who is getting an active dose and who an inactive one, until the results are in.)

From Roche Products I got a camping holiday in Vienna and £50 for a flame photometer for the laboratory, in order to measure lithium. In those days I thought that was rather good. I made a lot more money later when I defended them when they were sued! However, we did act in good faith. I didn't realise lithium was addictive until it had been in use fifteen years.

I think I gave out drugs too freely at the beginning of my career. I was only a junior doctor, however, and you can't imagine the length of the queues waiting to see me. That is something else that has enormously improved. When I started doing out-patients surgery there were dozens of people outside the door, all to be seen in an afternoon. I didn't have an hour to see every new patient in those days. I didn't know what psychiatry was. I did what I was told. What else would you do until you began to figure out what was going on? Yet by the end of my career I think I might have made some people worse by refusing to give them drugs. A rabid resistance to giving drugs is not necessarily in the patient's best interest. It's a matter of some sort of balancing discretion, using drugs as little as possible but not being dogmatic about it. What I used to say to people was 'Let's try it for six weeks, let's honestly discuss it together, and throw them away if you don't feel any better. But let's at least give it a chance, if you're feeling so bad'.

I favour the switch to Care in the Community that began in the 1980s. Of course the community must learn to care more for its own. I think the Italians, who took the lead, did it better than us. They began by 'softening up' or educating the general population by first dealing intensively with the media. Here there has been such a battle, which is still going on, between those trying to put the policy into effect and those who are misled by fear and sensational newspaper reports. If it's going to be care it has to offer something worthwhile, and it's best for people to live as far as possible in ordinary houses and in moderately small groups, and people should have places to go to and things to do.

I had patients complain to me about being turned out of the hospital which had become their home, where they had few responsibilities and lovely gardens and sports fields, and so on. Even so, it does appear that the majority have had their lives greatly improved by the move back into the community. I think it has, on balance, been therapeutic. Though I think the Italians made a dreadful mistake by saying that it would be cheaper than hospitalisation. You do have to pay for what's worth having. However, in terms of it being therapeutically better, it has probably worked out to be cost-effective. It's so difficult to arrive at any meaningful figures. A great deal depends on how the sums are done. Do you include the non-psychiatric medical facilities of a mental hospital when you work out the cost per bed?

The question of Community Treatment Orders is difficult. I am on the whole opposed to the idea but also I'm opposed to the idea that you can run a mental health service without a hospital at all. I think there will be cases where there has to be some compulsion. I feel the 1983 Mental Health Act provided quite sufficiently enough for coercion, and we didn't need a new order for compulsory treatment in the community. That does mean, of course, that some people do sometimes need taking back into hospital.

I'm much in favour of patients' self-help groups and advocacy, which has really come along in the last thirty years or so. Though I have come to the conclusion, having been involved with a drop-in centre that patients run for themselves, that there is something a little unrealistic about thinking that people who are very disturbed are the ideal agents to take total control. It's a bit of a contradiction in terms. Such people are not necessarily all kindness to each other just because they share a fate. They shouldn't be romanticised. On the other hand, I don't think it does them much good if they are not given as much sensible control of the situation as possible. I've found at that drop-in centre that many of those involved do need help not to be vicious to each other in the face of the inevitable problems that arise. You're talking about giving power or control to people who are often only just recovering from states of quite extreme desperation, and the slightest conflict can easily escalate amongst desperate people. The drop-in centre that I'm associated with was set up by a group of students with a social conscience, with some help from people like me. It evolved out of the students setting up a half-way house. By 2000 it had been running for about thirty years, and is part of the survivors' movement. After a time people like me were told that we weren't wanted, and then the place got into

a bit of trouble and professionals were allowed back in to help, and then again they decided they didn't want professionals around. There's a changing clientele but some of them have been going there for years.

The place tends to be bedevilled by a massive use of drugs. This is against the rules of the set-up, but it's very difficult to stop people buying and selling there. There has been a tremendous increase in drug abuse during my career. When I was a student, a heroin or opium addict would be an unusual case. Not now. What is interesting is that laudanum and opium were widely used at the end of the 19th century yet they disappeared at the beginning of the First World War. The problem just ceased to exist from about 1910 until the 1960s and the Vietnam War. Of course, there were the odd medics or the odd bohemian who'd got hooked. Currently there is a big and growing problem of psychiatric drug-dependency. I'm for the total legalisation of all drugs. Alcohol seems to be more trouble than it's worth - Muslims are probably right about that. I don't think the police and prisons can deal very well at all with the huge problems posed by completely outlawing certain drugs.

Unfortunately, the present constraints and boundaries of funding mean that the drug-dependency agencies tend to say that the people they see have psychiatric problems while the psychiatric clinics say they are drug-dependent. The addicts, meanwhile, often fall between the two. This illustrates a pressing problem in funding. Governments are so concerned about accounting and the possible misuse of funds that budgets demarcate populations that refuse to fit into the pigeonholes. There is, of course, the major divide between Social Services and the NHS; and then each of the multitude of agencies within those two Departments are supposed to deal only with strictly demarcated, finite, defined populations. Meanwhile, people live their lives in processes of constant flux, and this often makes the response to them bureaucratic and insensitive, too late, inappropriate, or ineffectual.

I think the benefit system needs a thorough overhaul. As it stands, the disability benefit system encourages some patients to remain ill. If you remain pretty psychotic you get a better living and rent allowance than some people who are in work. It's not a great incentive to get better. As things are, monetary return stands in the way of people's own efforts and their own self-respect. A fairly generous Disabled Living Allowance is necessary for someone who has lost both his legs, for example, but if a psychiatric patient gets the same amount because he demonstrates that he is totally disabled it isn't going to help him get better. At the moment a fair number of people have the attitude of screwing the system for as much as they can get, which has nothing to do with improving anybody's mental health.

I think the fear of madness is essentially due to a concretised view of what madness is. It is frightening to contemplate the loss of your reason, but most people's ideas about it are not very realistic. I think psychiatric workers, dealing with it day in and day out, become a little indifferent to the generalised fear of madness. Medicine is strange in that respect. I remember working in a Casualty Department, with people being brought in with their legs hanging off and so on, and it didn't worry anyone. We just did what we had to do. Then you might walk home and see a cat run over and get upset about it. I don't think you can be involved with psychiatry and not build up some defences. You need to be concerned, but you'd be no good if you kept getting massively upset.

What the mad say is not what the society wants to hear. In German there is no word for 'common sense', by which we mean 'good sense' but which also indicates a consensus. The literal translation of the equivalent German term is 'healthy human understanding'. It's a matter of health. Politics and language are intertwined, and unless you're willing to get a little metaphysical you won't see how language influences our understanding and hence our politics - and our psychiatry.

I believe that psychiatric care or help should be based on intelligence and humility. We are dealing with things that are far more complex than we can comprehend - yet we still have to deal with them. Usually we can deal with it best by assuming that the person who confronts us is more like us than not like us. A psychiatric patient is not from outer space. So the best thing to do is the thing to which you yourself would respond most favourably.

Chapter 10: WORKING AS A MENTAL HEALTH NURSE

Lin Bigwood, RMN, BA (Hons) and MA (York), Dip Couns¹

What about all the people living in the nightmare hurt
That won't go away no matter how hard they try?
They've got to pay time and time again, time and time again.

Van Morrison²

These recollections mainly concern work on wards, and they begin with an account of coping with psychosis. This leads to a discussion of the developmental dynamic of insanity. Emphasis is put on the need for good psychiatric organisation and for officials to listen to the patient. This is followed by an exploration of the reasoning behind the major categories of psychiatric diagnosis.

Lin Bigwood points out that the medical model cannot account for functional mental disorder - which is to say, the behaviour of most psychiatric patients. Consequently, orthodox psychiatry is essentially and literally careless - formal treatment consists mainly of drugging and electroshock. This is the result of muddled thinking and blind faith in the medical model, and it is too often positively untherapeutic.

She then briefly considers the invention of the modern psychiatric treatments, in which it seems that psychiatry is ruled not by science but by confusion and wishful thinking. Among the officials, ignorance and fear, ideology, professional self-interest, political ploys and career advancement, the wish to dominate patients, and the inertia of mindless routines all conspire against genuine care and therapy. Drugs and shock treatment are administered ritualistically as a modern kind of magic; even the better ideas about how to help patients are distorted as they enter practice.

As opposed to the confusion generated by the medical model, Lin Bigwood proposes care and therapy as: trying to provide for patients' basic material and emotional needs, building sympathetic human relations with them, and trying to help them to explore their problematic biographies and social relations. She also discusses the psychology of psychiatric work and the survivors of psychiatry. Finally, she argues that, in cases of functional mental disorder (mental illness) counselling or psychotherapy should be offered in preference to medical or behaviourist treatment.

Working with psychosis

It seems to me that most people come into psychiatric work with the best of intentions. My experience of student nurses is that they usually take an intelligent and sympathetic interest in the patients, but there are such strong forces in the psychiatric system working against their enthusiasm that all too often they are reduced to confusion, disillusionment and cynicism. Much of this chapter necessarily amounts to a warning about bad ideas and practices. I discuss a number of cases in order to illustrate the nature of various types of mental disorder and their apparent causes, as well as the routine types of psychiatric response; these are too often in conflict with the precepts of therapy that could more often provide lasting success.

The general assumption is that anyone who suffers from a psychological problem has an illness which can only properly be remedied by a medical intervention. But this makes for a certain

¹ From discussions with Phil Virden.

² Van Morrison (1995) Days Like This. *Ancient Highway*. Polydor.

untherapeutic and even callous atmosphere throughout psychiatry. The near-universal deference to the medical model of mental illness results in few patients being given the time, sympathy, empathy and understanding of staff who are willing and able to engage helpfully in the process of exploring and rebuilding each damaged self. Medical intervention does not remedy mental and emotional processes - the best it can offer is 'put things on hold'. Furthermore, to the extent that everybody believes in the officially endorsed medical treatments, to that extent action which might substantially help someone is deferred or never offered, and many patients' emotional or psychological problems become chronically stuck for years, or a lifetime.

It is more than forty years since I came into psychiatric nursing as a cadet. Since then I have experienced many areas within the field, including service on eight different admission wards and in every nursing capacity up to the level of ward manager. I also have experience of secure units. People should understand that despite all the changes in organisation and the fashions for particular drugs and treatments, neither the fundamental nature of mental disorder nor the psychiatric response have changed very much. I don't recollect ever encountering a case of any mental disorder that did not make some sort of reasonable sense, however twisted, in terms of the patient's basic problems of living. Positive steps have to be taken to discover and understand the circumstances which give rise to the emotional distress and the 'bizarre' ideas.

I began my career by working on a professorial psychiatric admission ward. The professor was responsible for training medical students during their eight weeks in psychiatry - eight weeks before they were let loose as doctors with 'an understanding of psychiatry'! Most of that training concerned diagnostic categories and drugs. What this meant for the patients was that if they were considered interesting cases and 'good examples' of their particular psychiatric condition, they tended to stay a very long time. In some ways this was beneficial since it meant they did not get sent off to a back ward - where the patients with no hope were sent, controlled by drugs and given minimal care. In other ways, though, it was a disadvantage because greater efforts might have been made to get them fit for discharge. It was also not so good for newly admitted patients since it meant that they might only have come in due to a moderately severe depression but they immediately encountered people who were much more disturbed.

One of the patients from that ward who particularly sticks in my mind was a woman, in her early twenties by the time I met her. Her diagnosis was schizophrenia. Lucy³ was very obese. The staff agreed that this was a result of the huge amount of Largactil that she had consumed during her career as a psychiatric patient. At her first admission she had apparently been a pretty, slim young girl.

This patient was pleasant and energetic, but it was often difficult to get her to communicate. She displayed few of the textbook symptoms of schizophrenia. She did not seem to hallucinate; possibly she had delusions. As far as the staff were concerned, however, the main trait to her 'character' was that she wanted to escape, get to the nearest port and leave the country. Because she was 'sectioned' this seemed like quite a reasonable idea. ('Section' refers to the part of the Mental Health Act under which patients are compulsorily detained.) Lucy was on a long-term section - Section 26 (1959 Act) - which was initially for 12 months, but it could be renewed for periods of two years at a time. This sort of indefinite sentence must be frightening, especially to a young woman.

It was well-known that Lucy was the daughter of a successful local businessman. He would have been fairly influential, and he and the psychiatrist would have had much in common - both were prestigious managers of a big enterprise. By all accounts, though, Lucy's mother was 'as mad as a hatter'. I did not meet the mother, nor did I ever meet any of the family because they *never* came to visit. Lucy did occasionally go home for an afternoon. I remember that Lucy's mother once sent her 'a gift' of six pairs of men's underpants. This demonstrated the mother's irrationality, and it certainly upset Lucy.

The staff complained that Lucy was 'difficult to control' and 'led them a bit of a dance'. Her favourite trick was to 'borrow' a nurse's uniform and a pushbike, and pedal out of the hospital at top speed. The staff thought this 'permanent warfare' was funny, and Lucy acted it out with a kind of

3 The name and identifying details in each case cited are, of course, changed to maintain confidentiality.

humour. And yet Lucy's intentions were not completely irrational - wearing a nurse's uniform would be a good disguise if she wished to escape. Because of this 'game' Lucy would often be kept in her nightwear so that she would be conspicuous if she did manage to get out of the hospital.

It seemed to me that one reason Lucy was kept on the ward was to demonstrate to students what psychiatrists call 'Knight's Move Thought'. This 'symptom of schizophrenia' is the tendency to respond to supposedly rational communication by 'leaping off verbally into a different direction'. Under other circumstances this kind of response might be called wit. While it was clear enough that other aspects of her comportment indicated that Lucy did have a certain psychological problem which needed addressing, it seemed to me that another reason Lucy was kept on the ward could have been that she was an embarrassment to her family. In the five years I worked in that hospital she remained on the same ward. Twenty-five years later, having left and returned to the area, by chance I met up again with Lucy. She was now consigned to a nursing home - a euphemism for a back-ward 'in the community' - and she was thin, haggard and reclusive.

After the professorial ward, I moved to work on a 'special unit'. Rather than a plain numbered or lettered ward, this was a showpiece and was run by the hospital's former Medical Superintendent. When they were fashionable, he had performed many leucotomies - meaning that he had sliced into many patients' brains. Perhaps the doctor regretted or was embarrassed by his former enthusiasm since it was widely rumoured that one of his patients was allowed to live an independent existence on a back ward. This patient was middle-aged and quite a character. He had commandeered his own room, ran the patients' social activities and carried on a relationship with a much younger epileptic patient from a female ward. The rumour was that the man had told the doctor that he had been damaged by the brain surgery and that he would sue if he was not allowed to live his own life inside the hospital. This patient had no wish to be discharged and simply got on quietly with his own life in his secure accommodation. By the time I worked with him, this doctor had completely changed his mind about physical treatment for psychosis, and was a local pioneer in family therapy.

On the unit there was a patient we'll call Jennifer, aged about thirty, whose delusion was that she was Joan of Arc. Lucy was from a very comfortable background, but Jennifer was from a very poor home. She was one of the most disturbed people I ever met. She had a younger sister I'll call Janet, also a patient but on the professorial ward.

Janet was labelled inadequate and prone to depression. She was simply unable to cope with life, and was riddled with anxiety and self-doubt. Jennifer must have got the worse end of the stick, though. She was so very anxious that she had tipped over into full-blown psychosis. She was dreadfully disturbed, and it was clear that she loathed herself and everybody else. She completely neglected her personal hygiene and would not respond to anybody, except that after a time she did finally start to form a relationship with the ward Sister, who was fairly young and pleasant. Jennifer believed that this Sister was called Mary. This seemed to be a religious allusion: Mary Magdalene or Mary the mother of Jesus. The Sister used to encourage Jennifer to go shopping with her in town, and she did finally persuade her, but every time she was bought a new item of clothing Jennifer put it in a rubbish-bin.

Jennifer's mother used to phone the ward and speak in a voice which once heard would never be forgotten. It was an excruciatingly slow and painful monotone. She would not ask after Jennifer but only ever complained about her own problems and her 'heart condition'. It was uncanny that Jennifer and Janet had *the same voice as the mother* - except not quite so exaggerated. This was awful to hear - a croaking, moaning monotone.

Once I was sitting in the hospital grounds with Jennifer when Janet came by. She proceeded to harangue her sister: 'We're all you've got in the world, Jennifer. You've got nobody else but us...' The message was that Jennifer was a sort of family traitor and that she should come back into the fold, become 'one of them' again. In her own way Jennifer was trying to escape from the loathsome, hypochondriacal, sickening and self-obsessed set-up in which she was trapped. The only way she could find to do it was to draw attention to her dreadful plight by identifying with Joan of Arc, a martyr. Trying to escape from the grip of her mother and sister was actually very heroic. At the same time, though, she sacrificed herself for her family. All she wanted to do on the ward was to lie in a

darkened room and regress. This is a familiar tactic.

The main nursing approach with Jennifer was simply to get her up and dressed, and this is what the student nurses were sent to do. It was an awful job. Possibly she would have been better off in somewhere like Kingsley Hall⁴ where she would have been left to regress, and for somebody to try to get down to her level, and communicate with her from that level, rather than to confront her and try to drag her out into the big rational world of the unit, which was obviously too much for her.

Jennifer was the sort of patient who would scare a student nurse, because she would come and sit by anyone and stare, and only say aggressively: 'What are you doing here?' It was very difficult to get close to her. It was clear that she was intelligent since she recognised that the only person worth relating to on that ward was the Sister (ward manager), who was old enough and experienced enough to have more of an understanding of her situation, but at the same time was not conventional and authoritarian - she was a decent, open sort of a person. She was also the one member of staff with any real power, so there was no point Jennifer bothering to relate to student nurses - young and inexperienced girls who had sympathy for her but did not know what to do.

The most productive time I was able to spend with Jennifer was once when she was trying to abscond. I noticed her as I was going off-duty. She was 'on a section' and was not supposed to be outside the grounds, due to previous suicide attempts. I tried to draw her into conversation and persuade her to come back to the unit. I remember that we did, in fact, have quite an interesting and coherent conversation. She told me she felt all alone in the world, and asked what was the point of living? She was preoccupied with her misery. She would keep me hanging in there for about a quarter of an hour, and then would rush off again. Then I would catch up with her and she would rush off again. She left the hospital grounds and went into a private garden. I knocked on the door and asked to telephone the ward, but Jennifer had run off again by the time I came out of the house. I did eventually get her back, but it took about three hours.

The sequence of events that ended Jennifer's life began with her receiving a letter from her mother. After this she went to the hospital shop and bought a box of matches. She then stood outside in the corridor, with the door open so there was a draught, and lit the bottom of her dress. It went up like a torch. A student nurse came out of the shop and saw her. Understandably, he panicked. Instead of taking off his coat, flinging it over her and pushing her to the floor so as to smother the flames, he ran back into the shop and told the assistant to phone the nursing officer.⁵ By the time the NO got there it was too late. But there you are - the student nurse was only eighteen.

The unit Sister visited her when she was taken to the General Hospital. Later she told me that Jennifer had been lucid, the sanest she had ever seen her. Jennifer had said that she didn't know why she had done it, and wasn't it a stupid thing to have done? She suffered 90% burns. Her mother came to visit her and told her what a stupid thing it was to have done, and didn't she know that her mother had a heart condition? The mother so pestered her dying daughter about her own heart condition that the nursing officer who was there asked her to leave. Three days later Jennifer died - a martyr like Joan of Arc.

As many men as women get a diagnosis of psychosis. Sometimes the cause of a mental disorder seems obvious to anyone with eyes to see, but unfortunately the medical model successfully bamboozles most people who work in mental health. For example, I remember a young man who was psychotic. Stuart hallucinated voices and scary presences, and he threatened people. The staff knew that his younger brother had died when he was quite young, and that he and his other brother had been put into care because his mother could no longer cope. It was known that both boys had regularly been abused when in care. Stuart always felt guilty about leaving his brother behind when, at fifteen, he escaped from care. It seemed fairly obvious that this man was preoccupied by his distress - he was grief-stricken, abandoned and made to feel intense guilt, anger and paranoia by the

4 This was the psychiatric residence set-up by RD Laing and others in the 1960s. For an account of its workings see Barnes, M & Berke, J (1971) *Mary Barnes: Two accounts of a journey through madness*. London: Hart-Davis MacGibbon.

5 The equivalent to today's Nurse Manager.

horrors he had experienced and with which he had never come to terms. Of course, he had never received proper counselling or psychotherapy - he was simply diagnosed with a mental illness.

Apparently much more perplexing are patients such as William, who was on the third admission ward I spent some time working on. This was also a new unit, built in the hospital grounds. It was the most clinical-looking ward I had seen so far. In the mornings, all the nurses had to wear uniforms so as to indicate the medical nature of the job, and also because that was when there was shock treatment. Then, in the afternoons, to show that the job had been properly done and now everyone could relax, staff wore their own everyday clothes.

William was in his early twenties, and was very disturbed. He was quite tall and had slightly longish hair, which in those days indicated that he had attempted some sort of rebellion. He came from a respectable working class background. He imagined that he was persecuted by Nazis, and when they shouted at him he would run around the ward screaming. He was obviously very unhappy and more or less completely uncommunicative, but when he was not experiencing the persecution he was unthreatening and amiable enough.

William had parents who visited him almost daily. His father was quiet and seemed submissive and rather hen-pecked; he seemed embarrassed, but otherwise did not show any feelings. In contrast, and though she was much smaller than her son, the mother was domineering. She treated William more like a small boy than a grown man. The family would sit together in the ward dining-room and the mother would hold William's hand. The weird thing was that after a time she would often go into the office and ask for the key to the bathroom so that she could bath her grown-up son. She would be given the key, and take William and bath him. In fact, there were male staff who could have assisted, and besides William did not need coaxing and encouragement to have a bath. The staff were simply complicit with the mother's bizarre, incestuous behaviour.

The psychiatrist must have condoned this activity since she collaborated with the mother, and together they quite inappropriately 'mothered' this young man. William only showed aggression towards his mother, and on one parental visit he hit her. This was construed as 'a symptom of his illness', and the psychiatrist told William off for 'being a naughty boy'. This simplistic and complacent moralising was more than unhelpful - the absence of psychotherapy was positively damaging. William's reactions to his feelings of persecution grew worse and worse, and he was finally sent to a back ward, a non-training ward, the dumping ground for the 'incurable' young 'schizophrenics'; their only prospects were to become middle-aged 'schizophrenics', and then old ones.

Some time later another young man was admitted to the hospital in crisis. I knew him 'on the outside' and so the same psychiatrist was interested in talking to me. It was his second or third admission so she had met him before, and this time he was admitted after hitting his mother. I had often witnessed the mother aggravating Steve, talking down to him and talking behind his back. On this occasion a row erupted and the police had been called. Steve was 'sectioned' and brought into hospital. However, it seemed to me that when the psychiatrist interviewed me she was flippant and only had a prurient interest in the case. In short, she seemed fascinated by whether or not Steve was capable of sexual relations, and not very interested in the rest of his life or his persecutory delusions.

Steve was then about twenty-four. He had a middle class background - his family had lived in a fairly big, comfortable house in a good neighbourhood. He was the second of four brothers. At the time of that admission his parents were recently divorced and he lived in a squat - although 'living' is an exaggeration. He barely survived in a mildewed room containing many books and files and papers, but otherwise he possessed only the clothes on his back, a filthy old raincoat, a trilby hat, an old mattress and a guitar. Goodness knows what he ate because he was beyond the point of being able to cook and clean. Scrawled on the walls were slogans such as: 'I Am Not A Toy'. Steve had gone to a prestigious college to study physics but had dropped out after a year. This also coincided with his taking LSD, which seemed to have tipped him off his precarious balance.

Apart from the LSD, it seemed to me that the family situation was crucial to understanding his condition, and psychiatry usually excludes from its remit any kind of analysis of family dynamics. Steve's main auditory hallucination was persecution by 'Clint Eastwood', but also sometimes by his

father and friends of his father. In those days Clint Eastwood personified male power, virility, sexuality, fame and success - and each of Steve's persecuting voices were dominating male figures. Steve's voices scorned, belittled and persecuted him.

The story here was that after twenty-five years of marriage, Steve's father had walked out of the house after a row and, except to collect his things, had simply not returned. Steve's mother told me that each time she had become pregnant her husband had forced her to drink gin and sit in a very hot bath, and each time she failed to abort and so she had produced four sons.

It was clear that of all the sons Steve had been the greatest threat to his father since he was the brightest. He was exceptionally intelligent and was fascinated by philosophy, advanced mathematical problems, physics and chemistry. Steve's father had blighted his childhood and adolescence by continually accusing him of being stupid. His mother said she could remember Steve crying with rage and frustration when his father called him an idiot. The father was conventionally handsome, strong, energetic and witty - 'a ladies' man'; in fact, just like Clint Eastwood. The mother was small and plain, and her husband had always mocked her. Left on her own, she could not deal with Steve since he tended to rave when he was psychotic - screaming and shouting at his voices, sobbing and unpredictable. He was also liable to pick something up and throw it at anyone who he imagined was the source of a hallucinated voice, or if the voice told him that the person was responsible for the bad things happening to him.

Sometimes I would accompany Steve to visit his mother. Unfortunately, she had no insight into the fact that she had a habit which aggravated her son: she would talk to me as if he was not there. A habit like that - denying a person's significance or having secret or private dealings - is a frequent characteristic of the dysfunctional family relations which fuel a psychosis. In view of the fact that he would sometimes sit with a blank expression or fluttering his eyes and in some manner responding to an auditory hallucination, sometimes it would seem as if Steve really *was not* there. Then his mother would look across at me and talk about him. Suddenly Steve would become aware of what she was saying and grow angry. Even when he did not show signs of psychosis - even if he was acting perfectly normally - Steve's mother would whisper to me behind his back. This was unhelpful, and though I tried to point out that it was bound to cause him frustration, the poor woman was unable to stop the habit.

Steve was also aggrieved by what he felt was his mother's hard-heartedness. She had been forced by her husband to sell the family home, and had had to move into a flat. Steve felt this as a blow since the house had been a secure base, even though a difficult one. Once, in the depths of winter, with snow on the ground, and when he was homeless and in a really bad state, she turned him out of her flat. Though he was not causing trouble at the time, and the youngest son was at home, she would not let him stay the night because she simply found it all too much. In those days, there was not even the idea of supporting family-members as carers.

Steve developed a back problem, in the form of a curvature of the spine which resembled nothing so much as 'having the weight of the world on his shoulders'. This badly disabled him, but the condition could be relieved by massage, which cured him for a time. One time his crouched, curved posture visibly unwound over the few days he spent away on holiday amongst friends. This seemed to indicate the psychosomatic nature of his posture - a response to the burdens weighing him down, to his oppressions. During his late-teens and early twenties Steve had been a nice-looking boy, with long hair and a sweet smile, but in the space of a few years he had retreated into a crouched, invalid condition.

When this posture was developing, and when he was in the psychiatric hospital, Steve experienced a lot of back pain. Still, his case notes referred to the fact that he had taken LSD. This was enough for the psychiatrist to order that Steve was not to be given any PRN (give as necessary) medication 'because he was a drug abuser and would pretend to have symptoms in order to get drugs of any description'. Once I visited him and he was unable to walk. He was lying on the floor and unable to get up. I asked the charge nurse if he could be given a pain-killer but was told no, 'because Steve used to be a junkie'.

Invariably, psychotic patients are administered large doses of major tranquillisers. Steve was put

onto depot injections. Once, just after he had had this injection, he went on an outing from the hospital. This involved a long bus-ride with a friend, and when they were way out in the countryside Steve began to seize-up due to the extra-pyramidal side-effects of the Depixol. This was frightening. He began to develop lock-jaw and his limbs began to stiffen until he could barely walk, talk or breathe. Luckily his friend understood what was happening and was able to phone the hospital and arrange for anti-parkinsonian drugs to be rushed out to him.

Schizophrenia

It seems to me that psychosis stands at the extreme of a continuum. At the other end are those individuals who we imagine are perfectly happy, well-adjusted, well-balanced, neurosis-free, secure and loved, fulfilled, without financial worries, etc. Along the scale are ranged most of humanity most of the time - those of us who are able to live with our neuroses. 'Normality' is bound to include episodes of troublesome anxiety or depression and even the odd delusion or hallucination, but mental health definitions are essentially pragmatic and someone is 'normal' if able to function relatively autonomously due to a workable sense of separation and integration between oneself, other people and the world.⁶

To the psychotic end of the continuum are individuals who are seriously deluded or disturbed by hallucinations, dangerously paranoid or apathetic (catatonic), or self-harming, suicidal or sociopathic. Few people diagnosed as psychotic are a great danger to others. The sort of patient regularly encountered is someone who in one way or another is not (or not always) 'with us'. This type of person has symptoms (or continues to be ascribed symptoms) which consign him to the diagnostic category: schizophrenia. He is someone who may never have achieved any kind of secure, integrated sense of a self in a tolerable and fully functional manner. Chronic psychosis is not manifested in the manner of a severe depression which the individual might live through and get better, in the sense of recovering his 'old self'. Rather, psychosis is often the result of a lifetime of insecurity, misery, denial, isolation and confusion - including physical or sexual assault, and the threat of it. A child who grows up with that experience is likely to develop all kinds of abnormal feelings towards himself and others. Someone who is profoundly disturbed as an adolescent or adult may not have experienced unconditional love as a matter of course during his childhood.

With a person like this, the cause of the psychosis is not simply his lack of experience of unconditional love, or the great difficulty he experiences in fulfilling the conditions which would call forth affection, or the impossibility of ever fulfilling those conditions. An essential component in the genesis of a psychosis is also *denial* of the processes to which the child is subjected. Someone might grow up in a family in which there are constant arguments and even violence, but so long as this is not denied and attempts are made to make amends one would not expect this to produce a psychosis in anyone caught at the centre of the conflict. By contrast, individuals who become psychotic often emerge from an environment in which there is consistent denial of the realities and responsibilities on the part of the powerful parties to the family conflict, and where guilt is only attributed to the one family-member, who is regularly made a scapegoat. A psychotic individual often comes from a place where, when he expressed himself, he was denied or ridiculed or hurt or otherwise forced to submit, and moreover it was demanded that he affirm a false version of reality - one that did not accord with his actual experience.

Laing documented the kinds of situations which drive people into the corner of psychosis.⁷ He concluded that chronic family conflict conducted in terms of habitual blackmailing, lies and scapegoating is most conducive to driving the weakest member of the family into psychological crisis. Unfortunately, this idea is usually fiercely resisted since it appears to blame those parents who 'naturally' (habitually) find it very difficult to see or present themselves as anything other than essentially benevolent. Any attempt to cope with psychosis must be an attempt to negotiate with the

⁶ And one is not (yet) diagnosed with a mental illness.

⁷ See, for example: Laing, RD, op. cit. (n. 11, Ch 9), and Laing, RD & Esterson, A (1970) *Sanity, Madness and the Family: Families of schizophrenics*. Harmondsworth: Pelican.

parents or separate the patient from his *blind* emotional commitment to his family. This has to entail understanding how *the parents themselves* became such damaged people as to act in their own disturbed ways. The question arises: What was it in that parent's life that made him or her into such a disturbed person? Again, how can that person be assisted and encouraged to stop playing a part which calls forth the pathological response of the person referred for psychiatric help?

That said, in my recent experience I have encountered many families caring for a psychotic son or daughter where the love and concern for the now grown-up child seems beyond doubt. The impact of forces beyond the control of the family must not be underestimated. For example, there is undoubtedly the impact of bullying during and sometimes beyond childhood, and that of the use of illegal drugs amongst adolescents and young people. (It is now known that the active THC content of genetically modified cannabis, a so-called 'soft' Grade C drug, has dramatically increased during the last twenty years or so; cocaine is also cheaper and much more widely available.) The impact of the splitting-up of families must also have increased in recent years; despite the best will and efforts of a single parent, it can be very difficult to compensate for the continuing negative influences of an irresponsible absent parent; or sometimes the best will in the world cannot prevent a child from feeling terribly torn between two separated parents.

Everyone - psychiatric workers included - seems to have trouble accepting the 'weirdness' and the involuntary nature of psychotic delusions. They should consider the weirdness and the involuntary production of dreams: nobody can choose whether or not to dream, and nobody can decide the content of the dream. There is nothing the unconscious cannot throw up, and whatever it throws up is always a product of emotional and mental life - some kind of representation of the person's preoccupations, fears and wishes. It is folly to decide that the 'weirdness' of a dream makes it insignificant - and the same goes for a hallucination, a delusion, an anxiety, an obsession, a mania or depression. Quite the reverse: it is entirely reasonable to assume that the 'weirdness' and the involuntary and insistent nature of very irrational beliefs could actually be the key to unlocking the secret fears and unacknowledged problems that so distress and confuse the person concerned.

I recall the case notes of an elderly lady whose presenting delusion was to insist on the reality of an overwhelming feeling that her rib-cage was stuffed with hot meat. She had maintained this delusion for more than forty years. This does sound bizarre. Would it have sounded so bizarre, though, had she calmly announced that her rib cage *felt as if* it were stuffed with hot meat, or had she declaimed the feeling in a poem? In which case, the idea would probably be perceived as an observation about her sensation of an organic condition or an emotion. This patient had become so preoccupied with the feeling that its conditional and metaphoric nature had become lodged tangibly and permanently as her preoccupying interest. She had become overwhelmed by the feeling, found no sympathetic response, and became chronically incapacitated.

A sympathetic response would recognise the likelihood that the unfortunate lady had been incapacitated by living a horrible metaphor - by being trapped inside it. As usual, psychiatrists denied the significance of her bizarre declaration. In their eyes it had no meaning at all. According to them, she 'had a mental illness' and therefore, by definition, any strange thing she said was simply nonsense - 'only a symptom of the illness'.

Still, what could a feeling like that possibly *not* mean? Her belief was clearly not random since she had clung to it doggedly for decades; she had descended so far into misery that she really did experience her inside, the locus of her heart and lungs, her centre, as not containing living organs but *as it were* slaughtered and prepared for human consumption. Surely it would be worth entertaining the hypothesis that this was a woman driven to distraction by forces around her which she was unable, *for some reason*, calmly and reasonably to speak about? And that these were forces which (she feels) kill her real self, cut her up and prepare her for their own consumption? Why can the patient not reasonably speak of these forces? Perhaps because the forces so undermined that capacity in her, and because she feared that to speak of them would invite further 'slaughter', 'cutting up' and 'cooking'.

From the psychodynamic perspective, this patient voices her experience in a metaphorical or 'poetic' manner - albeit one which plagues her and those around her. It is not impossible to imagine

that this could be the case. Critics who live under totalitarian political regimes employ similar metaphoric devices so as to speak allusively about what oppresses them. Freedom-lovers call this 'satire', and praise it. In the psychodynamic perspective, a patient's resort to metaphor is most likely the response to her experience of a totalitarian kind of social oppression by her most significant others. And yet few psychiatric workers seem able to imagine that the basis to such profound emotional distress and mental disorder is oppression - or the memory of it, or repression of the memory of it. The imaginations of the psychiatric workforce are already pre-empted by the vacuous belief that there is no accounting for the 'weird' beliefs of the mentally ill, which simply amount to random nonsense generated by their 'illnesses'.

The training of psychiatric officials is not adequate to the need to understand the metaphoric intentions of the patients, and especially those in a state of psychosis. The first rule with a psychosis is: do not collude with the patient's delusions. Obviously, this is sensible. The second rule, however, is to train nurses to say 'I know that you believe XYZ, but you only believe it because you are ill'. Attributing a feeling or a delusion to illness effectively denies the reality of whatever it is that the person feels that he experiences and tries to comprehend or express. This amounts to negating his integrity as a fellow human being, and it is no basis for entering into the only lastingly effective therapy: genuinely mutual conversation. Insisting on the medical nature of the person's misery and confusion puts him into another double-bind. Effectively, nurses are trained to say 'I will only talk to you if you will accept this unacceptable condition: that anything you say which we find ridiculous or uncomfortable has no meaning whatsoever, and that what is really wrong with you is that by sheer bad luck you suffer from an illness called schizophrenia'. With the medical model, any patient who refuses to accept this definition of the situation only ever supplies further proof of his 'lack of insight' - which is viewed as yet another symptom of the purported mental illness.

Therapy cannot begin until a relationship of trust is established. This means accepting that whatever belief the person declares - however 'weird and wonderful' it might sound - is indeed a representation of his experience; that this is not something to be suppressed by coercion and medication; and that it is in fact a valuable therapeutic resource which might lead both therapist and patient to the actual source of the malaise. Obviously, this does not at all mean that the psychiatric worker accepts (for example) that there really are government agents out to get the patient, and that they really have bugged all the televisions and radios. Rather, that the patient really does feel so intensely persecuted and under surveillance, and that somewhere in his life lie undisclosed conflicts and traumas which constitute the actual basis for his bizarre beliefs.

Psychiatric workers ought not to be fazed by the bizarre delusions of the patients. They should know that hallucinations and delusions are not limited to the experience of psychiatric patients but tend to intrude into the consciousness of anybody subjected to overbearing stress. In everyday life we are all of us susceptible to paranoid misperception, at unexpected moments, but especially when we are tired or otherwise under stress: we are all likely to have experienced hallucinations or proposed delusional ideas. Some people do so very insistently, though - to such an extent that they remove themselves too often and too far from reality and the ability to function adequately. This obviously indicates that most of us are lucky enough not to live under those extreme levels of stress which cause the unfortunate minority to register so much distress and confusion that they are consigned to psychiatric care. *Obviously* there is a concentration of morbid and desperate imagining - delusion and hallucination - in a psychiatric institution: such is the very stuff the institution was established to contain and remedy. Meanwhile, so many psychiatric workers seem surprised or even affronted by the patients' 'weird' beliefs and behaviour. Generally, psychiatric officials see their role as denying and containing patients' aberrant ideas and behaviour; very seldom is a member of staff encouraged to assist the patient in a psychological effort to make a reasoned and reasonable recovery. In such a project, of course, the patient would have to be given due respect for everything he feels and expresses - which essentially is only to say that psychiatry should unreservedly include patients within the human community.

David's case is interesting since he was able to remember much of what happened when he 'went off his head'. His was not a happy outcome, but when I met him he was about thirty and still had a bit

of his former personality about him, although he was also very much adjusted to the life of a long-term patient. He had been sent to the innermost rooms of psychiatric care: he had done the admission ward, failed the rehabilitation programme, and was now on a long-stay ward. He was the son of well-to-do people. His father was a high-ranking army officer and was strict, authoritarian and emotionally cold. David had spent his childhood moving around the world with his father's postings, and he had no real roots. I think he might have been sent to a boarding school in England, too.

I did not imagine that art would have been the career chosen for him, but David had had enough strength of character to pursue it. Still, this was presumably at a cost because he had 'cracked up'. He told me that when he was an art student in London he 'started to feel strange', got weird notions into his head and thought he was Jesus Christ. He could remember rushing around London on a bike in that state, and at the same time understanding that things were definitely not right. He had recognised that he ought to get help, so he went to a friend's place. Then, thinking he was doing the right thing, his friend called in a doctor.

Under psychiatric care, David went from bad to worse. He was not at all happy to find himself heavily medicated. He had hoped for psychotherapeutic help, but he was simply admitted and administered a major tranquilliser. He was then caught in the classic *Catch 22* situation in which so many people in distress find themselves: they don't welcome the enforced admission (being 'sectioned') or the tranquilliser (and especially its side-effects), and yet they crack-up again when they try to cope on their own in the outside world. So they find themselves back with a psychiatrist, and the cycle repeats itself. This is what had happened to David. Eventually his father moved to our area and David arrived on our ward. I understood from other members of staff that his father was on good terms with the consultant, and if he was going abroad for any reason he could more or less say: 'Here's David, can you take him back into hospital?'

This patient is a good illustration of what happens to somebody who fails the rehabilitation process. When he was sent to a psychiatric hostel he failed to fit the criteria and did not behave in the acceptable manner. This meant he failed the hostel experience, as would any patient who was not absolutely obedient to its humourless and authoritarian set-up. (Amongst themselves, the patients called the hostel 'Colditz'.) David was placed in a bed-sit, but he could not stand the isolation. By then everybody had given up on him, and he was put on a back ward. So that was David at thirty years old: written off, no prospects. And he was resigned to that life. These days NHS 'clients' or 'service users' like David most often find themselves consigned indefinitely to a privately-run home, nursing or residential, 'in the community'.

At least his usual disposition was such that it is unlikely he would have ended up on a locked ward. The patients there were the most restricted of all. If anyone came to the male locked ward, the heavily sedated patients would shuffle over to the door in a kind of lethargic crowd, out of curiosity for the big event. Patients on the locked wards would have nothing to call their own - not an item of clothing, no personal possessions - and nothing at all to look forward to. The atmosphere on the female locked ward was possibly worse - it was known for occasionally erupting into a riot.

Anyway, I met this patient when he had just failed the bed-sit experience and had come into the admission ward for a short period, before being relegated to a back ward. His case-notes indicated that when he was sectioned at his initial admission, after he had gone to his friend's place for help, he had reacted to the loss of liberty and enforced drugs by taking to his bed. This was 'a symptom of catatonia'. This must have been the final, hopeless despair of a young man who had nobody else to turn to. I found it interesting that I never once heard him express a delusion or appear to hallucinate, and yet his current case notes said: 'schizophrenia'. In the medical view of things, once a schizophrenic, always a schizophrenic.

I found David completely pleasant, but most of the staff did not. I believe this was because he had a mind of his own, because he was a bit of a rebel and would rather lie in bed, and sometimes failed to get up when he was supposed to. None of this behaviour was considered acceptable by the ward staff. What was particularly interesting was that David had clear memories of his psychotic episode. It is unusual to meet many patients who talk about recognising and remembering the process of psychosis, but he knew what he had done and that he had been temporarily mad. David's form of

insanity was to imagine he was Jesus Christ: on the face of it, this is a delusion in which the person is persecuted and martyred for the sins of others. I would imagine that this was probably an allusive representation of his life.

The story of a certain patient and his wife again illustrates the fact that something awful was going on in his life which nobody bothered to find out about, even though he had been taken into psychiatric care many times. Both Bill and his wife had been diagnosed with schizophrenia. On the advice of her psychiatrist, his wife had been sterilised when they got married. There is no evidence to support the notion, but most psychiatrists believe that schizophrenia is a genetically-based disorder. Bill's wife regretted the sterilisation.

Bill was considered hopelessly inadequate. He had been through numerous admissions when I met him. All the staff had given up on him and he was not well received. He was not at that time floridly psychotic and I never saw him in that condition, but I suppose he must have been once, at least when he was initially admitted. At the time of this admission he was worried about working on the production-line at a local factory. Having to do the work was upsetting and agitating him, and 'bringing back a lot of his symptoms'. This was a simple enough problem. I do not know why no-one else had done it but I simply asked the psychiatrist to write a letter to the company asking if Bill could be moved off the line. The management actually preferred a happy workforce and immediately moved him onto a job where he could cope. Bill was pleased, and to tell me he traced me by phone to a different ward where I happened to be working. This showed initiative and sociability - it was not the behaviour of an inadequate person.

By talking at some length to him and his wife I discovered that they were living under the permanent shadow of Bill's domineering and megalomaniac mother. She had fully supported and urged the sterilisation of her daughter-in-law. At that time - when Bill and his wife were in their forties - his mother had a key to their house. When they were out, she would get in and do things like re-arrange their furniture in a way that *she* thought fit, and leave instructions about how it was to be left as *she* wanted it. Both of them were overwhelmed by her and neither felt able to stand up to her. In fact, since *they* were the ones with the diagnosis of mental illness, they did not even feel that they had the right to feel angry about it, to feel that Bill's mother's behaviour was unacceptable. Their thinking was that if they were mad then presumably anything Mother did must be sane and must not be opposed. This couple simply needed a sympathetic person to confirm that they were fully justified in feeling angry about such outrageous interference. Nobody had bothered to find out any of these circumstances before. I could imagine how such a crazy mother would cause distress and confusion in her son, from the day he was born, or the day she began to assert her own craziness against the child's own natural and healthy feelings and wishes.

I came to know the details of patients like these because I was able to talk to them by deliberately taking a little time out of the busy schedule of running the routines of the ward and organising things for all the other patients. These are selective recollections of certain patients rather than many others, of course, but each clearly illustrates the principle that if one will only take the time to listen to what the person has to say one always discovers that there are underlying real events which cause people to become overwhelmed by emotional distress, to the point of mental disorder.⁸

Listening sympathetically to patients is the last thing on the agenda of a busy psychiatric unit. Moreover, where it is scheduled, counselling or psychotherapeutic work is the first thing dropped when a problem or crisis arises. In these circumstances, I found I could rarely get beyond the stage of being able to say to a patient: 'I think I understand why you ended up here.' But even that minimal recognition seemed therapeutic. I cannot say that I was ever able thoroughly to achieve the next stage of planning with a patient and implementing a strategy to cope with his problems, to the extent of his feeling thoroughly reassured because he had achieved sufficient control over his life. In some cases I was able to find time to set up some sort of ongoing therapy, but never more than a few sessions. This might involve the patient alone or include members of the family. In every case this was beneficial,

⁸ The real organic diseases which cause mental disorder are well-known and easily tested; they affect only a minority of the psychiatric population.

but never sufficient.

The only time in my career that I felt really actively involved in a full program of ongoing counselling or psychotherapy was when I was a staff nurse at a psychiatric day hospital run by a consultant who used drugs only in very exceptional circumstances. This psychiatrist absolutely opposed suppressing patients with drugs, and encouraged them to express themselves and thereby begin to deal with their problems. He was a Jungian and advocated psychotherapy, either as individual or group therapy, psychodrama or art therapy - any means other than drugs - in order to enable people to discover more about themselves and to learn to live less miserably.

Other diagnoses, and typical treatments

Doctors regularly used to discriminate endogenous from reactive depression. In the first category there is supposed to be no external cause - it is an unaccountable mental illness which simply 'develops'. There was no evidence to support the idea, but an endogenous depression was supposed to arise from a biochemical imbalance. With reactive depression, there is an obvious reason in the person's circumstances. In reality, the diagnostic difference could only have arisen from lack of information and the doctors' blinkered vision of what constitutes sufficient cause for depression. If someone loses a loved one or his job, or his marriage breaks up, or something obvious like that, he was more likely to get a 'reactive' diagnosis. But if the psychiatrist failed to recognise or simply refused to acknowledge that a patient lived such a problematic life as to cause a deep depression, he called it 'endogenous'. Since I began my career, 'endogenous depression' has been re-branded as 'major depressive disorder' (MDD).

Patients do better to receive a 'reactive' diagnosis since officials are more likely to give them a modicum of understanding and consider them less mad. These days it is fashionable amongst some psychiatric officials to protest that the idea of endogenous depression is out-dated - that all depression is reactive. All the same, while there might nowadays be widespread superficial acknowledgement of the reactive nature of depression, the overriding medical model of mental illness and its treatment ensures that depressed patients are still routinely treated first and foremost with drugs - as if depression really is a brain disease. More than this, the category MDD is taken seriously, and nearly all the research is still concerned with trying to discover a genetic or biochemical cause - that is, an endogenous, neurological cause.

Here is an example of how the disease model works in practice. I met Mary on an admission ward for about her thirteenth time. Her diagnosis was endogenous depression. When she was about to be admitted I can remember hearing from the other staff who had already met her: 'Oh, God, not her again. Oh, it's Mary, she's always in and out...' The consensus about this patient was negative: she was inadequate and nothing could be done to help her.

One had to make a big effort to get to know her, but when I did it turned out that about seven years previously she had lost her eight-year-old daughter, crushed to death under the wheels of a lorry. This had been witnessed by Mary's son, who was then aged nine. Shortly afterwards Mary had her first breakdown. I suppose that at the time the nursing staff would have been aware of what had happened, and that Mary would have been given sympathy and understanding. But this information was certainly missing when I met her. Mary did not talk about her bereavement, even when she saw a doctor about being depressed. She told me that no psychiatric official had ever discussed this tragedy with her before.

Of course, the family was devastated by the child's death. Mary's breakdown had cut her off from her husband. He had given up trying to communicate with her, and as a means of coping had retreated into filling all his spare time with a hobby. Her son became delinquent. Mary was left on her own trying to deal with the overwhelming grief, guilt and anxiety; consequently she was forever in and out of psychiatric facilities.

When I invited her husband to come in and talk with me and Mary together, they both poured their hearts out and said that this was the first time that they had been given that opportunity, and how grateful they were, and how helpful it was. It seemed to me that this was what a proper mental health

service should provide, as a matter of course. Eventually Mary was discharged. In a decent psychiatric set-up she would have been offered continued counselling - not just for her but for the marriage. At the time, there was no such provision. Mary did come back and see me once or twice after she had been discharged, but unfortunately the demands of the admission ward were such that I was not able to provide her with ongoing counselling or psychotherapy. I do not know what became of her. I hope I convinced her and her husband that the child's death and the repercussions on their lives were sufficient reasons to feel how they did, and that Mary had been given a raw deal by the mental health service. If just one person can confirm that a person has good reason to feel the way they do, that in itself is helpful.

I could give many other examples of the absurdity of the diagnosis 'endogenous depression' or MDD. Simply because a depression does not seem to be due to an event which is neat and easy to categorise - an event a doctor or nurse can recognise and name in a few minutes - or just because a traumatic event took place a long time ago, that does not mean that there is insufficient cause. Even today, depressive reactions are still generally not taken seriously as having *sufficient* external cause. According to 'common sense', for example, grief is something anyone should overcome in maybe two years, at the most. If a patient fails to recover from bereavement in this 'reasonable' time, the doctor assumes that the depression cannot be reactive and there must be something else that is *really* wrong with her - that she has a mental illness called Major Depressive Disorder. This ignores the enormity of the repercussions of bereavement on a person's whole life (or any other psychological trauma), especially where there may be other factors causing vulnerability. In this case, the doctors and the psychiatric functionaries ignored the profound effects on Mary, her son, the marriage, the father's state of mind - all of which the bereaved mother had to cope with immediately after her daughter's death. One might hope that the grief would have subsided two years after the event, but there was no official recognition of the effect on the whole family, and how year after year grief might continue to influence each member of the family, especially if it were left unexpressed and unaddressed. Mary would not only have had to deal with the loss of her daughter, she also had to deal with her son's grief and reactions, *and* her husband's, *and* continue to live 'as normal'. Nothing had ever been talked through, and no efforts been made by anyone to deal with the problem and its ever-present ramifications. On top of this, Mary was officially informed that she had no reason to be depressed, and 'had a mental illness'. It could hardly be said that psychiatry had helped her.

Women are disproportionately diagnosed with depression. Doctors often seem to have difficulty seeing that there could be any significant problems if a woman is married and has children and a roof over her head. Women in care tend to be accused of 'manipulation' - in other words, they are casually accused of fraud. Very often a woman in serious distress says she can't cope with the housework. This is understood by everybody in psychiatry as indeed a symptom of unaccountable depression - as if it could not be a problem having to live a life of permanent poorly compensated drudgery, always servicing everybody in the family, with little or no help or thanks. Doctors acknowledge only stark and obvious causes of depression. The finer details of private misery are ignored, especially when the patient herself may not always be aware of them or might not be able to talk about them very easily.

It is also striking that very little (if anything) is ever said about a patient's sex life, unless the patient manifestly has a sexual disorder or commits a sexual misdemeanour. It is not normally recognised that sexual problems may cause depression or may be affected by depression and worsen it. Even in the case of Mary who lost her daughter, an ongoing contributory factor was the effect of the grief and guilt on her marriage, and undoubtedly she carried an extra burden of guilt because she failed to be loving towards her husband.

I remember a patient I'll call Sally who had been admitted for the *eighteenth* time. All the staff thought she was quite mad. The diagnosis was endogenous depression, and Sally was reputed to be manipulative and prone to dangerous behaviour - once she'd set fire to the sheets with her husband in bed. Neither the nurses nor the doctors were sympathetic. Yet conversations with her revealed that twenty years previously she had become pregnant and been forced into marriage. She said she had not even wanted to have sex with the man again, let alone marry him. So he frequently masturbated in the bed beside her, which she found repulsive. None of this had been discussed before. Once again,

talking helped her. I arranged for her husband to come in and gave them both the chance to air their feelings about the years of accumulated frustration, disappointment and repressed anger which was driving both of them mad. Sally had acted out her frustrations, whereas her husband had kept all his feelings bottled up inside himself, in lonely misery. Talking was a huge relief for both of them. Nothing of their story was mentioned in the case-notes, and the unhappy situation was never considered the cause of Sally's depression.

There is no fine distinction between anxiety and depression, only different manifestations of anxiety. When a patient retreats into herself it is called depression; if she responds to anxiety with extreme agitation the diagnosis is 'anxiety state'. In reality, there is always an element of both in each response. A depressed person feels anxiety viscerally, in the stomach or head; the agitated person is undoubtedly depressed but the anxiety causes them to become irrationally active. Often they are driven to compulsive behaviour, such as scrubbing the floor in the middle of the night. A significant proportion of patients on an admission ward are likely to be diagnosed with 'anxiety'.

A patient I will call Hannah was typical. She came in after many previous admissions. Once again the staff's attitude was 'Oh God, it's Hannah again. She's hopeless', and so on. Hannah was about forty, and was certainly one of the most anxious patients I ever nursed. Instructions to the staff were: 'Keep her occupied and she'll be all right'. Hannah had a job as a care assistant outside the hospital, and staff were instructed to get her to go to work every day. I remember the hard work it was persuading Hannah that despite her fears she was in fact able to get up, go out and do her job.

Once again there was a coherent history to her condition. When I got to know her, I discovered that she was the daughter of a sadistic father - an alcoholic who regularly beat her and her mother. Hannah had a bad stammer and had lost her hair as a child. This was most likely a nervous reaction to her traumatic home-life. Her hair was thin when I knew her. She had married a man whose wife had abandoned him and his children. Hannah believed that she should never have children in case they turned out to be like her father. She had been through many psychiatric admissions since adolescence, and the idea of hereditary mental illness was most likely suggested by the doctors she had met - the idea that it was not wise for her to have children would have had the support of both 'common sense' and Medical Authority. On the advice of her psychiatrist at the time, she had been sterilised fairly early in the marriage. This was a cause of regret for Hannah who was unhappy in her commitment to a life raising another woman's children, as well as having to live with memories of the horror of her own childhood.

Once again none of the 'background information' was in the case-notes or seemed to be known to any other member of staff. Again, some progress was made by talking to her and bringing the husband in and talking to him, trying to get him to recognise that Hannah was not simply 'mad' but that she was plagued by very difficult problems. The husband's original point of view was 'Well, I love her. Why isn't that enough?' However, it turned out that Hannah made considerable progress simply by talking things over between the three of us.

Until this intervention, like any other long-term 'anxiety state' or 'depressive' patient, Hannah had endured years of every supposedly medical treatment imaginable - every 'appropriate' drug, shock treatment and even (years before) narcosis therapy. It seems to me that there are both rational and irrational reasons for patients welcoming even the most extreme forms of treatment. Obviously they are desperate for medical help, but they also often suffer from feelings of guilt and have an urge to be punished, to be atoned and 'cleansed'. Only talking things through can really relieve patients of such intolerable feelings of guilt and anxiety.

Nowadays significant numbers of patients on admission are diagnosed with bi-polar disorder (previously known as 'manic-depression'). With the advent of more effective drugging, patients tend not to go into full-blown mania so much. It seems to me that mania is a response to anxiety and depression: it is flight from depression, the attempt to survive when the depression threatens to overwhelm and engulf the self. It is as if the person runs away as fast as possible from being overwhelmed and swamped by his anxiety and misery.

I think a degree of mania is a common experience. I can remember a bad time in my life when I responded by just keeping on the go from morning to night. I felt as high as a kite and everything

seemed to have significance and everything would be all right so long as I kept moving, doing this and doing that, and if this works out, then I'll do that - and so on, manically, with all my plans fitting together in my mind like a huge jigsaw. Fortunately, this only lasted about six weeks. In fact, mania is a response to a powerful personal event which has blown apart and made chaos of one's hopes and dreams; it is a defence against anxiety and depression. Like all pathological defences, though, it very soon becomes self-defeating and the presenting problem itself. The person fully in the grip of mania does not eat; he does not go to the toilet; he loses his inhibitions; he takes his clothes off; he runs around; he spends all his money and gets into debt; he spends other people's money! He is a great nuisance to everybody else trying to get on with their lives. In the end, of course, mania leads to physical exhaustion.

I am sure there is a link between mania and literary or artistic talent. There is a manic form of wit that is so much quicker and more radical than normal. Sometimes it can fly off into absurdity but at other times it is definitely very astute. You could say the same thing about the connections made during a psychosis - often they sound like disconnected nonsense, but sometimes they sound sharp, insightful and witty. Normal people might well find incisive wit and off-the-wall comments quite threatening to their self-images and their settled lives within the predictable rounds of daily life.

I once met a patient on an admission ward who illustrated a classic case of bi-polar disorder (manic-depression). Bob was in his forties and used to have a steady but boring office job. He was not happy with his marriage, and because he had a good education he felt he had under-achieved. One day at work, in his filing office, he became manic. He let rip and flung every file out of every filing cabinet all over the room. This naturally compounded his problems - he got the sack. I never saw Bob in completely full flight because in a hospital you never see the full-blown state. As soon as anybody exhibits any signs of such an outburst they immediately get sedated. He did display the classic signs of both extreme depression and mania, though.

Anyone presenting with depression is prescribed an anti-depressant. Someone unfortunate enough to display the signs of both depression and mania, or who only shows signs of mania, attracts the diagnosis bi-polar disorder or hypomania, and is administered lithium. This is a heavy metal, a poison which 'damps down' the entire nervous system. It was purely by accident that lithium was found to 'stabilise' mania. There is supposed to be a therapeutic range within which a patient is safe, and outside of which the drug is fatal. The problem is that the metal accumulates in the bloodstream, making regular monitoring necessary. I have witnessed several patients suffer from lithium-poisoning, even though the doses were supposed to be within the therapeutic range. Overdose causes the patient to scramble his speech and become confused, and then to become incontinent and almost catatonic. The person gradually recovers as the lithium is excreted from his body.

On any admission ward there are usually a few patients with the diagnosis 'personality disorder' (PD). This is a category applied to patients who appear rational enough but are distinctive for their lack of the civilised graces or respect for the niceties of social interaction. The diagnosis is a residual label used for any patient who does not immediately appear to fit another diagnostic category. These patients are not obviously depressed or anxious - they simply manifest a residual, catch-all 'nuisance' value. They come into care through a variety of routes. Perhaps they come from the courts, having committed some kind of petty crime; others present themselves to A&E, and others might be drug-abusers. Even today, those who commit self-harm are likely to attract the diagnosis, and if the self-harmer cuts her arms superficially - this side of a serious suicide attempt - they are still often treated very unsympathetically, and viewed as 'attention-seeking'. I remember one woman who caused bad blistering by scalding her arm under a hot tap. Nurses were concerned and called the duty doctor, but his response was to give the woman a severe telling-off for wasting important medical time with a self-inflicted injury. In the last twenty years or so, however, the category 'self-harm' was increasingly recognised as a particular response, and it joined the official list of mental illnesses. There is still by no means any guarantee of sympathetic treatment, though.

Everyone is more or less ordered, more or less happy, secure, well adjusted and committed to the social niceties, or more or less miserable, angry, insecure, confused, antagonistic or careless and destructive of their self. Personality disorder is not a disease like (say) a skin disorder. One *is* one's

personality, and anyone who 'has a personality disorder' is simply a disordered (or disorderly) person. It is mainly young people who attract the diagnosis, and in the background are invariably factors such as chronic poverty, a troubled family, fostering, local authority care, adoption, or habitual subjection to assault or abuse. These patients are not so much the products of material poverty in itself, but rather of an unremittingly degraded, abusive and confusing quality of life.

One case of personality disorder was a girl I will call Natalie. She had been through the adolescent unit before she turned up on the admission ward.⁹ Natalie was a bit wild, a bit too loud and uninhibited for most people's comfort. She had not fulfilled her educational promise and did not want to get a job. She swore a lot and showed little respect for authority. Had she received some family back-up she would probably have got by in life as 'a bit of a loud character'. She was sexually aware and rather disinhibited, and everybody felt she was 'over the top'. I remember a trip into town with her. She would shout out to any young boy we passed: 'Whoo-hey! All right then, darling?' A psychiatrist would find this unacceptable, of course. It was therefore decided to put Natalie on a drug to dampen her sex drive - the idea was that a person can have too much of a sex drive and this leads her into compulsive immorality or sexual crime. Before the 1959 Mental Health Act she would have been classified as 'morally degenerate'.

I had already nursed a boy of eighteen who was given this hormone therapy. It did not seem to have helped his mental state, and in fact it caused him the new worry of developing irreversibly deformed lumpy breasts. Having talked to the consultant over the phone, the junior doctor in charge of Natalie had prescribed the drug. I was the Deputy-Sister taking over the running of the ward on the next shift and was informed of the decision by the Ward-Sister at the hand-over meeting. I refused to give the girl a drug that had already been shown to cause horribly damaging side-effects. I was willing to discuss the prescription with the consultant, but I felt that it was ethically wrong and would defend my position. A nurse has a right to do that - in fact the Nursing and Midwifery Council (NMC) enjoins upon nurses a duty of care. I got my way and the drug was withdrawn. Nurses do not always have to do whatever a doctor might ask. A serious issue like that can go either way, depending on whether nurses are totally submissive or actually take up their duty to have their say in care and treatment.

I would guess that the basis of Natalie's 'personality disorder' was most likely the fact that she was a working-class girl with a chaotic and insecure upbringing, and that her family was incapable of giving her the support she needed. I do not know the full story since her case-notes lacked biographical detail, and no member of staff showed any particular interest in her circumstances. However, this illustrates how easy it is to be assigned a psychiatric diagnosis and then given a very dangerous drug. I do not know what became of this patient, but her outlook was not hopeful.

What alerted me to the dangers of the drug the doctors wanted to give to Natalie was the case of the youth who was also diagnosed as 'personality disorder'. John had come from the courts to the admission ward at the age of nineteen because he had threatened several women: he had habituated an isolated pathway so as to brandish a pen-knife and make obscene demands of solitary women passing by. He had run off at the slightest hint of a refusal and had carried out these attacks in such a way that he had been easy to catch. Perhaps he wanted to be caught. He had been sent to the ward on the understanding that he had to undergo at least six months psychiatric treatment. We were not a secure unit but John was not allowed to leave the ward. Luckily he was not keen to escape.

The treatment for John's personality disorder was Androcur, a drug supposed to dampen the sex

⁹ Although by the 21st century they were not supposed to be held on adult admission wards, in 2006 the UK's Mental Health Commission expressed concern that 1000 psychiatric patients under the age of 18 were still placed in an adult facility due to a lack of any other provision. By 2009, this situation was all but rectified: only three children (under age 16) found themselves so placed during that year. But the improvement was not maintained: in the year to March 2015, 391 children spent time on an adult psychiatric ward, and it was estimated that the number would rise to at least 446 for the year to March 2016. Lombard, D (2009) Trusts miss target to keep under-16s off adult psychiatric units. *Community Care*. www.communitycare.co.uk/ 17 July. Campbell, D (2016) Revealed: dozens of children still treated on adult psychiatric wards. *The Guardian* 13 Nov.

drive. As a result he developed lumpy breast nodules. His consultant ran a clinic for psychosexual problems. Each week at the ward-round this consultant asked John to recount to everyone present what he had done to the women. The consultant seemed to find this public confession amusing.¹⁰ Eventually John went back to court. I was a witness to his safe conduct towards women when he had been on the ward. He was allowed back onto the ward and gradually he was allowed out, to see how he would cope with the outside world.

I happened to be on duty when John came back from his first trip out. He was very agitated and looked for me to tell me that as soon as he was free and had seen a woman he had experienced exactly the same urge, which was to threaten her to get her to undress. He had approached the woman and asked her the time, and had to keep a strong hold on himself to stop from doing exactly the same thing that had put him in court. For the first time I got an opportunity to discuss things with him. What emerged was that when he was thirteen he had been attacked by a gang of boys of the same age who had lured him to an empty house, accused him of homosexuality, held him down and forced a poker up his anus. John had been unable to tell his parents since he had been brought up in an evangelical, bible-bashing home where everything sexual was repressed. It seemed to me that events in his adolescence were undoubtedly the key to his behaviour, yet never in all the months of his 'care' by a psychosexual expert had any of this material even been touched upon.

Everybody knows somebody with a phobia. One young woman I knew was outwardly happy and full of energy and the joys of life, but if she saw a spider she shrieked with terror and was paralysed. She had been a spiderphobe for many years. Sarah was from a comfortable middle class home but she had a strange love-hate relationship with her father, a handsome man with a successful career in the church. She admitted to me that her older brother had started an incestuous relationship with her in her early adolescence. Sarah no longer went to church, and an imminent visit from her father always made her very anxious.

What could such a phobia signify? Most people - and especially women - find spiders repugnant or frightening. Sometimes paralysis when confronted with a spider makes life difficult, but the spider is an acceptable object of fear: people agree that there is 'good reason' for the repugnance, the fear and even the hysteria. A spider is a small dark, creeping, crawling, silent and insidious creature which darts into dark recesses - perhaps into one's self: the threat of invasion by spider does not seem completely irrational. All the same, an incapacitating phobic response ought to alert any mental health official to the metaphoric meaning of the feared object. The basis to phobia has to be a traumatic event (or series of events, or a relationship) which the person cannot name. Surely the phobia was a reaction to the activity of her brother and/or father? She expressed great affection for her brother and her father, but felt that her brother had exploited her. I wondered about the father. Certainly, it seemed to me that fear of her father (and of sex) was displaced onto the culturally acceptable object of fear - spiders. Sarah found it difficult to live with the phobia, but not as difficult as openly naming the real object or objects of her fear, which risked losing the affection (i.e., security) of her family.

The most commonly diagnosed phobia is agoraphobia, popularly viewed as the irrational fear of open spaces. It is not in fact open space which is the problem, since being in someone else's house is just as likely to bring on an attack. It is more accurate to read agoraphobia as morbid dread of public places, i.e., *of being seen*. Whatever its genesis, it is a response to very low self-esteem and severe anxiety, made worse by subjection to the gaze of another - or, worse, many others. Someone

¹⁰ Fifteen years later this doctor was eventually debarred for having sexual relations with patients - but for lack of victims willing to testify, not prosecuted. Five years after that he was the subject of a criminal investigation and trial, found guilty and imprisoned. Later, a fellow consultant at the same facility was also prosecuted and found guilty of sexually abusing many female patients over a period of at least thirty years. He escaped imprisonment by pleading ill-health. These linked prosecutions appear to be unique in UK psychiatry. In 2003/04 there was a Government Enquiry. It turned out that when I had to work with him, some patients had already made complaints against the first psychiatrist, but management had ignored them. See *The Kerr-Haslam Enquiry (Report)* (2005) London: The Stationary Office.

suffering from the condition can just about cope when secluded at home.

Whereas phobia is an irrational fear of an object, event or situation, obsession is an irrational preoccupation with an idea. It is possible to suffer terribly from obsessive thoughts, which always go hand-in-hand with a compulsion. This is now known as obsessive-compulsive disorder (OCD). In the case of one patient, her obsessions were largely linked to the letter K, 'because it is the first letter in the word: kill'. Veronica's fear was that if she touched anything with the letter in its name - for example, a knife - she gets the urge to kill someone. She felt compelled to carry out ritualistic behaviours in order to assuage the anxiety which accompanied the obsessive thoughts. Her compulsions acted as magic to ward off both the dreadful anxiety and the terrible consequences of acting without due care and attention to the obsessional thoughts.

This patient was a small, frail, submissive-looking, quietly-spoken woman with two children. In every other aspect of her life she functioned perfectly well, but she secretly harboured wild thoughts of murder which she could only contain by means of private rituals. She was preoccupied by the need to perform her rituals. In Veronica's case there was the compulsion of a prohibition against discarding rubbish such as packets because they had the letter 'k' in the word - cornflake packets, for example. At that level of compulsion, by chance *any* object can take on significance and determine a responding behaviour. Because the behaviours needed to ward off the anxiety had taken over her life - as they do in those severe cases which get recognised as a mental illness - this had a very upsetting effect on both her and the family.

Like most patients at the time, and until she attended a more enlightened facility, this patient's treatment included exposure to a behavioural regime. (Note that 'regime' implies coercion.) The trouble with this kind of therapy is that it addresses only the behaviour, not the *meaning* of the behaviour. Behaviourist therapy endeavours to replace 'bad' rituals and responses with 'good' ones; it does nothing to address the underlying reasons for the obsessional thoughts or fears which drive the compulsion or the phobia in the first place.

Behavioural treatment is devised so as to punish deviance and reward the behaviour required of a patient. The extreme form is aversion therapy (also known as behaviour modification, negative reinforcement, and operant conditioning). The idea is to train the body to be physically repelled by certain triggers. Usually, images of a desired object are presented to the subject, and when he is exposed to this stimulus he receives a painful electric shock or is given a shot of apomorphine which makes him nauseous to the extent of vomiting. This is a pernicious kind of remedy: the punishments can hardly help from being experienced by the patient as gratuitous cruelty or torture. Milder versions of the technique are still employed to counteract addictions, OCD, phobias and sexual disorders such as paedophilia. Until the end of the 1960s, aversion therapy was regularly used in an attempt to 'cure' transgender patients and, even more, homosexuals, who were often subjected to particularly brutal treatment. In the NHS, this use of aversion therapy ceased when homosexuality was legalised, in 1967, and under pressure from gay rights activists, the American Psychiatric Association removed homosexuality from its list of mental illnesses in 1973.¹¹

The research is poor, but there is no proof that behaviourist therapy is effective. On the other hand, there is much evidence of harm, in that such treatment regularly makes patients feel depressed and suicidal, and in the UK at least one gay young man died after aversion therapy. Despite this, in 1972 Britain's best-known psychologist, Professor Hans Eysenck, still advocated 'curing' homosexuals by means of electric shock or nausea-inducing aversion therapy. He conceded that the success rate was 'not high', and did not dispute that aversion therapy often resulted in gay patients becoming sexually dysfunctional rather than heterosexual, and that consequently many suffered serious, even suicidal, depression.¹² Aversion therapy was no longer so popular when I came into nursing, and I have no experience of patients having to undergo it. However, I did meet patients who had been forcibly subjected to the technique, and they all reported pain and distress - but no cures.

11 *DSM-II-6th Printing* (1974) New York: The American Psychiatric Association, 44.

12 Tatchell, P (1997) Aversion therapy exposed. petertatchell.net/lgbt_rights/psychiatry/aversion.htm; Dr David H Barlow and aversion therapy for gays. neurocritic.blogspot.co.uk/2013/01/29

For the last few years, it seems that clinical psychologists have been unwilling to give up behaviourism yet wish to respond to mounting demands for 'talking therapy'. This would explain the current fashion for the compromise known as cognitive behavioural therapy (CBT). Just the same, someone only becomes a psychiatric patient *because she is governed by her irrationality*. Hence, the same criticism applies to CBT as for any therapy which attempts to work by means of punishments and rewards (i.e., in terms of rational choice) or simply urges the patient to exert her will to overcome her irrational presenting behaviour.

This kind of treatment can only ever have limited success since the underlying cause of the initial anxiety is never addressed. In effect, behavioural therapy gives the irrational anxiety-object or compulsion more credit than is its proper due. Instead of acknowledging that they are only substitute or displacement fears and compulsions, which hide the real objects or events at the root of the incapacitating anxiety - and which are much more difficult to acknowledge or deal with - psychiatry misses the point. At best, the benefits of behavioural therapy are only placebo and temporary. At worst, this kind of therapy actually increases the patient's anxiety because the demands of the therapist cannot be met without increasing the anxiety - which is usually temporarily relieved by carrying out the compulsive behaviour or expressing the phobia. Besides, if she already feels guilty, a patient's failure to adhere to a behavioural regime or respond positively to CBT is likely to increase her guilty feelings - again increasing her anxiety. Meanwhile, the obsessional or phobic patient often expresses full awareness of the irrationality of her thoughts and behaviour, yet she still feels helplessly enslaved to them.

A person in pursuit of her compulsive rituals is like a drug addict. In the sense that it is the only way the person knows to alleviate the great anxiety which oppresses her, compulsive behaviour is an addiction. Therapy which fails to address the root anxiety is rarely successful. The chances are that if hand-washing (for example) is to an extent alleviated by behavioural therapy, the anxiety simply displaces into some other dysfunctional compulsion. Veronica was lucky enough to be offered fairly intensive psychotherapy with a more enlightened consultant. She was encouraged to talk out her fears and problems, the only possible route to a cure. In her case, the letter 'k' was not just some sort of random and inexplicable obsession. Veronica herself had mentioned that the letter 'k' stands for 'kill'. This should alert a therapist to the probability that she really did feel like killing someone, but could not or would not consciously admit it. I was not around for the outcome of this patient's psychotherapy but I suspect the bottled-up, repressed anger beneath her meek-and-mild exterior was a response to abuse in her childhood. Her entire demeanour seemed an elaborate denial of repressed anger; she faced so much internal conflict that she was only able to act out her frustrations in a mad, compulsive manner which had taken over her life.

When the object of the psychiatric enterprise is to bring patients back into the fold of reason, the appropriate therapy is to attend carefully to what each patient says and does, and try to trace the reasonable connections between the 'bizarre' metaphoric speech and behaviour and the features of their lives. Psychiatry continues to ignore the possible significations of a patient's behaviour, including whatever he wishes to communicate - whether it seems, on the face of it, quite irrational or quite reasonable. Instead, the patient must first of all accept the official definition of his 'illness', and of anything he says and does. This is counter-productive to remedy since denying the patient's experience (or ideas about his experience) invariably drives him deeper into frustration, despair and whatever delusional system he has already constructed. In the absence of genuine counselling or psychotherapy, psychiatric 'cure' (or 'management of the symptoms') amounts only to coercion and drugging, and the patient's coming to an accommodation in which he stops expressing his true thoughts and feelings in order to escape from the clutches of psychiatry.

Outside of psychiatry it is a common intuition that madness is a response to intolerable conditions - that madness is not a strange illness which randomly blights people who happen to be unlucky, but rather that certain circumstances or particular human agents drive a person mad. In response to intolerable stress we say 'I feel as if I'm going mad' or 'If you carry on like that, I'll go mad', etc. Everyone understands that the basis to individual irrationality is stress, often caused by impossible demands or assaults on a person's sense of reality.

Psychiatric workers are best placed to offer the most useful assistance. They come to the patient from outside of his normal social circle and are employed to give a fair and equal service to every patient, so they could offer to listen and advise in a dispassionate and less motivated manner. But the medical model denies the social and psychodynamic roots to any functional mental disorder, and the first concern of almost every psychiatric worker is his blind commitment to defending the medical definition of the situation. Given the ruling medical model, how could there be a true commitment to listen with an open mind to each patient, so as to explore the basis to his mental disorder?

Long-term patients

Many patients used to spend anything from twenty to forty years or more tucked away on hospital back wards, some of them geriatric wards. In effect, these were dumping wards. When the old mental hospitals began to close, about thirty years ago, most long-stay patients were moved to privately-run nursing or residential care homes.

Few long-term patients display florid signs of a mental disorder. Some are mildly eccentric but most are quiescent and not spontaneously communicative. This is a combination of sedation and resignation to the demands of the institution. Even after many years of medication, institutionalisation and depersonalisation, however, some patients seem to retain amazingly strong personalities. They would have had to spend year after year with very little to call their own, neither space and time nor clothing and personal effects. Each re-organisation of wards or hospitals would shuffle them around, and they would see their friends shipped off here and there, and see staff come and go.

Maddy was over eighty when I met her. She was mobile and had a side-room on a back ward. She was not unfriendly but kept herself to herself. In her case-notes was a photo of a young woman in a psychiatric 'strong dress' (i.e., it could not be torn or removed). She was twenty-six when committed 'due to a confinement'. This means that she had been poor and unmarried, became pregnant and was removed from society. There was no other indication of a reason for her committal. Whether she had originally shown signs of mental disorder or developed them later, Maddy had a harmless delusional system in which she always had to wear a headscarf as protection from the mumps and measles, which could be caught from the television. She had monitor jobs on the ward, such as pushing the dinner trolley round. She used to make little dolls out of recycled materials for staff she liked. She gave me one made out of an old vest stuffed with green paper towels out of the kitchen, with a jeyecloth dress and an embroidered face. It seemed to me that the dolls represented her lost baby.

In one hospital there was a ward containing all the more bizarre elderly women. These inmates had also been secluded and medicated for decades, and medical side-effects added to their strangeness. Staff on this ward were not intentionally unkind, but possibly as a form of defence against the depressing milieu, it was normal for them to refer to the patients by nicknames. For instance, Mrs Smith was known as 'Mother Smith', and then somewhere along the line she became known simply as 'Mother'. This was cruel since she had been in the hospital since being admitted for post-natal psychosis after the birth of twins (who were by then in their late thirties, and still came in to visit her). This patient was very tall and had a huge bloated stomach. She was well over sixty but appeared pregnant. She wore hospital clothes, had no teeth, rarely spoke and walked around on her own. It seemed to me that her aloofness signified integrity - that she maintained her integrity the only way she could, which was by refusing to recognise and collaborate with the enemy - those who kept her imprisoned.

I got to know quite well two other elderly patients on the ward who seemed to be hospitalised for no apparent reasons other than 'marrying a foreigner'. As if it had been the reason for her admission, staff always said about Carrie that 'she married a Chinaman'. There was nothing in this patient's case-notes and nothing to indicate that anything was seriously wrong with her. She only seemed slightly odd, and was an ardent taker of snuff. She was joined in this forbidden pastime by the other old lady who had 'married a foreigner', who happened also to be called Carrie. These two had been inmates for decades and only seemed bizarre in that they conspired to 'act-up' like naughty girls with fairly harmless 'bad habits' - against instructions they took too much snuff, smoked too much and ate

too much.

I met Maria on another back ward where all the patients were sedated and the doors kept locked. She suffered from obsession-compulsion. She had been in psychiatric care for many years and was a tiny, frail and quietly-spoken elderly lady in a constant state of torment. She was always nicely dressed and her brother sometimes used to come in and take her out. Maria felt compelled to wash her hands. She would search for soap and a brush and scrub her hands until they were raw and bleeding.

Maria was another example of someone who had been institutionalised so long that her notes were never read. Years before I met her, though, a psychologist had noted sessions with her which elicited biographical details. She had been at a Catholic boarding school and as a young adolescent had formed a strong friendship with another girl. This had been forbidden by the school authorities. Whether the friendship became a full lesbian relationship was unclear, but very close relationships are well-known to have been discouraged in that type of environment, and the individuals made to feel guilty.¹³ The school separated the two girls and instilled in Maria tremendous feelings of guilt. On the face of it, it seemed obvious that something like this might be the cause of the obsessional hand-washing, and that what she had needed was counselling or psychotherapy to address and allay the underlying guilt. Her notes gave no indication of any such action, however. It appeared that the psychologist who discovered the background to her case had simply gone ahead with behavioural treatment. Maria's outlook was grim. The only nursing care was to keep soap away from her and drag her away from the sink, kicking and screaming.

A typical male patient was Austin. I met him on a mixed rehabilitation ward intended to take patients off the back wards, de-institutionalise them, and make them fit for the outside world. This project was ill-conceived and doomed to failure. The theory was to train-up the patients to a high standard of etiquette - they were all supposed to eat with napkins, say grace, and so on - so that when they were discharged (usually to a Salvation Army hostel) and their habits inevitably deteriorated it would take longer for their personal habits to slip back to a very low level. Many of the patients found the new ward difficult since they had spent so many years on a single-sex ward. Both Austin and his twin brother were on the ward, but they were known to have spoken to each other only once.

Austin's defensive tactic was echolalia and echopraxia, which is where he would simply repeat over and over again whatever anyone said to him, or if anyone asked him to do something he would do it, but repeatedly. Male patients were supposed to learn the 'good habit' of wearing a suit and tie. Austin would be instructed to put on his tie, and half an hour later he would be found still in front of the mirror, winding his tie over and over and over. Once he had been told to lay the table and I found him repeatedly picking up and laying down a knife. I asked him why he was doing it and he replied: 'I'm mad. I'm not responsible for what I do.'

This patient was about sixty-five and had been hospitalised since his late-twenties when he had a breakdown while training for a profession. Nearly every one of these long-stay patients who were supposed to re-enter the world was thoroughly habituated not to communicate with anyone. Staff used to put on a kind of psychodrama session once a week to try to get the patients to relate to each other. One evening we had Austin and his twin Arnold in the same little group, and the patients were invited to reminisce about childhood holidays. Both Austin and Arnold talked, for the first and only time that I knew them - not exactly to each other, but in a kind of collective manner about a pleasant experience they had shared. This was wonderful, but immediately afterwards both men relapsed.

Austin's echolalia and echopraxia was persistent. It appeared to be a rebellion, a kind of satirical obedience. There was certainly much in the psychiatric routine that was absurd and might elicit protest. For instance, on that particular ward staff were supposed to encourage the patients to sing a song to re-enforce self-medication: 'Now we've sat and filled our tums/Time to take our tablets, chums!' Some of the staff actually sang along. This was one amongst many other sad and embarrassing attempts to de-institutionalise long-term patients and make them ready for the outside world.

13 See Antonia White's biographical novel. White, A (1933/78) *Frost in May*. London: Virago.

The dynamics of madness

It seems to me that psychiatric patients are typically unhappy to the point of distraction, and are often absolutely preoccupied by their own misery; since they also suffer from a great lack of self-confidence, all this combines to make them unable to perform to required expectations. If there is no sympathetic response to this condition, it is prone to escalate and the person may enter a state of frenzy because nobody listens and nobody believes anything he says. What starts out as possibly a reasonable enough objection, in the face of unjust and arbitrary demands and assertions, tips over into what is seen as madness.

Denial is always a key factor in the genesis of madness. For example, it would not be possible for somebody like William to get away with saying 'My mother treats me like a baby', because his mother and probably everyone around her would flatly deny it. I remember his mother saying 'William needs me. *Don't you* William?' The tone of voice carried a threat. It is often difficult to get a grip on the dynamic because a threat need not be overt. William's mother was not about to say 'I need you to act like a baby because I can't cope with you growing up and becoming independent.' Instead she said: 'You need me, *don't you* William?' The tone of voice indicated that her son must not disagree because that would upset her. William knew he was not permitted to argue with his mother, and the frustration drove him into a frenzy.

When this kind of family dynamic is established, the growing or grown-up child does become dependent and baby-like since his own integrity and independence has been denied so consistently for so long. William's anger was fuelled not only by his domineering mother but also by everyone complicit with her - and of course he was angry with himself. In this case, then, there were multiple projections of frustration and anger: onto William, back from him onto those around him, and back on himself - as guilt for antagonising his mother by his mere existence. It is likely that William wished to pay back all that was visited on him by his parents, but he was not able openly to admit that to himself because he depended upon them and would have felt extremely guilty had he admitted it. All the cruelty done to his nature, and all the mental harm he would have liked to pay back - none of which he could openly and calmly admit - came to him as voices, as projections and introjections.

Reasonable parents encourage their children to express themselves and develop and act out independence appropriate to their age and capabilities. It is important that a child is not thwarted in attempts to demonstrate his maturity or ability to follow his own path. Obviously it would be inappropriate to expect a five-year-old to light a gas and cook a meal, but surprising if a healthy and intelligent fifteen-year-old was not allowed. What was most crazy in the case of William was that (presumably due to her own feelings of insecurity) his mother acted towards her manifestly grown-up son as though he were a baby.

The trouble is that those looking at the relationship from the outside all failed to grasp that the situation in which mother and son were embroiled was one where they were *both* stuck because it had been going on for years - possibly since William's birth. All that those outside could see (or would admit to seeing) was a kind mother looking after her poor, semi-invalid son. By the time a psychiatrist was called in, William had probably spent his entire life in an infantile state - ever since he actually was an infant; or perhaps a particular crisis had precipitated the mother's inappropriate behaviour. Nobody knew and nobody seemed to have tried to find out. Nevertheless, a psychiatric crisis only erupts when a child manifestly fails to grow up as a more or less independent and viable person. At the point of the crisis, and while the child appears as some sort of bad or deficient person who embodies unreasonableness, the parents appear normal and responsible.

To understand why a mother would raise a son like that we would have to explore what happened in the history of the family, what is in the parents' minds, what happened particularly to the mother in *her* childhood, and what it is between her and her husband that makes her so insecure as to prohibit her child a secure sense of himself and to discourage him from developing into an independent adult. In that particular case, as regards the marriage, on the face of it the mother appeared domineering and the father self-deprecating and hen-pecked. Who knows what childhood traumas and current delusions, what anxieties and sexual frustrations conditioned the parents' behaviour? These kinds of

questions are taboo in orthodox psychiatry, and nobody in the psychiatric team ever asked them about William and his family. Orthodox psychiatry does not routinely engage in any sort of meaningful exploration of the social or biographical genesis of mental disorder. This means that it cannot help patients to comprehend the forces which produce their misery and confusion, and thereby help them to formulate and carry out plans to contest and overcome their troubles.

Instead, 'mental illness' is supposed to be 'managed' by medicine. This idea denies the actual processes of madness. Often, when someone is 'mentally ill' (or is defined as such) what is in fact going on is an unhealthy or irrational system of relationships in which at least three generations are involved. Unless there is some understanding of the role of the parents, and hence of the upbringing of the parents, one cannot possibly understand what is going on in the life and mind of the person who becomes a psychiatric patient. Why does a parent need to act in a warped manner towards his or her child? It seems obvious that a mental disorder is in a way a result of the upbringing of the previous generation, and one could say that a child is the product of the grandparents through the mediation of his disturbed parents.

Take the case of Jennifer, whose mother was so self-obsessed she would only talk about her own 'heart condition' to her dying daughter. It seemed clear that her mother's hypochondria must have been a major influence on Jennifer all her life. It was originally the mother who had needed help. The form of the mother's pathology was the notion that anything the daughters said or did would have negative repercussions on her own health. This forced her daughters to live in a permanent state of fear and guilt concerning the impact of their behaviour on their 'invalid' mother. This leads to the question of the mother's extreme hypochondria. What was there in the mother's upbringing and circumstances that led her to such a state of mind? Perhaps she did have a metaphoric heart condition - the emotional condition of 'a broken heart'? Anyone wishing to help Jennifer or Janet would have had to address the problem of their mother's emotional and mental condition.

Psychopathology is often connected to a self-stroking system of family pathology. Where a young person is mentally disturbed there is often one fairly obviously disturbed parent, and sometimes it seems clear that both parents have serious mental health issues.¹⁴ In Steve's case the father was overbearing, and it appeared that he was unable to cope with the emerging power and intelligence of his son: this indicates the father's psychological insecurity. Steve's mother had been dominated by her husband. If she submitted to her husband in the matter of her pregnancies, it was likely that she was complicit with his attitude towards the children. With Lucy, isn't it strange when a mother sends her daughter a gift of men's underpants? But no-one stopped her, let alone questioned the part she must have played in the genesis of her daughter's malaise. And how about the history to the family ruled by the hypochondriac mother? Nothing about it was recorded in the case-notes. As for William, a timid father acquiesced to the disturbing and incestuous behaviour of the mother - none of that was of any interest to the psychiatrists or to other staff.

Most patients begin their psychiatric careers at a critical moment during the time when everyone else their age wishes and is expected to take on an adult identity involving much more independence and more responsibilities. Whenever one manages to find out something about the context to a mental disorder, the relationship between the patient's parents is almost invariably troubled. Where there is not healthy mutuality in a marriage there is usually an accommodation where one partner wields power and the other is submissive - and whatever the age of the child, he is liable to suffer from that state of affairs. Sometimes the parents seem even more bizarre than the patients. Psychiatry fails to realise that what is only 'the family background' for an observer - such as the doctor - is in fact the patient's foreground, the context in which he or she has to make a life.

All that the doctors achieve by diagnosis is to give different sorts of behaviour different names: a diagnosis explains nothing and does not help to remedy the disorder. Madness is mainly a function of family dynamics, pathological child-rearing and traumatic events in a life - the obsessive 'medical' categorisation of different types of madness is only a therapeutic distraction. According to the

14 Of course, if a parent was absent during childhood or the individual was raised in care, for various obvious reasons this may often have been problematic in itself.

medical model, treatment cannot proceed without identifying the particular mental illness from which each patient suffers. However, this is not based in any medical evidence, and it largely serves as mystification - it only makes the officials *appear* to know what they are about.

This is not to say that discrimination between different kinds of mental disorder is pointless. For example, to say someone is neurotic is to indicate that his behaviour is *to a degree* pathologically conditioned, whereas when we talk about psychosis we mean a more complete dissociation from the reality most of us inhabit so as to safely negotiate our lives. Obviously, different conditions require somewhat different types of care. This is fine, so long as we remember that we are talking about a continuum of distress, and that people change. If someone enters a crisis in which he displays extreme distress and incoherence, that does not mean that every day thereafter he *is* a schizophrenic. At one end of the continuum of sanity and madness are those who are fairly happy with themselves and the world, and can function in it without a crippling emotional or mental disability. Further across the continuum would be someone who has a persistently dysfunctional relation to himself, to others and to the world, to the extent that his mental disturbance is a worrying private or public nuisance; he would be characterised as neurotic. Further along the line, though, the neurotic maladjustment escalates so severely that it tips over into an emotional and mental state which is more completely disjointed from the rational consensus, to the extent that the person no longer recognises some or many of his thoughts as his own, but experiences auditory and visual hallucinations, and becomes a positive danger to himself or others. With a psychotic perspective of the self and the world the delusory images take over as, for example, with the belief that one is Joan of Arc or Jesus Christ. Yet any delusion is bound to signify *something significant* about the life of the person who expresses it. Why, in particular, Joan of Arc or Jesus Christ?

We should view the clinical categories as lying on a continuum from emotional and mental well-being to abject and completely confused misery. In addition, the abstract categorical naming of psychiatry should not blind everyone to what is actually going on in the patients' individually unique, complicated and changing lives. Laing suggested that 'schizophrenia' - literally 'split mind' - is not the fundamental issue, and that we would do better to recognise 'a broken heart'.

To the casual observer, psychotic voices and hallucinations may seem *absolutely* weird. Even so, the images are not 'plucked out of the air' - the voices, comments, instructions or visions are not random. A sympathetic enquiry into the life of the individual often indicates a certain 'poetic' sense to such phenomena that is absolutely to some point. Steve's voices, for example, were all those of powerful male figures who mocked, baited and derided him; this was the obsession that ruled his mind and life, and it seemed clear to me that they harked back to his unhappy childhood and adolescence with his mocking father. William's voices were persecuting nazis, and his mother, albeit unwittingly, appeared to wish to destroy him as an autonomous individual; nazism is an obvious symbol of the arbitrary but organised destruction of persons said to be inferior, and until recently, nazis figured in many patients' delusions. As regards Jennifer, she actually was accused by her mother and sister in the same way that she heard herself being accused by her 'voices'.

If each of these patients had simply accepted their fate according to the ideas of their close family (and almost invariably the ideas of complicit psychiatric workers) they might not have been driven so far into the frustrating, persecuted, anxious and confused states in which they found themselves. This implies that there is a choice in these matters, but of course there is not - a baby, a toddler or a child has little choice, and by the time the child is an adolescent or a young adult the emotional and psychological damage is done. In each case, what was demanded of the young person was impossible to fulfil, and he or she was caught in the middle of the conflict: a fully-grown young man cannot act like a baby without some sort of protest, yet to refuse would offend and upset the parent.

In benign circumstances, a parent's role changes positively as the child grows up. The role of provider, protector and decision-maker diminishes, and the parent's self-image has to change. Anxious parents are likely to resist these changes, though, and sometimes they refuse to accept them. This makes them devise a twisted definition of the growing child and the whole situation. Inevitably, the developing child is caught in the conflict between his own needs and desires and those of his parents. Putting it baldly, the more the parents feel anxious or inadequate the more likely they

develop a distorted, emotionally and cognitively harmful response to the energetic and growing child.

The problem of mental disorder is the problem of conflicts in the patients' private lives. This often includes the experience of real, often habitual and calculated instances of violence, threats, abuse or emotional trauma which nobody acknowledges but which are very disturbing to the victim. Anyone who does not wear the blinkers of the medical model can often clearly see conflicts between the generations over basic issues of the getting and losing of love, and of sexuality and independence. When a child matures and issues of independence and sexuality become ever more pressing, this often incites a crisis between the child and parents who are themselves emotionally insecure. It is not always easy to watch a child grow up and away, the child who the parents have watched over and feel they have protected from birth. Emotionally insecure parents often feel an urge to resist a child's movements towards independence. This resistance is not necessarily conscious, and the parents often deny it; and almost always it is in the name of love that such parents deny, exploit and confuse their children. Obviously, this exact dynamic is not at the root of every psychiatric disorder, but in one way or another childhood trauma seems like the best hypothesis.

The failure of conventional psychiatric treatments

Psychiatry does not provide sufficient opportunities for patients to express what troubles them, and then to receive an appropriate sympathetic, thoughtful and practical response. It is true that in the case of Jennifer there was an understanding amongst some senior staff that hers *was* a family-based condition, and some of them thought drug treatment was not enough. The ward did provide some family therapy. But this was and still is exceptional, a low priority, and under-funded.

In the other cases I described, staff were not interested in the dynamics of the mental disorder or of interaction in the family. In the case of William, the psychiatrists and nurses collaborated with the bizarre ideas of his mother by allowing her the key to the bathroom so that she could continue to bath her huge, twenty-four-year-old 'baby'. Instead of viewing the patient's aggression towards his mother as a product of the family dynamic, and asking why it happened, he was only treated like a naughty child and 'told off'. Instead of considering the possibility that his persecuting nazi 'voices' expressed profound feelings of persecution - as the breakthrough into his awareness of a truth he wished to repress - the response of his psychiatric keepers was: 'Oh, isn't it sad?'

The normal response, meanwhile, is first and foremost to give the patient whatever is supposed to be the appropriate drug depending on the diagnosis. The benevolent view of the psychiatric patient is that he is like a poor, sick and naughty child. In the malevolent view, the patient is blamed; this always finds the easiest rationale (e.g. 'He takes illegal drugs') and is hostile towards him because of his transgressions.

It seemed to me that the common factor in each of the cases I have described was that the parents did not give unconditional love to their children. If there were expressions of affection they would only be on conditions which could never be satisfied by the child because that would have destroyed his own integrity. Each individual was required to submit and acknowledge something which they could not accept as true. In each case, whenever the patient rebelled against his incarceration and the label 'bad' or 'sick', this was defined as 'another symptom'. And yet attempts to escape are understandable in the face of indefinite imprisonment and psychotropic treatment, and although aggression is regrettable, lashing-out in response to confrontations or great frustration is hardly a type of behaviour confined only to people who have a mental disorder.

Too often staff seem to forget that each long-term patient has a personal history, and was not always old and, in effect, neutered. This means that even though the sexual aspect of many cases is fairly obvious, the organisation does not address the matter in any clear, compassionate and helpful manner. When Lucy's mother sent her men's underpants, might this not have indicated that the mother had a problem accepting her daughter's sexuality? In fact, Lucy's sexuality was being destroyed by medication which had already turned her from a slim and beautiful girl into an overweight young woman who had lost her good looks - and no-one viewed that as a medical failure. William's mother could not accept that her son had grown up, and insisted on bathing him like a

baby. All of Steve's delusions and persecutions hinged on 'his inadequacy' (i.e., virility, sexuality), while his persecuting father was threatened by any signs of his son's superior intelligence. The whole demeanour of Jennifer and Janet, copied from their mother, completely negated femininity. It is hardly original to suggest that sexuality is an important factor in the precipitation and perpetuation of many cases of mental disorder. But this is rarely acknowledged within psychiatry.

The importance of sexuality is illustrated by the case of an unfortunate young patient who had been given the same name as a well-known menswear company. He was in his mid-twenties, and quite good-looking. When I met him, I was sitting on a ward chatting with some other patients. Suddenly he looked across at me and shouted 'Stop that blinking! I know what it means! Stop it now! I know what it means!' This was quite difficult to deal with. When he was not in that kind of mood, though, like many other patients he was very pleasant.

I was a novice at that time, and as a prank the charge nurse set me to give the first injection I had ever given - a two-week depot jab of Depixol for this young man. The charge nurse took me into the clinic and supervised the drawing-up of the injection, went and got the patient, and then - left us on our own. This was irresponsible to me and the patient, and quite unprofessional.

So I had to say to the patient 'Would you please take your trousers down?' He became very agitated and began to shout 'I'm not homosexual! No, I'm not going to take them off! I'm not homosexual!' When he had quietened down he insisted that I inject him in the arm, so that is what I tried to do. Understandably, he screamed with pain, ripped the syringe out of his arm, hurled it across the room and ran off. I was lucky not to get hit by the needle. This 'initiation' was set up by a bored charge nurse who liked nothing more than to make young girls blush: an everyday sexual motive on an everyday ward in the normal routine of an average psychiatric unit.

All along, there was a patient involved in this 'joke' - someone who had spent his entire life as the butt of a joke. Clearly, he was disturbed by homosexual feelings. His parents were not the sort who might easily cope with having a homosexual son - they were conventional working class people, and their only concern was that he should get a job. Anyone genuinely trying to help this patient would have had to address the sexual disturbance and also mediate diplomatically with his parents. The psychiatric response was little more than to keep him off the streets and on long-term tranquillisers.

Nowadays, the apologists for orthodox psychiatry want to have it both ways - they want every instance of disabling emotional distress and mental disorder to be an illness which mandates medical treatment *and yet* they want the person subjected to this medical coercion to be a 'client' or 'service user' who exercises his own rational free choice. This indicates psychiatry's great confusion about agency and responsibility. It is quite normal to find staff indignant about the behaviour of some of the patients - about the very sorts of behaviour which brought the patients into care in the first place! Mental health legislation and the institution of psychiatry exist precisely because society recognises the problem of individual irrationality, and the consequent loss of responsible agency. There is something wrong with the training when so many staff are perplexed and indignant due to the failure of their 'clients' to act at all times quietly and rationally, just like general medical patients. Too many members of staff wish to hold every 'troublesome' psychiatric patient fully accountable for what he says and does, as if he were not consigned to their care precisely because of his irrationality, his emotional distress and his mental turmoil. At some point, of course, the recovery of emotional and mental equilibrium is something which must be negotiated with each patient. This is not possible when staff find their patients intolerable and cannot understand the nature of the deviance they are employed to manage - their own confusion and self-righteous moralising only exacerbates the frustration, distress and confusion of the patients. It is no wonder that some patients respond to staff with verbal abuse and occasional violence. Of course, this calls down on them the depressing psychiatric response of overwhelming force and instant sedation.

In order to understand the way the medical model of psychiatric treatment and care continues to be so obstructive to recovery and better social relations - in fact, continues to be positively destructive of the person concerned, and of those around her - consider the following example of the mismanagement of one patient's life. Sadly, this case is not untypical.

A young woman became a patient when she was twenty-two. Since the psychiatrists had never

been sure about her precise ‘condition’ or ‘mental illness’, by the time I met her, when she was twenty-seven, she had been prescribed a total of nineteen different drugs, each supposed to work differently. By simply assuming the truth of her case-notes, and taking a little time to talk to her, it became clear to me that during those five years her alternate agitation and extreme lethargy and depression was always based in the fact that she was terribly upset about being sexually abused by a member of her family when she was adolescent, and that although *she* was denied access to her small daughter (who was taken from her when she became a psychiatric patient), the social services permitted *her own abuser* access to the child. The patient had been literally worried sick. She remained in that condition, and it was most unlikely she would ever recover until something was done to address her serious concerns.

Although her case-notes refer to the abuse she suffered when a teenager - as nothing more than one ‘fact’ amongst many others - this had never been taken seriously as a (or the) possible source of her anxiety. Naturally, due to her experiences at the hands of the authorities, who had consistently disbelieved her or simply ignored her realistic fears, she was extremely wary of confiding in anyone. And since her extreme anxiety had caused her to become and remain a drugged-up psychiatric patient, nobody listened to her, she was powerless, and she was still at her wits end. By the time I met her, she was so depressed that nobody would take the time to gain her trust and get her to express her fears, let alone do anything to try to remedy the terrible situation which so preoccupied her. Instead, she was pumped full of drugs and shunted through the bureaucratic system as simply ‘having a serious mental illness’. This did not prevent her from still asserting: ‘You can give me as many drugs as you like. You won’t stop me hating my family.’

We can therefore see that not everyone who suffers from excessive emotional pain is unaware of the cause of their anguish, and cannot clearly account for it. In my experience, a fair number of those accused of ‘having a mental illness’ know very well what caused them all the frustration, anguish, confusion, anxiety, panic and depression that ended up with them being given a mental illness diagnosis. Due to the blinkered medical perspective, however, in which any undesirable thing that the patient says can be discounted as an irrational belief and viewed as ‘only a symptom’ of the alleged illness, a mental health diagnosis is difficult to contest once it has been assigned. Patients like this are only too aware of having been subjected to cruelty and abuse, and it is that, combined with implacable denials on the part of all those they turn to for help, which drives them to distraction. Their problem is not that they ‘have a mental illness’ but that no-one around them or with official responsibility is ever willing to listen to their complaints or take them seriously and respond with any meaningful help. They do not suffer from an illness but rather from a dreadful and intrusive knowledge, and on the part of all those around them, from denial, contempt and a complete lack of justice.

Obviously, any mental health patient who articulates a plausible or verified narrative of cruelty or abuse does not require depth analysis - certainly not in the first instance - and to suggest it would be a further slap in the face. Formal counselling might be helpful, but essentially so as to elicit a full history, and for trying to decide on appropriate courses of action for both the individual and the authorities.

Misguided therapy and care

There is nothing sophisticated or sensitive about conventional psychiatric treatment. In fact, it is crude and sometimes barbaric. Only recently have organisations like the Royal College of Psychiatrists and NICE shown any sympathetic interest in ‘talking cures’. Therapy is still hardly ever considered a process of discovering and working on the emotional and social roots to the patients’ misery and confusion.

The psychodynamic perspective is completely opposed to the medical model. In the latter, the mental illness is supposed to cause the patient’s emotional and social problems; in the former, the person’s emotional and social problems cause his mental disorder. Doctors are not concerned with patients getting insight into the reasons for their distress: in their view, there are no reasons, there is

simply a yet to be discovered organic (neurological) illness with a yet to be discovered organic cause. The nearest conventional psychiatry comes to a plausible theory of its own activity is to suppose that once the symptoms are 'managed' the problems in the patient's life may be addressed. In which case, doctors are only really interested in repressing symptoms, which they view as 'the cure' - or at least, 'managing the illness'.

It is true that a person is unable to communicate very well if he comes into psychiatric care seriously depressed, manic or experiencing hallucinations. Little can be done until he is restored to a state in which he is able to communicate, or indeed to a level of general health - he might well be malnourished or exhausted. Nevertheless, at the point of the recovery of his ability to communicate fairly reasonably, it is possible to begin to explore issues such as those discussed in the two previous sections. What is frustrating is psychiatry's complete disinterest in the wealth of signification expressed by the patients' 'bizarre' symptoms.

Psychiatric workers are simply not properly introduced to psychotherapeutic practice in their training. Patients are discharged as soon as they cease to display florid symptoms. The lack of intelligent and systematic psychotherapeutic work explains the recidivism of a considerable number of patients who never properly recover. Instead of adequate training in counselling or psychotherapy, for the last thirty years or so psychiatric nurses have been introduced to 'communication skills' and suchlike public relations techniques, which are intended to exact the patient's compliance. Of course nurses should be skilful at communicating. Even though official policy and training seems to adopt a 'hearts-and-minds' approach only via the notion of attempting to persuade or *trick* patients into believing that psychiatry works in their best interests.

Medication is by far the main psychiatric treatment. The way in which powerful chemical concoctions are used as a matter of course is not justifiable, however. Psychiatric medications are often dangerous toxins which routinely produce hideous effects. These ill effects are called 'side-effects'. Besides indicating that the effects are not intended, the phrase also seems to imply that they are unimportant - not the major effects. Nonetheless, at some time or other - perhaps in a few days, or weeks, or perhaps years - it is likely that the 'side-effects' become a worse problem than the presenting psychiatric problem. It is well-established that long-term use of some psychiatric drugs is likely to cause irreversible damage to the nervous system.

Psychiatry has never properly investigated or used herbal or homeopathic remedies. There is evidence that they may be equally effective, but without the side-effects, e.g., Valerian to counteract insomnia, and other natural sedatives, such as Passiflora, to reduce anxiety. There are many others. It is high time to explore alternative medical avenues. I have seen dramatic homeopathic effects on friends and relatives suffering from emotional problems. Homeopathy has an affinity with the better sort of psychiatric therapy, where diagnosis and physical intervention is only decided after the patient is given a full hour's consultation about his whole condition, emotional as much as physical. A sympathetic interview is already therapeutic for anyone with a psychological problem. Psychiatric diagnoses and treatments come and go as fads, and market pressures tend to invent diagnostic categories and push the same pill for everybody with 'the same' complaint. With homeopathy, the individual is not subsumed into the diagnostic label - the therapist is attentive to the unique person, and there is no single remedy for any one particular emotional or psychological condition.

Anyone experiencing an emotional or psychological crisis might benefit from homeopathy, which works on the principle that the body is able to heal itself. This principle could also be applied in psychiatry, since 'healing the mind' is a project that cannot work without the patient's conscious co-operation. Patients do recover in the right environment, although the normal psychiatric environment is not organised in a manner specifically conducive to positive psychological changes. Rather, when the body is attacked with toxins and the patient becomes submissive, bored and powerless, it mainly serves to prevent full mental health. The forms of psychiatric care and treatment tend to reinforce many of the pressures which so upset the patients originally. From this point of view, homeopathy is a better form of sedation for working with psychosis since it works on the principle of treating like with like. A homeopathic treatment for anxiety, for instance, might be a minute dose of caffeine; this gently triggers the body to react against it, in order to correct the imbalance within the body caused

by anxiety. The body then sedates itself by means of its own biochemistry. This could at least be attempted; even if it only worked as placebo, it might save poisoning by medication.

Doctors often defend themselves against the criticism of indiscriminate drugging by maintaining that their critics 'lack compassion'. However, in itself, doling out pills is not very compassionate. Where is the compassion in barely listening to a patient before putting into his body toxic and addictive chemicals which *might* have a certain required effect but also might well lead to a whole new set of health problems? Too often medication is unnecessary. The psychiatrists argue that if the patients do not receive the drugs they are not receiving treatment, and whoever opposes this view must be suggesting that patients should be left in misery. I argue that the manner in which psychiatry intervenes should not itself cause harm, as is too often the case at the moment.

This applies equally to shock treatment, of course. The supposedly beneficial effects of all of the regular psychiatric treatments were discovered by accident. In psychiatry there has never been any well-worked-out, theoretical and experimentally verified knowledge of organic causes. How could there be? There *is* no specific organic seat of depression, anxiety, delusion or hallucination - although, of course, the centre of all higher sensation, thought and feeling is the brain. It is the whole person who becomes anxious, depressed or deluded to the point of eliciting a psychiatric intervention; that is to say, usually a more or less organically healthy and vitamin-sufficient organism with a psychologically complex life within a social context.

The discoveries of the 'efficacy' of the major tranquillisers, the anti-depressants and shock treatment were each purely by accident. There is no theory to explain exactly why any of those treatments 'work'. For example, a drug might have been made to combat TB or some other real disease, and it happened to make experimental subjects euphoric; it is then tested on patients diagnosed with depression, and if to some extent it appears successful it is marketed as an anti-depressant. Similarly, there is no theoretical basis for shock treatment. All that is known is that it destroys brain cells. In the case of many widely used drugs, as well as ECT, there is good evidence that placebo works just as well as active treatment. If by therapy we mean the reduction of symptoms, when a patient *imagines* he is being treated by an effective medical technique, that can be as therapeutic as actual treatment.

The myth of Medicine is extremely powerful. Everyone assumes that doctors and nurses are going to help them by means of an appropriate chemical or physical technique. Few mothers would refuse to give medicine to their children if the doctor prescribed it. But if they only went away and read up the side-effects of the antibiotics they give their children, perhaps several times a year, they would be horrified. Few of us imagine that a doctor is going to administer a poisonous substance. Nobody wants to believe that their doctor is a more or less successful, more or less failed and fallible or ignorant and misled human being, much like anybody else. We believe in doctors as if they were God. The power of the myth of Medicine is such that if the doctor administers a treatment, the patient wishes to believe in it, and very often he does begin to feel better even when the medicine is only an inactive sugar pill.

When I was a student nurse it was not unusual for staff to give placebo Mogadon, the sleeping tablet dished out to all the patients at the time. Most patients would sleep just as well with the placebo - especially the ones who had been on Mogadon a long time. If Mogadon is taken over a long period, of course, it loses its physical effect. This means that for the long-term users the drug had *already* been a placebo for a long time. What was happening was the reassuring ritual of taking a drug that each patient *believed* would give him a good night's sleep.

I meet people who are unfamiliar with psychiatry and imagine that ECT went out of use years ago. Not so - despite all the arguments against its alleged efficacy, and the barbarity, it is still in use. It is true that there was a decline in its use from the 1970s until about 2000, but now it appears that it is on the rise again. Every psychiatric nurse has always been expected to participate in the procedure, at least during training.

Patients often complain about all the sitting around and chatting in psychiatric facilities. They say that nothing is being done to make them better. Compared to the usual air of relaxation and informality (or pointlessness), electroconvulsive treatment (ECT) seems like an authentic medical

intervention with an immediate effect. Shock treatment has a big placebo value. It is delivered in a clinical setting by means of a technical-looking apparatus. All the staff wear medical uniforms, the patient is given a general anaesthetic, and the whole thing has the appearance of an operation in a general hospital. The patient is given surgical-sounding reassurance beforehand: 'You are going to have an anaesthetic, you might feel groggy afterwards, but it will be no worse than a trip to the dentist...' A desperate patient can take a lot of comfort from the idea of being an important individual case served by a team of experts who all seem to know what they are doing, using a lot of complicated-looking medical apparatus.

Because it causes memory-loss, at least in the short-term, some patients report feeling better for ECT: a patient who cannot remember her problems is likely to feel that much better. In that sense, shock treatment sometimes works. There are also psychological factors which certainly make it *seem* to work, but which psychiatry ignores, such as the play on patients' guilty feelings. Many depressed and anxious patients are preoccupied by guilt, even if only the guilt of feeling depressed and anxious and letting down those they love. ECT is so awful as a notion and in its effects: it is an electrical discharge through the brain, with painful and distressing after-effects. Some patients find temporary relief from their guilty feelings by construing the fear and pain of shock treatment as to some extent an exonerating punishment. ECT is also rather like the 'good kick up the backside' said to be needed by anyone who is needlessly despondent. Another factor is simply that the idea of shock treatment is terrifying. Patients who wish to avoid further treatment are likely to say that they feel better, and to comply with psychiatric authority if they possibly can, so as to avoid further punishment. All of this is a dubious kind of medicine.

In the early days, when an unanaesthetised *grand mal* fit was induced by ECT, it was powerful enough to fracture some patients' spines. During the last sixty years or so, patients have been given muscle-relaxants so that the sign of the fit is perhaps only the twitch of a finger. Certainly the horrific *grand mal* convulsion of the old days is no longer visible. Nevertheless, it is only invisible due to the counteraction of the muscle-relaxant. This is dangerous since all the muscles are relaxed, including the respiratory muscles. That is why a trained anaesthetist must be on hand.

It is difficult to view ECT as anything other than a degrading spectacle, even though psychiatry cloaks the procedure in clinical benevolence. The doctor is invariably male and the patient is most likely female. The whole procedure smacks of sadomasochistic perversity, with the white-coated and all-powerful doctor and his white-coated attendants zapping electricity through the temples of a prone and unconscious person. As she convulses, nurses are supposed to gently hold the patient down. The mild convulsions are reminiscent of a shallow orgasm. Then, just like general nursing, as the patient 'comes round' the nurses are required to reassure her and remind her who and where she is. In this case, however, the patient not only has to recover from general anaesthetic but also from a blast of electricity through the brain. Patients experience headaches, loss of memory and depersonalisation, all of which can persist for days or longer. ECT is a sickening procedure and there is no evidence for its efficacy.

I was a nurse tutor in the mid-1980s, and some student nurses came to me with their concerns for a young woman on an admission ward who was on maintenance ECT. The patient was diagnosed with schizophrenia and was held on a long-term section and given shock once a week, month after month. They wondered why she was being given that treatment at all, since ECT had largely fallen from favour for schizophrenia, especially when it did not seem to work. (Nowadays it is mainly used for severe depression). The patient was terrified, fiercely resisted the treatment and was forced to submit. She continued to cry even under the anaesthetic.

The student nurses told me that they were very worried since the treatment seemed to do the patient no good and much harm. They also thought notice should be taken of her home circumstances. She would sometimes have home leave for an afternoon, and when she returned she always had a hand-written note which anyone would think had been written by someone with a serious mental health problem. The note was a report by her father on his daughter's behaviour during the home visit. I saw one. It was written in typically psychotic style, with a bizarre use of quotation marks, capitals and underlining, completely inappropriate to any meaning. The content

concerned the most mundane details of his daughter's behaviour. All the student nurses realised that the patient's father was fairly mad. All the same, this was ignored by the psychiatrist who determined that long-term weekly ECT was the appropriate treatment, against the patient's will and in the face of her pleading and tears.

According to rates of recovery from functional mental disorders, there is no evidence to show that any medical intervention is significantly more effective than placebo. This is not surprising since these conditions are *actually* caused by problems of living. It seems to me that when a treatment 'seems to work' on a patient's emotional or mental condition, rather than a genuinely medical effect this is *just as likely* a placebo effect, or the result of rest and recuperation, or unintended (and unrecognised) psychological and social factors. Most psychiatric treatment is *a medical charade* which raises everyone's hopes - only to dash them very often, when the patient does not recover.

Muddled thinking and blind faith in medical authority

Psychiatric care and treatment is confused and often confusing and harmful to patients because of the confusion in psychiatric thinking. In my experience, few psychiatric workers understand the true nature of the functional mental disorders. If pushed to it, most would probably vaguely claim that mental illness is caused by 'bio-chemical imbalance' or 'genetics', and they would feel most certain about this with regard to depression, schizophrenia and bi-polar disorder. And yet, at the same time, many would also allow that 'environment' has an effect, too. In other words, they believe that, at the same time, mental illness has a constitutional and an environmental cause. This is cobbled together as the notion that some unfortunate people have 'a genetic predisposition' which is triggered by 'precipitating factors', e.g., stress. Most psychiatric staff would be hard put to explain exactly what they mean by 'environmental factors', though, and neither the average official nor even the most senior psychiatrist has more than a foggy idea about genetics and biochemistry, nor can they ever point to any evidence about the extent to which 'mental illness' is supposed to be caused either genetically, bio-chemically or environmentally. Despite the general belief in the medical model, however, a fair number of psychiatric workers are humane enough to have an *intuition* of a connection between emotional and psychological trauma and the genesis of mental disorder.

In fact, there is no evidence for a genetic or biochemical cause for any of the functional mental disorders - which make up most of the mental healthcare caseload. Most psychiatric workers just *muddle through* by reference to a hazy pseudo-medical consensus. This muddling is rationalised as 'pragmatism'. Neither is there evidence that current practice is in fact the most cost-effective, whether cost is estimated monetarily or emotionally and in terms of wasted lives. It seems to me that medical psychiatry is in fact systematically deleterious to patients' welfare - it is the cause of *endemic* mistreatment and neglect. Only rarely are a consultant's prescriptions questioned by another member of staff, for example, one who might know the patient a whole lot better.

Three classic social-psychological experiments illustrate the way in which bogus medical science and blind obedience combine to constitute the prevailing counter-therapeutic, and too often abusive, nature of psychiatric care and treatment.

Volunteers in the first experiment were asked to administer what they were told were increasing and ultimately life-threatening amounts of electric shock to a person who they watched being strapped into a wired-up chair. An unemotional and white-coated 'expert' assured the volunteers that this was a scientific experiment into how well punishment trains people to use their memory. He told them that he had everything under control and took full responsibility for any harm done to those being subjected to the electric shocks. But the real subjects of the experiment were the volunteer 'teachers', and the real interest was in how far people would go in complying to authority.

The subjects ('the teachers') were then taken into an adjoining room, set before a panel of buttons and told to give 'the learner' an electric shock for every mistake in a memory test. They were told that each shock was more powerful than the last, and that they must ignore everything but the task at hand. At the same time, through the wall they could clearly hear the person they assumed they were punishing with increasingly powerful shocks. As 'punishment' for his mistakes escalated, 'the

learner' was heard to protest, and as the experiment progressed further, to scream, cry and plead for mercy. Finally, he would fall silent. This sounded as if 'the learner' had reacted to increasingly painful and damaging levels of shock and then finally passed out - or died. The white-coated 'expert' continued to reassure the subjects 'administering the punishment' that everything was fine and that he took full responsibility. Under these circumstances, and even with 'the learners' screaming and pleading for mercy, 65% of the volunteer 'teachers' pressed the button on shock levels marked 'dangerous' and 'lethal'. In reality, the buttons were a sham and the hidden 'recipient' of the punishment was an actor.¹⁵

Within a few years, Stanley Milgram's findings were confirmed by the equally controversial Stanford Prison Experiment, devised by the psychologist, Philip Zimbardo. Of twenty-four college students who tested psychologically normal, a random selection were assigned to act as 'guards' in a carefully constructed mock prison. These 'guards' received no instructions other than not to use violence: supplied with uniforms and dark glasses, they took their cues from Hollywood-informed conventional wisdom. The remaining volunteers had no idea what the experiment entailed, and were simply told to wait at home for the researchers to contact them. Zimbardo had the co-operation of the local police, and each of those unfortunate volunteers suddenly got a knock on the door and was accused, dragged off and apparently processed on a serious criminal charge. Hooded and shackled, they found themselves taken to solitary confinement in what certainly seemed to be a real jail. The students who had been made into 'guards' entered into their roles with alarming ease, and within days most of them were acting with various degrees of cruelty. Simultaneously, and unsurprisingly, the 'prisoners' all quickly displayed high levels of passivity and depression. One-third of the 'guards' were judged to have exhibited 'genuine sadistic tendencies', but more of the 'prisoners' were emotionally traumatized; four were so upset that they had to be removed from the experiment almost immediately. A fellow academic happened to witness the experiment and only found the powerful situational effects 'interesting'. Parents who were in on the trick were allowed to visit 'the prisoners', and even though one mother in particular expressed great concern for the psychological condition of her son, she was persuaded to leave him in the experiment. It took the chance visit of a horrified outsider to open Zimbardo's eyes to the dangers involved, and after six days he brought the experiment to a premature end.¹⁶

It seems that even when the evidence is right before them, and even in matters of life and death, *the need to believe in Authority will most often outweigh the urge to be compassionate*. Moreover, when officially authorised agents are able to wield great power over a vulnerable population, this tends to encourage the abuse of that power - *whatever the prior disposition of the people exercising that power*.

The profound situational effects of these two experiments repeat themselves in the normal daily routines of real psychiatric practice. Families are let down just as much as patients when their medical hopes are raised by everyone who works in the field. People may feel that medical care and treatment is necessary when someone is in crisis, but many psychiatric patients must feel that, out of the blue, they are unjustly apprehended, incarcerated and assaulted, i.e., administered treatment against their will. This is unlikely to remedy a patient's tendency towards depression and passivity. Meanwhile, the practical training of each member of staff essentially involves following the lead of more experienced staff; trainees are not encouraged to question routines and, despite any misgivings they may have, they are unlikely to seriously challenge anyone in authority. While nurses carry out the consultant's orders - often irrespective of visible ill-effects on the patients, and of their distress and complaints - the medical expert assures everybody that he knows what he is doing and takes full responsibility.

15 Milgram, S, et al (1963) A behavioral study of obedience. *Journal of Abnormal and Social Psychology* 6 371-378. Also see Milgram's conclusions, in the text to footnote 46 in Chapter 14, below.

16 Zimbardo, PG (1972) *The Stanford Prison Experiment: A simulation study of the psychology of imprisonment*. Stanford: Philip G Zimbardo Inc; Zimbardo, PG (1972) *The Psychology of Imprisonment: Privation, power and pathology*. Stanford: Stanford University.

It seems that most people will carry out harmful orders when they have been worked on ideologically and an authority figure exempts them from personal responsibility. No matter how pleasant and well-intentioned they might have been when they began their careers, blind faith in the medical model and the concentration of power and responsibility into the hands of the doctors systematically encourages psychiatric workers to become callous, irresponsible and even punitive functionaries. As those two experiments indicated, this does not mean that recruits to psychiatry are particularly callous. It is just that psychiatric patients are particularly vulnerable, and officials in a hierarchical organisation who have been worked on ideologically (i.e., to believe in the medical model) really cannot recognise the harm they do - or if they begin to feel that something is wrong, they dare not make their own decisions or question a bad decision passed down from above. Worst of all, some functionaries begin to revel in the power they wield, and abuse it.

The third notorious experiment concerns the bogus nature of the pseudo-medical categories employed across the field of mental health. David Rosenhan's experiment showed how psychiatric diagnosis does not depend on objective evidence but simply on doctors' expectations when they use the bogus medical model. In his experiment, described in Chapter 5 above,¹⁷ eight sane researchers found themselves easily admitted to twelve different hospitals on the flimsiest signs of mental disorder, but they were not so easily discharged because in every instance they were diagnosed with a psychotic condition. They were careful to act as normally as they could once they were admitted, but just the same they were caught in the diagnostic bind whereby almost anything they did was likely to be interpreted as 'a sign of the mental illness'.

When it was reported, there was a professional outcry about 'the ethics' of Rosenhan's study. The head of one institution maintained that the results were faked and that he could guarantee that such a thing could never happen at his facility. Rosenhan took up the challenge. He advised the hospital that over a three-month period one or more persons masquerading as mentally ill would present for admission. Out of 193 new patients, this led to forty-one being 'detected as fakes' by at least one member of staff; twenty-three were suspected by at least one psychiatrist; a psychiatrist and one other member of staff suspected nineteen. Actually, no attempt had been made to infiltrate anyone! This demonstrated that many psychiatrists and staff are predisposed to diagnose as insane *anyone* who presents or is presented to them, but if there are doubts they have *no* safe criteria for discriminating mental health from mental illness.

The universal but blind belief in the medical model has profoundly untherapeutic consequences - emotional, psychological, social and not least physiological. Stigmatisation is inevitable, and care and therapy is misguided or deficient, and not the best use of resources. Beyond that, patients who are supposed to be possessed by an illness which causes psychosis are routinely maintained on massive doses of tranquillisers which change the bio-chemical equilibrium of the body such that if the drug is withdrawn the person experiences massive compensating over-activity, which in turn is most likely to cause a severe psychological reaction: the body seeks its equilibrium and the imbalance of tranquillisation is corrected by a certain over-activity of the neural system. Psychiatrists do not wish to run the risk of that reactive physical and psychological response; this means that it is hard ever to take patients off tranquillisers, and it is routine for any diagnosed psychotic to remain on a tranquilliser far too long or even permanently.

The failure of medical treatment

Every psychiatric worker ought to know about the origin and evolution of the theory - or lack of theory - which dominates the field to this day. To see how the management of individual misery and irrationality arrives at the muddled, untherapeutic and often harmful position it is in today, I refer the reader back to the argument and evidence earlier in this Volume, especially to Chapters 3, 5, 6 and 7. There we show that psychiatry's so-called medical model is not a coherent theory, and that there is no evidence for the efficacy of the medications, or for shock treatment. None of these interventions has ever offered any unambiguously clear proof of cure. Accident and research has also shown that

¹⁷ See text to Rosenhan, D, op. cit. (n. 41, Ch 5).

placebo medication and ECT work just as well as active treatments.¹⁸

I can illustrate the failure of the psychiatric imagination by the case of a patient who I met very early in my nursing career. This woman's obsession was that one side of her bottom was bigger than the other. She was in her fifties, and it had got to the stage where she was unable to talk about anything else. Her husband and all those around her were at their wits end. No-one seemed to know the roots to this obsession, or ever tried to fathom it, and no-one knew what to do about it. The patient was eventually taken for electrode leucotomy at the local neurological centre, famous for its leucotomy research. On our ward this was a major event, and a big fuss was made about the nursing care the patient must be given when she returned. After the operation, when I eventually got to speak to her the first thing she said was: 'One side of my bottom is bigger than the other.'

Surely there was a basis in some emotional trauma to this patient's obsession, some terrifying fear (probably sexual) which the patient was unable consciously to acknowledge or express? The psychiatrists had never taken an interest in that possibility. Just as the profession has never offered a theory as to why burning out brain cells would cure schizophrenia or depression, neither has it offered a theory of why severing frontal lobe connections should cure an obsession. The only possible 'benefit' to any kind of attack on the brain is that it depletes or destroys the capacity of the person to think at all, to have a memory, and to be a person.

Brain 'surgery', ECT and narcosis therapy were each invented in response to the (wrong) premise that any responsible doctor must surely invade and alter a brain which is so faulty as to produce a disabling mental disorder. By contrast, the major tranquillisers, Lithium, the anti-depressants and the anxiolytics were all discovered by accident.¹⁹ Research is nowadays directed towards developing chemical agents which directly affect the nervous system, but so far there have been no genuine 'breakthroughs' to compare to the original accidental discoveries, and most research and marketing involves minor modifications to existing products. Medical interventions are sometimes able to alter mood or impair general functioning, but medication cannot directly alter an undesirable mental condition since it is impossible to determine the connection between a condition of the brain and any ideas or beliefs. When a drug company gets lucky (or invests in a clever marketing campaign) and a new drug is taken up by the psychiatrists, it tends to become the vogue. Then, when it finally proves no better and perhaps worse than the old drugs, invariably the new variety slowly slips down into the ranks alongside all the other proprietary brands.

After a potentially useful drug effect is discovered, research focuses on alterations to brain biochemistry. This leads to theories about a causal connection between the chemistry of the particular drug and the chemistry and metabolism of the brain. But a drug effect is not proof of abnormalities in the biochemistry of the brains of psychiatric patients - in levels of serotonin, for instance. Psychiatric drugs remain pragmatic interventions only made on the basis of trial-and-error. This does not prevent the drug companies from pouring millions into attempts to research the 'missing link' in some determinate causal chain between chemical activity inside the brain and peoples' thoughts and feelings. The most recent playground for the researchers is gene structure.²⁰

Most psychiatrists are committed to the medical model and have few reservations about the utility of medical intervention. Drug reps are welcomed to promote their wares inside most psychiatric facilities, and I have only ever heard one doctor express his disapproval of the drug companies. Just like selling any other consumer good, bribes buy the attention and good will of any member of staff who may influence purchasing decisions. Bribing ranges from little trinkets for the nurses to more expensive freebies and all-expenses-paid trips to drug companies' conferences in exotic locations (i.e., free holidays) for consultants or senior managers, not to mention highly paid consultancies.

18 See text to footnotes 11, 12, 28 and 74 in Chapter 6, above; text to footnotes 24 and 25 in Chapter 7, above; and the discussion in Chapter 8: Placebo & Faith Healing.

19 The history of the development of psychiatric drugs, up to 1980, is documented in a booklet commissioned by a major drug company: Allderidge, P & Lader, M, op. cit. (n. 7, Ch 6).

20 The issue of cause, in relation to genetics and 'abnormal' brain chemistry, is discussed comprehensively in Chapter 12 and its Appendix, below.

Medicine as magic

Over the years, experience has given me a much clearer perspective on what now appear to me as the obvious connections between every patient's abnormal thoughts and behaviours and the precipitating reasons or causes. Even if he already subscribes to a psychodynamic view of mental disorder, however, the novice psychiatric worker is introduced to an overwhelming professional consensus in favour of the medical model, as well as an established organisation which embodies that perspective on care and treatment. This means that the average mental health worker is permitted little space to gain a patient's trust, let alone go beyond that to get much insight into the cause of the emotional and psychological damage which constitutes the patient's mental troubles. Psychiatric ideology not only ignores the actual processes of mental disorder but mystifies the event by calling every psychological problem 'a mental illness', by categorising it with a bogus medical name, and by endorsing only so-said medical therapy. This is the normal practice and theory with which a nurse has to deal, and simply coping with this massive, grinding consensus depletes the straight-ahead clarity of one's better perceptions, convictions and responses.

I recall the clever re-marketing of one particular drug which was initially released as an anti-depressant, but not very successfully. So the makers decided instead to advertise it as 'The Treatment for Obsessional-Compulsive Neurosis'. Ingeniously, it was to be administered intravenously, as the Anafranil Drip. Many psychiatrists were enthusiastic about it for a time - it was a new treatment which looked like *real* hospital medicine. In the field of mental health, the medical model is childish concrete thinking, and the more apparently technical the therapy, the happier the staff. One could almost hear everyone thinking: 'Yes, we're real doctors and real nurses! We know how to administer drips!'

The drug company had astutely capitalised on the wishful thinking, the mystification and the status-seeking of the insecure psychiatric professions - with their pseudo-scientific ideas and their perennial wish to carry out 'proper medicine'. The Anafranil drip was not unusual. It simply sedated the patient for about two or three weeks, in the hope that perhaps he would be rested and then he could be discharged - and hopefully would not come back. There was no demonstrated or even theoretical connection between that particular sedative and any genuine remedy of obsessive-compulsive disorder.²¹

Drug company literature is a gross form of advertising. There is little difference between selling medicine and selling breakfast cereal or cars - the publicity plays on the consumers' prejudices and wishes, and is just as 'economical with the truth'. Years ago, adverts in the professional journals used to proclaim: 'Give the Schizophrenic his Ticket Back to Society', and 'Depixol Injections to Control the Aggressive Schizophrenic'. Similar claims are still made today. However, there are in fact essentially only two medical effects with psychiatric drugs: they either sedate or accelerate a person's metabolism and nervous activity. For example, a patient who exhibits florid psychotic symptoms is quietened-down when he is sedated, and *perhaps* he becomes less emotionally chaotic. To an extent a sedative (e.g., a major tranquilliser) can sometimes give someone a measure of relief from the continual onslaught of his tormenting ideas, simply by slowing down his entire brain and responses. As a matter of fact, no proprietary-named drug of a chemical type is a better sedative than any other, but advertising hyperbole works on what most doctors and nurses wish to believe - that this or that particular drug is 'better at treating delusions', for example. Psychiatric workers really do believe that they treat delusions with drugs. And of course the patients and relatives are told that the delusions are being treated by the drugs - as if certain chemical concoctions are able to 'clear up' somebody's thoughts in the same way that antibiotics are able to 'clear up' an infection.

This is a crude misconception of the dynamics of mental disorder. Nevertheless, it permits every psychiatric worker to proceed mindlessly in a manner which *seems* efficient and medical, meanwhile happily ignoring the significance of the patients' apathy or hyperactivity, their obsessions, preoccupations, hallucinations or delusions. Of course, to allow that a patient's problematic thoughts

²¹ Anafranil was tested by the Federal Drugs Agency (FDA) for only ten weeks, yet patients might be put on it for years. See Breggin, PR, op. cit. (n. 107, Ch 1), 362.

and behaviour have significance - that possibly they allude to meanings and intentions which might be deciphered so as to solve the conundrum of the patient's distress and disability - is immediately to enter into social criticism. But in the absence of any other clear cause, disabling emotional distress and confusion is almost invariably the result of traumatising stress due to some or many aspects of the patient's normal life. In everyday discourse everybody understands full well that it is particular pressures - even particular relationships - that 'drive a person crazy'. Almost invariably, granting significance to a patient's aberrant ideation would point to social pressures, and that would lead to investigating the parts played by other people in the genesis of the disabling mental condition. The people around someone going through an emotional and mental crisis are often motivated to fiercely resist social-psychological analysis - if only because they themselves are under great stress. There are a variety of motives for everyone around the patient to simply wish him cured by means of a medical intervention, without any awkward questions being asked. On the other hand, I have also encountered some very frustrated families who seem to have good ideas about the cause of the crisis, and yet they cannot get a psychiatrist to listen or take them seriously.

Politics, domination and inertia

Alongside medical treatment, there is always an idea of the therapeutic value of proper care and pleasant and humane sociability, especially on the nursing side of things. Unfortunately, the non-medical side of good nursing is too easily subverted by the personal ambitions and politics of the staff and managers. Politics and ambition intrude on the proper aims of any kind of organisation, but the consequences are particularly far-reaching in psychiatry because the officers are so powerful and the patients so vulnerable. My earliest experiences of the irresponsibility and outright corruption of some powerful figures within the psychiatric organisation have been reprised again and again throughout my career. I cannot believe that I have somehow been remarkably unluckier than everybody else by continually finding myself posted to a part of the psychiatric system in which there is negligence and abuse. I also soon found out that most members of staff would prefer to turn a blind eye to bad practices and even outright abuse. To a great extent this is due to the concentration of psychiatric power into the hands of doctors, senior managers and executives who are virtually unaccountable.

When I was a nurse teacher it was commonplace for student and junior nurses to feel threatened by those who held psychiatric or nursing power. It was as if there was a concerted effort to destroy the humane instincts of the youngsters coming into the psychiatric professions. Too often student nurses would come to me with problems - that they could not understand what was going on in the ward, or they thought a patient was being maltreated, or they thought they could see a way to help a patient with his psychological and social problems and the psychiatrists could not or would not see it, or they were told by trained staff to stop asking awkward questions. Few of the other teachers would address these complaints. Some of them saw their role as 'keeping everybody happy'. Obviously, 'everybody' did not include trainee nurses or patients - they meant senior nursing staff, management and the psychiatrists. The senior nurse tutors saw their role as going around having cups of tea with ward managers, and were just as inclined to call dissident student nurses 'bad nurses' as the psychiatrists and trained staff were to call their unruly and awkward charges 'bad patients'.

In my experience, most student nurses came with a good attitude, genuinely concerned to relieve distress and genuinely interested in the causes of mental disorder. As the first year progressed and they went out onto the wards and experienced the nitty-gritty of it all, some recruits maintained their integrity but, albeit reluctantly in some cases, most began to buckle-down and ask fewer questions. Novices soon realised that an independent attitude would affect their nursing careers, and that if they wished to get on and qualify the best thing to do was to keep quiet. Some felt that once they qualified they would be able to act more positively. Once qualified, of course, they would be on the ladder of promotion and would *still* have to keep quiet. In my experience, fear of management is realistic: a lonely voice speaking out against malpractice or abuse is *most likely* to be victimised by management, and even by colleagues. Any criticism is too much of a threat to the cosy routines and defensive mind-set of the average psychiatric worker, who justifies callousness and turning a blind

eye to bad practices by the need to maintain the smooth-running of the organisation. Likewise, a trainee psychiatrist cannot afford to upset the consultant who gives him a reference when he qualifies - so long as the trainee does not in the meantime risk his qualification by speaking out. Whatever the policy professed by the organisation, it is a sorry fact that there is no welcome for genuine debate, free-thinking, criticism and any concern for a patient's welfare which goes against the doctor's judgement.

Relations between staff and patients are usually fairly straightforward: those patients who make life easy for the staff are liked and those who give the staff a hard time are definitely not liked. To an extent this is not just a matter of compassion, but also of time and energy. Yet any psychiatric patient suffers from emotional, psychological and social problems, by definition, and the doctors and nurses are not hired so as to take personally the unpleasant things a patient might say or do. There is a tendency for some staff to find one or two of their patients particularly offensive, and to let them and everybody else know it. These people should not be working in psychiatry. When a member of staff is personally affronted by a patient, this immediately has untherapeutic consequences, which in turn makes life more difficult for any colleague who has truly therapeutic intentions.

It is like a breath of fresh air to come across a happy and well-run organisation which frees-up some time for the relaxed exercise of compassionate interaction between staff and patients. At the same time, it is always difficult to be a member of staff who has insight into the psychodynamic nature of mental disorder, even in the better facilities. Any criticism of the diagnostic labels and routine medication and treatment is too much of a threat to the mind-set and routines of most members of staff. Generally, when I start to explain my ideas about a patient's problems to other members of staff I run the risk of *also being seen as crazy*. This is especially the case with regard to the most psychotic patients, who tend to be the most troublesome. As a result, the more one demonstrates understanding of a patient's weird and wonderful delusions, hallucinations or behaviour, the more one risks isolating oneself as someone who is also mad.

Besides these constraints on good nursing, there are unfortunately some psychiatric workers who act as little more than mindless functionaries who would rather shirk the full responsibilities of care so as to get through the shift as easily as they can, and who 'keep their heads' down for fear of jeopardising their job or career. No doubt this is the case in all walks of life. In many lines of work this might have no great effect on the job in hand, but psychiatry does not deal with unfeeling objects, or even with people who can stand up for themselves and refuse to be short-changed. The psychiatric organisation is supposed to deliver a service to a vulnerable population, and the duty is to respond with care, sympathy and humanity. Anybody in a psychiatric team who fails to pull his weight is not only unproductive but can be positively untherapeutic and tends to destroy the good work of his colleagues. This is obscured by the medical model, however: if therapy equals medication, then what does it matter if a psychiatric worker is a bit of a slacker or lacks insight into social dynamics?

I ought to say that I have met many excellent, compassionate and thoughtful psychiatric workers. Fundamentally, what is demanded of a carer is intelligence and decency. A psychiatric worker does not need to be an intellectual, but he does need to be compassionate and willing to listen to patients and try to understand them. It is impossible to perform the task properly without thinking about the problems of each patient, using imagination to empathise with the person's plight, and then organise help as best one can. Unfortunately, workers willing or able to act like that - to do the job properly, in my opinion - always seem thinner on the ground than those who prefer to do the minimal required.

I have mentioned the powerful pressures on enthusiastic new recruits to submit unquestioningly to the demands of those who hold psychiatric power. What fundamentally obstructs therapy, though, is the lack of a proper social-psychological education and dogmatic insistence on the medical model of mental illness. Because psychiatry lacks a theory of psychopathology to make sense of each patient's unique way of being irrational, so many workers experience the more extreme or chaotic behaviour of some patients as *only* unpredictable and potentially dangerous, *only* disruptive and frightening. Because there is no official theory of *the significance* of irrationality, the behaviour which brought the patient into psychiatric care remains forever puzzlingly unaccountable, and hence anxiety-inducing. When a patient 'acts out' or expresses uncomfortable thoughts and desires, or becomes

apathetic or catatonic, too many psychiatric workers imagine that he could and should consciously modify his behaviour. Few psychiatric workers understand that irrationality is a sign of profound emotional trauma, and many of them show their anxiety in the face of any patient who 'acts up'. They call the patient's undesirable behaviour 'attention-seeking', and they wish only to suppress any patient who dares to disrupt the routines of family or psychiatric life.

Since the core duty of nursing is meanwhile conceived as administering dangerous medications, psychiatric bureaucracy offers many chances and even encourages and rewards staff for avoiding patients and engaging in displacement activities such as spending a disproportionate amount of time in the office writing, collecting and responding to unnecessary communications, making schedules and attending unnecessary meetings with managers and other professionals, etc. My observations are confirmed by Rosenhan's research, in which it was also discovered that while it is a matter of course that the public generally tries to avoid anyone said to have a serious mental illness, most psychiatric staff *also* avoid the patients as much as possible. Rosenhan's study found that the psychiatrists spent significantly less time with patients than nurses, and nurses less time than the attendants;²² the latter were employed specifically to be in close contact with patients, but even they spent *most* of their time in the office or otherwise away from the patients. And when each pseudo-patient in the experiment asked about his progress or the possibility of being discharged, hardly any psychiatrists answered helpfully or sympathetically, and even fewer other staff did so.²³

The role of key-worker might have provided a means to focus on the dynamics of each particular patient and his social relations, so as to explore the pathological relationships which produced the pathological response. But this is not encouraged. The key-worker's duty may involve helping to organise social and occupational aspects of the patient's life, but his main duty is to monitor the patient's progress for signs of psychiatric symptoms and to ensure that the symptoms are 'managed' by regular medication. Relaxing exercise and CBT are often offered to those who suffer only from a neurosis or 'affective disorder', but a diagnosed psychotic is much less likely to get those therapies.

Within a psychiatric facility, the nursing team organises each patient's day. Nurses organise getting up and getting dressed, breakfast and going to occupational therapy, appointments for physiotherapy, etc. Organising and attending ward rounds and other meetings is time-consuming, especially if preparations have to be made for three different consultants, with three ward rounds each week. There is a constant stream of meetings with consultants, social workers, other professionals, family members, and so on. Whoever is in charge of the facility has to spend a lot of time talking to doctors, social workers, relatives, etc. So much of a nurse's time is spent on the organisation of routine that very little time is given to constructive therapy. At last policy-makers recognised this fact. Acute wards have been encouraged to set aside a period each day - one or two hours was suggested - and during this 'protected time' phones should not be answered and interaction with patients should be positively promoted.

The ambience of any psychiatric facility very much depends on the personalities of the staff. Patients can occupy themselves therapeutically where there happens to be an enthusiastic art or drama therapist - or even a psychiatric worker interested in therapy. Still, many facilities are simply places in which patients do little more than fester. I remember an admission ward which featured its ECT suite in the middle of the lounge; patients were wheeled in and out of ECT on one or two mornings a week, while other patients just sat around smoking as usual.

Both the general organisation of psychiatry and the often bizarre details in the organisation of particular facilities are a product of the inertia encouraged by the medical model. Psychiatry will continue to suffer from the inertia of its pseudo-technical organisation and from a lack of any

22 In the UK, the attendant role is now played by junior nurses (RMHNS) and health care assistants (HCAs). After training, HCAs are soon to be promoted to nursing assistants (NAs), thereby coming round full-circle to the NA role which was abolished in the 1990s.

23 Rosenhan, D op. cit. (n. 41, Ch 5). Along with the genuine patients, the pseudo-patients in the experiment also experienced serious invasions of their privacy and unnecessary restrictions on their movements, as well as witnessing some patients being assaulted by staff.

meaningful engagement with the patients so long as therapy is conceived as essentially *medical intervention*. Meanwhile, the psychotherapeutic potential of lively and enthusiastic young psychiatric workers will continue to be dissipated by their becoming dispirited and forced to buckle down to the routines of a tired old organisation.

The abuse of patients

I have been witness to both petty and extreme forms of outright abuse. When members of staff take personally what a patient says or does this often leads to untherapeutic responses and petty abuses such as targeted unpleasantness and 'making the patient's life difficult' by withholding rights and privileges, etc. Beyond this routine 'low-level' abuse, I also witnessed a particularly damaging instance of managerial and executive malpractice which led to the death of many patients. This was the mismanagement of an outbreak of Salmonella at a psychiatric hospital.²⁴ For some reason of institutional politics, senior management refused to admit that it did not have the necessary resources. As staff fell sick the hospital became very short-staffed, sick nurses were rushed back to work without a proper period of quarantine, dirty sheets were piled uncollected in corridors, and faeces were literally trodden around the hospital. Political reasons of their own made management pretend that all was well, and they refused to call in extra staff from other hospitals. Half of all the nurses and patients fell sick, and twenty-three elderly patients died. An official enquiry decided that the cause was food left too long on hot trolleys; a cook was sacked. As is generally the case the origin of the Salmonella might have been the kitchens, but it only spread like wildfire due to the managerial incompetence.

Another example, by no means unique it seems, is my being told by a patient that a hospital's senior consultant psychiatrist had had sexual relations with her and then threatened to end her care and treatment if she told anyone. The patient was very distressed. When I reported her allegation to my Nursing Officer all I achieved was my own and the patient's victimisation. I made enquiries and heard from a senior member of the nursing staff that she knew about the doctor, and that the abuse had been going on with various patients for years. It turned out that quite a few staff knew about this, and yet nobody had done anything about it. To begin with, why believe a patient's accusations? Senior management colluded with the psychiatrist, the patient was silenced and attempts were made to silence me. I received threats from various managers, for the first time in my career my work was suddenly officially criticised, I was moved off the ward and, via a devious route too complicated to explain here, I was finally sacked.

The psychiatrist had been abusing patients for at least twenty years. When I began to look into the matter I discovered that a second senior consultant also abused patients, while a third consultant came looking for me so as to threaten me with the sack unless I dropped the whole thing. Officials from my union used threats to try to stop the local branch from pursuing the case, but the branch persisted. At the time, however, and after much prompting from the local branch of the trade union, the only official response was an internal enquiry by the Divisional Nursing Officer, who found - surprise, surprise - no case to answer. A report was sent by the local union branch to the Regional Health Authority protesting this decision, but the RHA declared the matter closed.

This must have heartened the consultants to continue their abuse since it seems that they continued with their activities. This is known because finally, fifteen years after I had tried to get the one psychiatrist properly investigated, an ex-patient complained to the police. A careful trawl was made for all of that consultant's ex-patients. This found half a dozen brave women willing to testify against him, and also many more who confirmed abuse or attempted abuse but were unwilling to testify. (Obviously, it is bad enough to suffer from emotional distress and to have suffered from abuse by psychiatry without having to stand up in open court to testify.) Although he had retired and was deemed 'medically unfit to plead', the consultant did finally face a few counts of rape and assault, and was found guilty on one token count. In the meantime, the other consultant had been encouraged to move to a post outside the area, and continued to practice. He too, was finally brought to book by

24 Stanley Royd Hospital, Wakefield, in 1985.

ex-patients who testified against him: he was found guilty on one count of rape and one of assault, and served eighteen months in prison. The subsequent Government Inquiry²⁵ made it clear that over the years more than fifty NHS officers (ranging from nurses to GPs, consultants, senior managers and executives) had failed to act appropriately on the complaints of many abused patients. Never mind - not a single complicit official was prosecuted or in any way punished.

I could not have gone to the police when it had happened, since all I had was the word of a frightened young female psychiatric patient who I felt I could not ask to testify in court. As it was, local, regional and national managers and executives together forced me out of psychiatric nursing, thereby terminating my complaint, which was about the ongoing conspiracy to protect the two abusive psychiatrists. When this scandal was finally aired, however, I was told by the police that my allegations would not have been sympathetically received had I gone to them at the time. Institutional abuse was not taken seriously by the authorities until they were forced to acknowledge it some years later, when it became public knowledge that there was systematic abuse at various children's homes.

The administration of psychiatric care depends upon suchlike wider political vicissitudes. The Public Interest Disclosure Act (PIDA, 1998), known as The Whistleblowers Charter, ought to have been an important vehicle for the prevention of abuses in psychiatry. It would be pleasant to think that such gross abuses as I witnessed would no longer go unpunished, but the Governmental Inquiry (in 2005) into the two psychiatrists abusing patients, and management covering it up for thirty years, was far from encouraging.²⁶ Since then, at least in the NHS, many whistleblowers have lost their jobs and careers but only a handful have ever won any compensation, and in 2018, while failing to suggest a remedy, let alone trying to implement one, the Health Minister acknowledged that 'too many staff remained "terrified" to speak out about mistakes in case they were disciplined or sacked, despite his efforts to protect whistleblowers.'²⁷

Patients' needs are easily denied

Organisation of care is crucially important to the well-being of any patient going through an emotional or mental crisis. A major factor in his behaviour is not only the person's particular set of emotional or mental problems but also the way those who work in the care system deal with those problems. A mental disorder does not simply develop of itself, in some sort of social vacuum. Each individual arrives from a particular kind of problematic situation, and finds himself in a peculiar new one - psychiatric care itself. Nobody working in the field ever sees any sort of 'pure' manifestation of a mental health problem. Each is a disorder manifesting in a psychiatric context.

One illustration of the crucial importance of method and clarity in psychiatric organisation comes from the time when I was working as a staff nurse on a thirty-bed female admission ward which had an excellent nursing team consisting of a charge nurse, a deputy and the luxury of three staff nurses. The night the charge nurse heard that a certain female patient was to be admitted, he took great care to prepare the staff and check every possible point of suicide risk. Sophie was admitted later that night and I met her the next day. She was about thirty, and was extremely dishevelled, very badly neglected. Her face was caked with dirt and her hair matted with filth. She had had absolutely no personal hygiene for months. With great patience and a lot of hard work, the nurses helped her to bathe, change her clothes and get every knot out of her hair, which Sophie found a great relief.

25 *Kerr-Haslam Enquiry (Report)*, op. cit. (n. 10).

26 *The Public Interest Disclosure Act (1998)* London: HMSO; Virden, P (2006) *The sexual abuse of psychiatric patients: The cover-up and the Government whitewash. Asylum 15* 1 9-33.

27 Jarman, B et al (2016) Letter: Whistleblower law. *The Times* 9 Feb; Martin, D, Allen, V & Marsden, R (2016) Whistleblowers out in cold: Struggling to find work, isolated and shunned, the terrible price medics sacked for exposing NHS failures are still paying. *The Daily Mail* 11 Feb; Campbell, D (2018) May will give NHS 'significant' budget increase, Hunt reveals. *The Guardian* 7 June, 1. Abuse of the vulnerable and victimisation of whistleblowers (including motives for their vilification and persecution) are explored in greater detail, and in the light of recent developments, in Chapter 28 (Volume 2). See the sections: Problems of abuse and accountability, and The regular victimisation of whistleblowers.

This patient was very withdrawn but would minimally respond to some questions. She had taken to her bed in a darkened room, and this remained her preference. She was the closest thing to catatonia while to some extent still mobile, so the diagnosis was 'psychosis'. She was self-neglected and withdrawn to a serious degree, but all the same I found it possible to talk to her. I do not recollect delusions or any responses to auditory hallucination.

Sophie came to us from living with her parents. Her father was the vicar of an evangelical church, where he preached hell-fire-and-damnation. The mother seemed abstracted from this world. When Sophie was brought to hospital in such a state her mother described her as 'serene' and 'Orphelia-like'. Her mother appeared to have withdrawn into a fantasy, and could not accept the reality of her daughter's condition. It was known that Sophie's father strongly disapproved of her before as well as after she had lapsed into her regressive state.

This patient's father dominated the family. According to the charge nurse, he considered his daughter evil incarnate, and when she was sane he thought nothing of using physical punishment (i.e., violence) to 'correct' her. During Sophie's admission, I took the opportunity to speak to her older brother. He told me he had joined the army as soon as he could, so as to escape his fanatic, domineering and cruel father. This brother sympathised with Sophie but did not have much of a relationship with her because they had lived quite different lives. He said she had been a model child and young teenager - strait-laced, well-behaved, wearing the sort of clothes approved by her parents, and doing very well academically. She left home to go to university and then won a scholarship to an American university. She had fallen in love with an American but it had not worked out. When she returned to England she had changed her way of thinking, her behaviour and her way of dressing, and was more like a normal young person. This transformation called down great disapproval from her father. Unlike her brother, however, she did not feel secure and independent enough to escape the clutches of her parents.

Sophie began to display mental peculiarities, apparently including one or two psychotic episodes. She was badly scarred around the chin and mouth due to a fall from her attic bedroom. The circumstances surrounding this event were not clear. She maintained that the fall was an accident but - perhaps because she had tried to get onto a roof during a previous hospital admission - the official version was that she had jumped.

Sophie's regression seemed to be a retreat from the situation in which she found herself. She did not wish to communicate or leave her bed. As with Jennifer, the main nursing task each day was to try to get her out of bed and get her to wash, dress and eat. This might sound simple, but it was a huge task which almost always failed, and left her lying in bed. Occasionally the charge nurse went in and resorted to a sterner voice and tried to help her to get up. This was not unkind - Sophie was literally festering.

After a time I established a trusting relationship with Sophie, and I talked to her as she lay in bed in her darkened room. She wrote poetry and had studied English, so she was quite well-versed on literary matters. At that time I used to write as well, so I took in a couple of my poems and read them to her, and this seemed to establish something of a relationship. Once she said to me: 'At last I've found a friend'. She also told me that her father wished her dead.

The other members of staff were sympathetic to her and we were all gradually building up trust and hope. We understood that the relationship with her parents, and especially her father, was the significant factor in her case. I got to know Sophie well, and we talked together for about six weeks - probably on each of my shifts - but only for twenty minutes, at most. Conversations had to be fitted in amongst the demands of other patients and running the ward, and there simply was not enough time. Maybe a couple of times I got half an hour with her.

During this time Sophie was 'on a section' (compulsorily detained) and was not allowed to leave the hospital. Suddenly a decree came from nursing management to break up the ward team. We were each to be sent to different wards. The rationale for this decision was 'to give staff experience of different wards'. In fact, it was because nurse management did not like strong nursing teams with liberal views about patient care. To break up and disperse a nursing team like that was highly irregular and showed a complete disregard for the welfare of the patients, some of whom had formed

bonds of trust with the staff and were beginning to work on their problems, and now had hopeful prognoses. The decision to disperse *all* the staff overnight was outrageous, harmful to every patient on the ward.

This decision meant that within the space of a few days Sophie lost all the people with whom she was building-up trust. Her consultant psychiatrist remained, but he was the kind of man who always took the easiest course of action. Because he does not see each patient day by day, that sort of a doctor tends to act on the information given to him by the nursing staff. He sees the patient very rarely, in fact - on a ward round once or twice a week, at best for a few minutes - so he gathers information from the nurses and the junior doctors. If those regularly on the ward have little idea about what is going on with the patients, that is not very helpful. No matter - some sort of nursing information, however bad or deficient, is always given to a consultant. And this leads to poor decisions about care and treatment.

In this case a tragedy occurred. It is not likely that the new staff understood much about Sophie. First of all, she was put on a high dose of anti-depressant medication. This got her up and dressed and out of her room. But there was something uncannily weird about her behaviour. She was high, very speedy - a chemically induced speediness. This was clearly not healthy, but it was officially viewed as an improvement. It was quite obvious to anyone who knew her that her sudden enthusiasm was not going to last. From the psychiatrist's point of view, though, he had achieved his aim: the patient was out of bed, up and about and smiling.

This was a smile too good to be true. In this condition, she was encouraged to go home on weekend leave. She never returned. At the hospital, we heard that she had gone home and smothered herself with her own pillow. This was the coroner's verdict at the inquest. Perhaps the verdict was correct. Just the same, it is a strange one. Surely, at the point of losing consciousness, anyone trying to smother herself with a pillow would loosen her grip and begin to breathe again? Another possibility, of course, is that someone had smothered her. Given that the polite consensus was that Sophie's father had suffered for years from the burden of such a troublesome daughter, a more sinister scenario is that Sophie's father had 'gone too far' when punishing her, or had even deliberately killed her, but was protected by the coroner since he was such a respected 'pillar of the community'. The coroner made nothing of the hospital sending Sophie home in a chemically-induced euphoria when she had been hospitalised for a condition bordering on catatonia. Whatever really happened, there was no question of holding to account those who organised - or upset - her psychiatric care and treatment.

Counselling, psychotherapy and material assistance

Even someone who is at times dangerously psychotic can have better moments in which he is capable of perfect lucidity. For example, fairly recently I had started on a forensic ward and was immediately approached by a young man who had been incarcerated for several years and was generally considered very aggressive. Having established that I was the new ward manager, he introduced himself and began to tell me salient details of his biography. He said he thought these were important factors in his mental breakdown. He also said that he had never been given the opportunity to explore these issues in a psychotherapeutic context, and that he would very much like to do so - he wanted to make sense of how he had ended up where he was. He explained that he felt compelled to abscond from time to time so as to prove to himself that he 'could still hack it' in the outside world; he would then return voluntarily and be at the beginning of the psychiatric process all over again. He also recognised his inability to perform up to the unreasonably high expectations of the system at all times, and that this sometimes caused him to 'lose it' and explode angrily at whoever was around.

Considering he was often engrossed in his own private psychotic world and could only ever be approached with caution, this was also a rare moment of sanity for the patient. I considered this a reasonable request and an important interaction, but a nearby member of staff simply sneered and suggestively commented that I had 'scored' with the patient. Soon afterwards I witnessed an example

of what this patient had described when, in front of other patients and staff, a senior nurse responded in a condemning, 'parental' way to one of his harmless jokes.

After receiving immediate care in a crisis, each psychiatric patient is almost always in need of psychotherapy or counselling and further material assistance. With his consent, of course, it is always therapeutic to discuss with a patient 'the background' to his crisis.

The strength of a psychiatric patient's system of beliefs is a function of his investment in it as a defence of his beleaguered identity: psychosis may be a particularly fraught and well-defended position a person happens to reach in the process of discovering the nature of his world and himself. Obviously, it is difficult to persuade someone to change his mind when it is firmly set. However, there comes a point when many patients feel ready to open-up a dialogue. Certainly, a person needs to feel that he will be unconditionally supported before he will entertain ideas different from those to which he clings, and premature attempts to strip a patient of his bizarre beliefs are doomed to failure. The psychotic's delusion is his rationale of last resort; it is defended resolutely since without it he would be left floundering panic-stricken in a cosmological vacuum. People need support and gentle encouragement to go through a process of emotional and mental change. First of all, the patient has to trust the therapist. Many patients experience paranoia, and psychotherapy cannot possibly proceed successfully where at the same time the therapist whispers about the patient behind his back. Either the patient has to be invited into discussions, or if he is discussed in his absence (e.g., in a ward round) this must be openly acknowledged and good reasons must be given.

These kinds of issues are well documented and described in the book *I Never Promised You a Rose Garden*.²⁸ The title sums it up: life is not a bed of roses, but the pathological way in which the patient tries to cope with his life actually makes it worse. If it seems to become clear to the therapist, the psychotherapeutic task is to find out and explain to the patient how he became mired in his particular mental rut. Counselling or therapy is a dialogue in which the therapist acts as a mirror to the patient and helps him to articulate the impact on his own present emotional and mental condition made by past events, relationships, actions, intentions, tactics and strategies. A therapist is unable to help the patient unless he can offer hope in the form of practical pointers to another way of living. In spite of this, psychotherapy is not encouraged by most psychiatric managers because they do not wish to risk taking on the responsibility of advising the patient about anything close to his real concerns - such as how he is to live. This untherapeutic opposition to normal human solidarity is rationalised as 'allowing the patient to make his own decisions.'

Almost every psychiatric patient is in need of material assistance. A good social worker is a wonderful asset, but unfortunately they tend to be thin on the ground. The bad faith of too many psychiatric authorities is paralleled by that of negligent social workers who invoke a 'clever' rationalisation for providing only minimal assistance, or simply leaving their 'clients' to more or less get on with it in isolation. They say: 'We are not here to help people. We are here to help people help themselves.' This may be callous with respect to many non-psychiatric clients; it is doubly callous with respect to most psychiatric patients, who, by definition of their diagnosis, are not very able to help themselves. Paternalistic over-involvement is equally unhelpful, so a balance must be found by way of a sensitive assessment of the situation at hand.

I remember someone who was forever in and out of psychiatric facilities. Sam was paranoid and sometimes floridly psychotic, but his main problem was desperate loneliness. At one point he was assigned a first floor council flat where pets were prohibited. He kept cats anyway, of course, for the company. But since he knew it was against the rules, he never let them out. Consequently, the mess was everywhere. The stench became oppressive and eventually the flat was so foul that his social worker got council cleaners sent in to take out and destroy all Sam's stinking possessions, gut the flat and fumigate it. The cats were destroyed. Sam was put into another flat where pets were prohibited, and he found another cat and began the process all over again.

Given that nothing else in his life had much changed, Sam was not likely to change his ways. Friends had already approached the social worker to try to arrange ground-floor accommodation so

28 Green, H (1967) *I Never Promised You a Rose Garden*. London: Pan.

that a cat might go in and out. If that much was not possible, perhaps an hour or so a week of home help could be arranged - minimal domestic help would probably have kept Sam ticking over. But the social worker maintained that Sam was a bohemian who wanted to live that way, and that 'a social worker is there not to help people but to help people help themselves.' This was short-sighted since a modicum of compassionate organisation could have maintained Sam viably enough in low-cost semi-independence, and prevented the constantly recurring public health hazard - rather than his forever being anxious, relapsing, and having to be readmitted to psychiatric care.

This history indicates the extent to which the quality of life is diminished not only for the 'client' but also for many people around him when the fragile network of care is disrupted by officials who refuse to act compassionately, intelligently or in good faith. Happily, the separation between the organisations of psychiatry and social work has been significantly reduced by reforms which mandate much more regular liaison and teamwork than even ten years ago. At last there is official recognition that any kind of psychiatric response is fairly futile in the absence of sufficient practical assistance.

Little evidence of significant progress in psychiatry

That said, if there is any progress I am afraid it is not concerted and very well thought-out but only halting and impeded by opposing trends. For example, after the millennium the Government introduced a policy of positively supporting the thousands of informal carers in the community so they are able to carry on, thereby saving billions in NHS spending. Carers are most often specific members of the patient's family, of course. This policy is mandatory, but the degree to which it is implemented varies a lot from one area to another. As a result, few authorities have fully taken up the idea, and it is not always well-funded when they do. Furthermore, when it is mental health care, staff do not always co-operate very well since they believe in the medical model, do not understand the social dynamics of psychological crisis, and are simply not interested in either the plight or the role of the carer. On top of which, many officials still pass judgements on both the patient and his carer (or carers) - especially mothers - and that is simply counter-productive.

Meanwhile, during the last twenty years or so, facilities have not been systematically developed so as to fully replace those of the old mental hospitals - that is, facilities such as drop-in centres and opportunities for patients to participate in meaningful activities and pastimes. Rather, the trusts are nowadays only resourced to treat the most serious kinds of mental disorder. In practice this means that someone who needs help tends only to get the immediate and full attention of the organisation if he presents with behaviour which appears to be clearly dangerous. Otherwise, he often has to wait - and suffer - for months. Even then he can expect little more than routine medication, since a recent idea is that a patient must pass a test of his 'motivation' if he is to receive any psychological support.

A few years ago I worked at a specialist rehabilitation unit for people who suffered severe and enduring mental illness. The unit was in some way successful due to two factors: an unusually high level of support and tolerance delivered by the more enlightened members of staff, and an unusual degree of useful occupation available in a non-hospital environment.

And yet much was still wanting when it came to understanding and responding to the patients' anxieties and needs. The staff estimated that, at any one time, eight out of ten of the residents would have suffered serious abuse during childhood. As examples, one male resident had been regularly starved when a child, and savagely beaten for taking food from the cupboard; another had been so severely starved that he had regularly taken to eating cardboard; another used to severely mutilate himself when he was a child, so as to get kindly attention from the nurses in A&E; yet another had been regularly stripped, beaten and masturbated over by his father. Of the female residents, one had been physically and psychologically abused by her step-father from the age of four, and also sexually abused by her step-grandfather with the full knowledge of her parents; another was the daughter of permanently drug-addled parents who maintained that they were unaware that she was regularly sexually abused by their 'friends'; another was the daughter of a woman whose own childhood had been spent in a Catholic orphanage and who had relentlessly criticised, blamed and undermined her daughter throughout her life.

So the staff knew that at least 80% of the patients coming through the unit had experienced extreme abuse during childhood. Surely this must have had a bearing on their subsequent extreme behavioural and mental disorders? But the consultant in charge of the unit specifically prohibited staff from discussing abuse with any of the residents; and when they were confronted with the facts - either in the case-notes or by a resident disclosing the information - most staff were either indifferent or disbelieving, and some even laughed about it.

Again, I have recent experience of a large private nursing home for severe and enduring mental illness, in the centre of a city. This establishment is used by the Mental Health and Social Services for patients who would otherwise be impossible to place. It substitutes for the previous long-stay mental hospital wards. Many residents had been in the home for years - some since it had opened more than twenty years before.

There were some staff working at the home who exhibited great humanity, compassion and care. In general, though, the place is a shameful blot on the psychiatric landscape. It seems that all manner of abuse has been perpetrated there since it opened. There has been sexual abuse of female by male residents; staff have regularly stolen from the patients; there is casual, unrecorded taking of money from residents by staff; racial abuse of residents by staff (I actually witnessed only black-on-black and black-on-white); organised religious proselytising by staff; employment of casual staff with no proper checks; illegal restriction of certain residents to certain areas of the building during specified times - in effect, imprisonment; poor diet due to unacceptable cost-cutting; and no understanding of the autistic-spectrum disorders suffered by several residents, which led to their regular admonishment and punishment whenever they displayed the symptoms.

Lastly, I will speak about my experience of the latest developments in forensic psychiatry, when I was involved in the move from a twenty-year-old medium-secure hospital to a brand new facility. The new hospital is funded by Private Finance Initiative (PFI): it was built and is maintained by private contractors, and is leased back to the NHS. In this context, at least, the motives of profit-making and public service do not sit well together; worse than this, in some respects the resulting facility and its organisation is dangerous and anti-therapeutic.

Despite some clinicians being involved in the design, the size of the various ward areas is inadequate to the numbers of patients. In the meantime, far too much was spent on non-essential 'artworks' and a state-of-the-art conference facility which the patients would never be allowed to use. In addition, all the furniture necessary for the number of patients on one ward could not be fitted into the lounge; and one patient had destroyed several 'resistant' dining-room chairs within a few weeks of opening, rendering the legs into dangerous shards of wood; staff were then told that there was no money available for better quality chairs. Also, as part of the PFI deal, coca-cola vending-machines are installed in the patient areas, even though it is well-known that caffeine increases aggressiveness.

Apart from these problems, the move from the old to the new hospital was deferred several times due to disputes between NHS management and the contractors about the readiness of the building. This heightened the patients' anxieties and led to an increase in aggression, which put both staff and patients at risk. This compares with the move twenty years previously which had been smooth and painless since financial constraints did not dictate the timing: at that time, all the physical and organisational systems had been fully checked well before the actual move took place. In the recent re-organisation, though, staff and patients were moved into the new PFI building before it was fully fit for use. For example, the pre-move security sweep was invalidated by last-minute work to reinforce dangerously flimsy shelving throughout the entire complex; as a result, within hours of moving in, a patient had discovered and reported workman's tools, nails and shards of wood in a ward area. Besides this, some vital alarms and door-locks still did not work properly.

For all their concern with finances and the PFI deal, management at the new hospital seemed to undervalue the nursing staff. They were very dedicated and put their lives at risk on a daily basis, and yet the new building did not even incorporate staff restrooms, cloakrooms or meal facilities. At the same time, Control and Restraint (C&R) training was only demanded of nurses, care assistants and occupational therapists: they were expected to come to the rescue of medical, social work and psychotherapy staff who had refused to train-up and reciprocate. This relieved those privileged

members of staff of responsibility for their own words and actions when interacting with patients; it also regularly reduced the number of available helpers in a crisis and left a few staff - mainly nurses and care assistants - to deal with the aggressive behaviour sometimes brought on by the very staff who refused to train in C&R and help in an emergency.

Lifting the curse of the medical model

Despite all the available psychological treatments - including therapy through drama, art and music, CBT and dialectical behavioural therapy (DBT) - the medical model still prevails. Medical management still demands that each patient attend an old-fashioned ward round. Too often this deteriorates into an inquisitorial ritual in which everybody is acutely uncomfortable: the patient can only display his psychotic symptoms to an audience of up to a dozen experts who expect this display, and who have nothing to contribute to his therapy, other than to tinker with his medication. It could be useful to work with the important facts of a patient's biography. In the eyes of the psychiatric experts, though, in comparison to the symptoms of his so-called mental illness, these pale into insignificance. Every patient is expected to admit that he suffers from a mental illness. Many refuse ever to admit it, and so they are forever deemed to suffer from 'lack of insight'.

In fact, it is far more helpful to understand and explain a patient's symptoms in terms of his desperate response to a desperate biography. It is highly likely that any patient with a history of extreme mental and behavioural disorder suffered emotional and psychological trauma during childhood. As one last example, the mother of one patient had also been a psychiatric patient and died during the young man's childhood. This left him brought up by his father who was an alcoholic and obsessively hoarded rubbish. Consequently, the patient's childhood had been extremely chaotic and insecure: he had to steal from his drunken father in order to buy food, and since he had had to fend for himself and was unable to get into the bathroom due to all the rubbish, he was bullied at school because of his filthy appearance. It is unsurprising that this young man grew up extremely paranoid, and that he committed offences in order to be confined to a secure environment so as to escape his imaginary enemies. The significance of his biography was not acknowledged by the psychiatric staff. Rather than absolutely consequential, the onset of his psychosis - 'his mental illness' - was perceived as simply coincidental.

By referring to events in the lives and psychiatric experiences of some of the patients I met during a career of forty years, in this chapter I have tried to describe my feelings about the medical model and the resulting psychiatric and mental health system. I understand that the critical tone may make this account seem rather bleak, and readers may wonder why I continued to work in this field. Luckily, my spirits have been kept up by sometimes working alongside staff who were genuinely sympathetic and responsive towards the patients, and put more into it than just running through the routines, as if psychiatric care were just a job like any other. More than this, though, my encounters with people experiencing a mental health crisis have been sufficiently positive to encourage me to carry on in good heart and in the knowledge that I am on the right track. I was never burdened by the groundless belief that the problem is that there is something intrinsically 'wrong' with every psychiatric patient's brain, so I have been truly gratified by positive results from working with patients and families - sometimes simply by bearing witness to the stories they tell about their very troubled lives. This outweighs the ongoing frustration of working within a system which, as regards care and therapy, is largely muddled, uncomprehending and too often counter-productive.

I believe that every mental health worker must try hard to imagine themselves in the sorts of situations faced by their patients or clients. They should ask themselves what it would be like if *they* were to experience a mental breakdown. Would they really appreciate little more than receiving a diagnostic label, having their life history reduced to a few notes in the margins of the records, and really no other treatment other than having to submit to drugging or electric shock?

Chapter 11: WORKING AS A COMMUNITY MENTAL HEALTH NURSE

Annabel Marsh, RMN, BA (Hons, York)¹

A nurse reflects on her experience of recent and ongoing changes in the UK's psychiatric funding, organisation and response. These include changes in the delivery of care and the current fashion for cognitive behavioural therapy (CBT). Her special concern is how medication serves to medicalise and sideline problems of living, and she views the urge to increase compulsion as retrograde. She sees the mental health-care team in which she practices as a viable and less medical alternative to conventional psychiatry, and argues that such initiatives should be strengthened and extended.

Introduction

More than one hundred and thirty psychiatric hospitals have closed in the UK since 1960. At least 60,000 beds went between 1980 and 1998; by 2016 there were just 19,300 psychiatric beds for NHS England.² Some parties to this process have undoubtedly benefited: health authorities sold the land for development, health service managers earned bonuses for moving patients out of the old institutions, and ex-managers, nurses and other private individuals and companies set up hostels or homes for the more manageable patients, as well as secure units. Now, at any one time, only about 1% of all those considered in some way mentally ill are not 'in the community'. Have patients seen overall benefits from these changes?

Of course, there has been the usual political struggle for funding. Most commentators agree that not enough has ever been put into community psychiatric nursing - adequately staffed hostels, crisis units and enough secure or medium-secure beds. It was recently estimated that at least 45% of the homeless and more than 30% of prisoners suffer from a mental disorder (the latter is a Government estimate).³ By 1998, the NHS was 400 psychiatrists under strength, and there was much concern about nurse shortages; despite recruitment from abroad, by 2014 the shortage of psychiatrists was still acute and in 2016 there were still not enough mental health nurses.⁴ 'Hot-bedding' always seems to have accompanied Care in the Community: few patients are given sufficient respite to properly stabilise their condition before discharge and, compared to thirty years ago, the 'revolving door' of intermittent hospital care and relapse has speeded up. In 2002 the Government announced plans to remedy the situation for an estimated 15,000 people who are so visibly mentally disordered that they need full hospitalisation or monitoring through 'assertive outreach'. But what would that do for the civil liberties of those individuals? And where would that leave all the other patients?

The last comprehensive guide for mental health care, *The NHS Plan*, was issued in July 2000, consequent to *The National Service Framework for Mental Health*, which was a document setting out

1 Interview and Introduction by Phil Virden.

2 www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/ March 2016.

3 In a large-scale poll of homeless people across the UK, 80% of the respondents reported some kind of mental health issue, and 45% had been diagnosed with a mental health problem. See: Homelessness and health research (2014) www.homeless.org.uk/facts/ - There is no regular audit of mental disorder in the prisons, but in England self-harm increased 73% between 2012 and 2016; there were 40,161 incidents in 2016 (with a prison population of 84,000). There was also a continuing rise in the number of suicides in the prisons, to a total of 120 for 2016. *Mental Health in Prisons* (2017) London: National Audit Office.

4 Psychiatrist shortage looms as training posts are unfilled (2014) *Herald Scotland* 7 July; Lydall, R (2016) Warning over 'critical shortage' of nurses as vacancies rise to 10,000 [for London alone]. *Evening Standard* 7 Jan. This news item mentioned the particular shortage of mental health nurses.

the standards by which mental health care must be delivered.⁵ A governmental review of mental health legislation was meanwhile published in 1999, in preparation for a new Mental Health Act, but this idea was shelved in 2006 due to the opposition of most of the other interested parties.⁶

The following is the account of a psychiatric nurse who experienced the advent and development of Care in the Community.

Ongoing changes in funding, organisation and response

I qualified in psychiatric nursing about forty years ago, and apart from a couple of breaks to have children I have worked in the field ever since. I've worked in child and adolescent psychiatry, as a researcher at a university Psychiatric-Social Work Department, in acute wards, and now in the community again but with adults.

It's difficult to generalise about Care in the Community, which started coming in about thirty years ago. There have been so many changes in administration and funding, too. Every different part in the country now decides how it wants to deliver its mental health services, so there isn't really a consistent picture. Services are delivered in different ways and with different funding priorities in different areas. I'm familiar with the situation in the big northern city where I live. I work in an area which takes in the city centre, and where the acute mental health care is delivered.

I think our trust is in many ways quite good. It's at the sort of cutting edge of community services, dealing with the problems of big city care. I'm not saying it's perfect, by any means, but it is one of the most radical set-ups at the moment. Our trust developed its own model of care quite separately from other trusts. It's not the traditional type of community nurses working with long-term clients.

In our trust, all the general practices are linked to a Mental Health Care Team. The team serves many GP practices. They can refer a client they think may have a serious mental health problem, or be in crisis, or have an acute problem, or even a chronic problem that the GP can't deal with. Referral can be made 24-hours a day, every day of the year. So they can refer at 3 o'clock in the morning, if needs be. If it's an acute problem, we guarantee to assess anybody within four hours, and within 48 hours if it's a long-standing problem. Within those times anybody can be seen by a mental health worker, *not* a doctor. Not a psychiatrist, but either a psychiatric nurse or a social worker - though it is mostly nurses who do it.

Through this particular service, the psychiatrist becomes involved if the person needs admitting to hospital, if it looks like they might have a severe mental disorder - for example if it looks as if they might be schizophrenic or bipolar (manic-depressive) - or if there is a complex situation where a lot of drug prescription is required, then we may ask a psychiatrist to see them. If it looks as if the person will respond well to non-pharmacological interventions, or will only need minimal pharmacological intervention, and the GP is happy to do that, then we don't need a psychiatrist.

The diagnosis can be done by the nurse. Although officially, with the Nursing and Midwifery Council (NMC) regulations, nurses are not supposed to make a diagnosis, effectively that's what we do. It doesn't need to be ratified later by a doctor, either. Because in the summary that the nurse or team makes on assessment a letter is written to the GP in which the team covers itself with the wording: '...On interview this person said this or that... There are these and those symptoms... It *looks as if* they have such and such...' I wouldn't say to a GP: 'Mr X has schizophrenia' but 'he is experiencing some symptoms which are psychotic...'

The GP doesn't have to come into the process at all, except for prescribing. What our team offers as well is 24-hour-a-day care. If somebody is admitted to the service they would be allocated a Care Manager, a qualified person who would work out a plan of action to help the person overcome

⁵ *The NHS Plan: A plan for investment, a plan for reform* (2000) London: Dept of Health; and *National Service Framework for Mental Health: Modern standards and service models* (1999) London: Dept of Health.

⁶ *Reform of the Mental Health Act 1983: Proposals for consultation* (1999) London: The Stationary Office. Apart from introducing a kind of Community Treatment Order (See Chapter 28, Volume 2, in the section: Voluntary and compulsory care and treatment), the subsequent *Mental Health Act (2007)* only changed a few details of the 1983 Act.

whatever problems they've got. So, for example, if it was a person who is depressed, a care-plan might involve seeing the person twice a week, or even every day. This could be at home, or if they choose, they can come to our base. They don't have to have people in their homes if they don't want them. We may want to see them to assess them further, to talk through their problems, or if they have already been prescribed medication, we may want to see them to sort out whether that's the right one, or whether they really need it, or whether they are struggling with side-effects. We may want to refer them for anxiety-management or counselling or psychotherapy or confidence-building or social skills - there are a range of services we might want to build-in once we know them and we know what they want, and what would help them. We might want to do some family work. Basically, at first, when you are assessing you can't decide immediately what might help. It takes time to get to know people.

The people we see are not necessarily already on medication. If we think they need it, however, even just a sleeping tablet, we can't do that. Recently, nurses have been able to get certificated to prescribe some drugs, but our trust has not yet got a protocol for that.⁷ We either get the GP to deal with it, or if we have to, or the person wants it, get a psychiatrist. We might decide we do want to involve a psychiatrist.

Of course, a lot of people are already on medication because GPs tend to use that first. If they think the person is depressed, for example, they are quite likely to put them on an anti-depressant. But that often doesn't work because the person's problems are far more complicated and can't just be dealt with by a pill. Then, when that doesn't work, they go back to the GP and say: 'Nothing's happened' or 'Why don't I feel any better?', and so quite often the GP gives them something else, or gives the person two or three different drugs, almost to shut them up, but to make them feel better about the situation. Then, if that doesn't work, the GP might think: 'Well, I can't cope with this person keeping coming back, I'll ask the mental health team to get involved.'

We have a counsellor on the team. However, some people respond better to nursing forms of counselling, which are less formalised, such as their care manager going in to see them perhaps once or twice a week. I might go in and have a chat, sort things through, look at welfare rights, look at housing, look at something to occupy the person's time. A lot of people have got nothing to do all day, so we might look at what courses are around, what groups they could join, whether there are suitable employment schemes. Obviously the person has to be able to function to a reasonable level for those sorts of things.

We have anxiety-management, occupational therapy - and everybody's trained to do some form of anxiety work. We talk though what anxiety is, ways of combating it. We have support workers on the team who do more active work. For example if somebody's agoraphobic, feels socially very uncomfortable, the support worker would go out with them for a couple of hours once a week or so, and start building up their confidence, getting them used to public transport, and so on.

Our area takes in a constituency with a lot of very poor people. There are three teams and fifteen GPs for a population of 55,000. In theory, there are fifteen mental health practitioners on the team and eight support workers - who used to be called Nursing Assistants. The front-line team would not normally involve a psychiatrist: the workers are mainly nurses, but also psychiatric social-workers and occupational therapists.

If he's wanted, the psychiatrist is called in from the hospital base. In the area there are three acute wards with twenty beds each, and also a service for the elderly. We have two psychiatrists who cover our area, and we can refer to them if we want. They are mainly ward-based. Quite a few people who are admitted to the wards don't come to us. They go through Accident & Emergency at the general hospital, or they're picked up in different ways. The police do sometimes bring people to us. At the local Casualty Department, which is the biggest outside London, we have a team of six RMNs who are the emergency liaison team and are on duty from morning to night. They assess everybody with a psychiatric past who comes through, and they also decide whether to involve a doctor, whether the

⁷ Since 2006, 2-3% of UK nurses have been specially trained to carry out independent diagnosis and prescribing. See Latter, S et al (2010) Evaluation of nurse and pharmacist independent prescribing. eprints.soton.ac.uk/

person can manage by going home, or whether they need to see our team. They have a responsibility to people with both physical and psychiatric problems.

The first pilot team was set up in 1997. Our team has been going for well over a decade, and the whole of the area is now covered by this system. Now the whole city is interested in this form of organisation. The current rules make the whole health system more or less GP-led. They have the purchasing power. The Primary Care Trusts gave them even more money. What GPs want is help to alleviate whatever clogs up their surgeries.

We do feel horrendously over-stretched with this system, of course, because there is no ceiling on misery in our city. It depends on the GP. Some are very interested in mental health, and manage really quite difficult clients quite competently. Others refer anybody with the slightest problem - they might refer somebody on the first presentation of anxiety, which is just ridiculous.

The Primary Care Trusts were supposed to look at what GPs needed at the primary care level. For example, a practice I work with has an RMHN (registered mental health nurse) working in it full-time, which means the GP practice itself can manage people with anxiety, monitor people with depression, monitor the use of anti-depressants, offer counselling, and so on. That practice only refers the very severe cases they feel they can't manage during the normal hours of surgery. These two GPs decided to buy the services of an RMHN because they are a city-centre practice and large numbers of their clients are youngish people with mental health difficulties. They didn't need a nurse to do dressings and take stitches out. What they needed was someone to deal with psycho-social distress.

There is now a move in the city to look at what would help secondary services like our team, which are over-stretched by too many referrals. I believe that for every ten referrals we maybe take on three clients. We make other recommendations for the other seven. We might advise the person to go to an ordinary counselling service or to take an out-patient appointment at the hospital to see the occupational therapist. Most don't need 24-hour mental health care. It's no good offering that service to someone who's just having a bit of a crisis or had a bereavement, or suchlike. It's just not necessary.

We can refer people to other NHS services or to voluntary services. The city has a Young Persons' Counselling Service to which people under 25 can be referred if we think they just need a bit of counselling or a support group, or something like that. The hospital has counsellors, Mind offers it, and quite often there are local organisations in neighbourhoods. Drug and alcohol services are separate and we can arrange for people to get to them if we think they have a problem, though we do take people who have both a major mental health problem and drug or alcohol problems.

There always seem to be changes in funding. The fund-holding GP scheme finished in 1998, when Labour got into power, and they introduced Primary Care Trusts (PCTs). These were groups of GPs organising care in their area to meet the specific needs of their communities. The one I was familiar with looked at the needs of a big city centre. These might be quite different from the needs of the suburbs: we have a lot of the poorest people, high unemployment, low wages, and a big student population. In 2013, PCTs were replaced by Clinical Commissioning Groups (CCGs), which have much the same kind of staffing, powers and responsibilities, except that some of the staff and responsibilities moved to Local Authority Public Health teams.⁸

The Primary Trust Board consisted of GPs, administrators, representatives of the Health Authority and representatives of such groups as nurses. I think representation was very varied. People can put their names up for it, and then hardly turn up. Others turn up and never speak. There are always a few people who have an agenda, and speak for it. It depends on a few people doing a lot of work.

The GPs form the base of a triangle of organisation, with nurses, counsellors, midwives, etc. employed at that level. Then there are the secondary services like ours, to which GPs refer people.

⁸ CCGs were established by the Health and Social Care Act of 2012. Planning and commissioning hospital care and community and mental health services, they are responsible for most of the NHS commissioning budget. All GP practices have to be members of a CCG, and every CCG board will include at least one hospital doctor, one nurse and one member of the public. See *The Health and Social Care Act (2012)* London: HMSO; also: *Clinical Commissioning Groups (2015)* www.patient.co.uk/

Then at the apex of the organisation is special provision, hospital care, lock-ups and so on. In my experience these are little used for mental health problems in our area: most people aren't so bad as to get beyond the secondary services. From now on this is the form of organisation that is being built.

The Clinical Commissioning Groups get the funds. In theory, if they don't like what the local Mental Health Care Trust is doing they can cross the border and buy the care from a neighbouring area. Then the favoured CCG would expand and the local one contract. The previous Primary Care Trusts made changes in the old Mental Health Care Trusts. After about 2000, the little trusts that tried to provide all the services got squeezed out as the bigger, wider-based trusts grew, and there were more specialist Mental Health Trusts.

No doubt our type of organisation will continue to grow. GPs love to be able to ring somebody up and say: 'This man's going crazy in my surgery now and I want you to be able to give him an appointment later today'. That's heaven on earth for a GP because the problem just disappears. Friday afternoons the phone never stops in our office because the week-end's arrived, the GP has got people he's been ticking over all week getting more and more distressed, so he rings up and says he can't manage the situation, he needs us to see them. I think it's also good for clients, since they don't have to go onto interminable waiting lists for hospital appointments to see a consultant psychiatrist. The clients don't see a psychiatrist. They see a nurse. And a lot of them are amazed because they expect the GP will have referred them to a doctor. They are usually very happy about it, though. In a way it makes them feel things aren't perhaps so bad - they only need a nurse. Being managed in the community like that is most people's choice but some do expect help from a doctor. Some people want admission, some have got used to going in and out of hospital, some are very scared about being looked after at home.

Very few of the people who were used to the old style of psychiatric hospital are left now. It's thirty years since clearing the big old institutions began. Obviously, there are survivors from that system. What we have now, though, is chronic mental health problems in peoples' homes and within the community. People who - for want of a better word - are very damaged by their mental disorder or by their medication, are looked after at home. Most of them haven't had extensive stays in hospital. Although chronicity is certainly still with us, people aren't kept in very long any more. A lot of people are quite disabled and disempowered, not functioning well, and chaotic.

I think what we offer is something better than a sort of mental health band-aid. It's not that we just contain things. People do get better. All the same, it's a huge effort, and challenging to manage. It is possible to see people through a psychotic episode until it resolves and we can do some work with them. But that depends very much on the individual worker. As always, there are those who are prepared to be quite radical in the way they manage clients, and those who aren't. Also, because each client gets just one manager, it's a matter of pot-luck if the client gets a very responsive and fair manager who is quite prepared to take risks or look at managing things in the way the person really wants to be managed. We need psychiatric workers who can step back a little and be prepared to go with what the client reasonably wants. If the client says he or she doesn't want to take any medication, the worker should be prepared to risk it rather than insist on it and thereby increase the person's anxiety.

It depends very much where you live whether psychotherapy, counselling and family therapy are really available. Some places never delivered any of that sort of talking, negotiation sort of help, and I hear from colleagues elsewhere that in some areas it can still be hard to come by. We were lucky in that our system was set up by people with some vision - perhaps financial vision, because medicated chronicity costs a lot in the long-term - who have pushed our sort of client-management organisation further forward.

In a way it's scary as a practitioner because we have taken much of the responsibility off the doctors. We go home at night and we don't know how safe everything is, whether a client might kill herself over-night. When a client is acutely disturbed it can be very worrying, and has to be talked through. I recently dealt twice with a 27-year-old client who had acute episodes and wanted nothing to do with going on a ward. Unfortunately, he was doing quite bizarre and dangerous things - he was wide awake through the night and day, not eating, jumping in front of cars, wandering around the

city, accosting people in the street. I had to talk it through with his family, particularly his mum, that we were taking a risk. It was a risk that if it paid off would benefit him, but that I couldn't guarantee his safety. There was one nasty episode where he got pushed around by a couple of guys in the street. Still, he came through it all and he is now at home. By his choice he does take a small amount of anti-psychotic medication. I don't think we would have managed him without it. He'll come off it, though. He did last time. He's had three such episodes now.

Psycho-Social Intervention is big in our city. It's research-based, and a bit tedious to read up on, but you work through a series of standard questions about the person's symptoms and behaviour - it's known as 'doing the KGV'.⁹ This takes quite a time to administer but it does give you a useful way of looking at everything that seems to be going on with the person at the time. This particular guy couldn't possibly have answered the questions at the time, he just couldn't sit still. Since then, he and I have done some work on his relapse signature - what sorts of thing push him to becoming very disorganised, and trying to look at ways of preventing those stresses from pushing him towards the disorganised behaviour which gets him into difficulties, if they occur in the future.

Under our system of community care we can do those sorts of things. It's up to us how we work with people. I've got a couple of clients who manage their own voices, and who don't want medication. They cope with the voices either by distracting themselves or they understand that it's just a voice that isn't going to worry them or scare them. They just keep it under control and try to get on as best they can, even though they're hearing voices. Some clients are not receptive to lots of information about what's going on and how to cope with it, and others are. It's really up to the manager to recognise that.

Compulsory Treatment

I think that because beds are so expensive, acute home care, crisis intervention and long-term care with 24-hour response capability will be the way that psychiatric care will go. The worrying thing is that some politicians are always talking about legislation to impose treatment, and want to lock people up before they've done anything, under Community Treatment Orders (CTOs). That is not what most nurses want. It would seriously damage the trust between psychiatric workers and their clientele. But various pressure groups pushed for it, playing on the fears of a public that doesn't know the real facts.

In the event, CTOs were not introduced in England as originally envisaged. Instead there is now the Supervised Community Treatment (SCT) Order. This is 'intended for patients following a period of detention in hospital, and it is expected to allow a small number of patients with a mental disorder to live in the community while subject to certain conditions under the 1983 Act, to ensure that they continue with the medical treatment that they need.'¹⁰ The wording in this legislation is ambiguous, since it intends to enforce compliance with treatment, and yet at the same time admits that this cannot be enforced: essentially, without going through each step of the original detention process once again, it permits the patient to be brought back into a facility if he fails to comply with his treatment.

SCT orders are usually (but confusingly) referred to as community treatment orders (CTOs). The numbers involved were never in the low hundreds per annum, as the Government suggested they would be. In England, the numbers put on a CTO more than doubled in five years: up from 2,134 in the first twelve months of their use, 2008-09, to 4,600 in 2013. The mental health charity Mind estimates that 30% of all CTOs are given for patients with no history of non-co-operation with treatment. It seems that in practice, and under the pressure of 'freeing up' beds, SCTs (or CTOs) are mainly used for prematurely releasing patients who are often recalled soon afterwards, when they

9 Krawiecka, M, Goldberg, D & Vaughan, M, op. cit. (n. 98, Ch 1). Their questionnaire and observation protocol is a fourteen-item measure of mental state. In the first six items the patient describes his condition over the previous month; for the other eight items the official observes the patient's behaviour during the interview. This is '...to provide a concise summary of the symptoms experienced by patients with serious mental illness, in order to assist with the regular and accurate monitoring of mental state.'

10 *Mental Health Act 2007: Overview* (2009) Dept of Health. www.dh.gov.uk 7 Dec.

relapse. Meanwhile, many patients complain that it takes too long to have a treatment order removed, and this forces them to take medication they believe they no longer need. In effect, CTOs are a looming threat of readmission hanging over the heads of people trying to rebuild an independent life.¹¹

No nurse wants to *make* her patients take medication. I don't mind trying to persuade someone that a medication might be helpful but I don't want to be put in the position of telling people they *have to* take medication. If somebody had to go into hospital I would prefer the ward staff to have to hold somebody down if necessary. I don't want to be having to do that, that's not how I see my job. I would go and visit one of my clients in hospital if that happened, but I wouldn't want to have to do it.

I think governments are concerned about people with a history of violence. They will be allowed to live in the community but under the threat that the minute they don't appear for their depot injection they can be dragged back in again and forced to comply, without going through the whole rigmarole of sectioning. And then the person will be put back into the community again.

In fact, most psychotics are not violent. Therefore, unless you get a psychiatrist who is really worried, CTOs really shouldn't be used a lot. Besides, I don't think using CTOs will make any difference to the number of people who get randomly murdered by diagnosed psychotics - those cases are very rare anyway, despite what people think.¹² Parliament's response was mainly to assuage peoples' fears. Most of these events tend to be either people who have slipped through the system or who have suddenly flipped despite medication. You can't monitor people 24 hours a day.

I think legislating CTOs was mainly a way of making the public feel safer. I don't think their existence will have a great new effect on patients' lives - if needs be, they could always be brought into hospital under a section, anyway. Except that it is likely to push some clients away from the services. Until this new legislation, it was the right of our clients to refuse to see us if we go round to their house. On a ward you can use institutionalised ways, and your power, to influence somebody to do something he doesn't want to. The person is out of his own environment, he's on your turf, there are lots of staff around and he can be talked round, intimidated or threatened to do the things he doesn't want to do. If you walk into somebody's house, though, you aren't really in a position to exert that power. CTOs represent a whole different level of invasion and could invite desperate and completely counterproductive responses, because you are on someone else's territory and it's their decision to let a psychiatric worker in. A community treatment order involves a psychiatrist turning up with a couple of heavies, after everything else had failed. That already happens anyway, with some crises. The idea of the CTO, however, is that someone comes out of hospital on medication, at some point refuses to take any more, and then, before they've done anything terrible, they get compulsorily medicated anyway. Anybody who doesn't co-operate will get threatened and bullied: 'If you don't have your medication we'll take you back into hospital'.

I hope that nurses advocate for people and try to stop the use of CTOs. In my experience, the Supervised Discharge that existed before, following 'a section', was neither much used nor effective. It was the equivalent of a CTO. Supervised Discharge was a very bureaucratic device that had to have a social worker as a key-worker, and people had to be seen every week, and if they were not seen they could be brought back into hospital. Under that system, though, people couldn't actually be forced to have medication; if they said they don't want it, they could be brought back into hospital.

11 Gould, M (2009) Hazards of a health safeguard. *The Guardian* 13 May; Carthwright, R et al (2009) Charities worried at amount of CTOs. www.CommunityCare.co.uk 5 Nov; Gould, M (2011) Under pressure. *The Guardian* 16 Mar; Campbell, D (2014) Concern over record numbers detained for mental health treatment. *The Guardian* 28 Jan. Under separate legislation, CTOs were first introduced in Scotland in 2005; see *Mental Health (Care and Treatment) (Scotland) Act* (2003) London: The Stationery Office.

12 From 1958 to 1995, in England and Wales, the percentage of homicides committed by people with a diagnosed mental disorder fell from 48 to 11. This decline continued steadily through the years of the closing of the big old asylums. Of course, this might reflect major shifts in diagnostic criteria, but there is no evidence for that. Murder rate by mentally ill falls (1999) *The Guardian* 6 Jan. These statistics are confirmed by Large, M et al (2008) Homicide due to mental disorder in England and Wales over 50 years. *The British Journal of Psychiatry* 193 130-133.

They were very rarely used, though. Nobody liked them because they were almost unmanageable and not very realistic. Under the Supervised Discharge, the weekly visit never seemed to work smoothly. And if something then happened with the person, the psychiatrist was held responsible. Everybody has to watch their backs these days and that made the Supervised Discharge fairly unpopular - if anything went wrong somebody had to take the rap. I remember a fuss in the papers about someone who had been out of hospital four months and he'd murdered somebody, and the paper wanted to know what the psychiatrist was doing. However, there's no tool to tell you that somebody sometime in the future is going to kill somebody. The only way you can know what people might do is be with them 24 hours a day. I think CTOs are being applied to people considered potentially dangerous. Behind the idea of CTOs was probably a combination of factors: public prejudice and fears, increased managerial fears about accountability, an easier way to make patients' comply with treatment...

Some politicians and think-tankers have suggested there should be some sort of audit of the number of people who have a dangerous personality disorder - 300 or 2,000, nobody seems to know how many - and they should be pre-emptively locked-up. There are some very difficult and dangerous people in the prison service who have been given a set time to serve, and people are worried about letting them out. Still, how would you know who were dangerous and who weren't, when they probably committed the crime years ago, in their youth? To back up decisions about these troublesome people, a psychiatric category had to be invented. They are labelled Personality Disorder, which is really used to describe people who don't fit any obvious other type of psychological nuisance or distress but just have difficult behaviour. It's just a label to justify a certain way of dealing with somebody that nobody knows how to manage. It's a really grim diagnosis, too: it defines people by the *absence* of any obvious pathology, but they must be *something* because they're always turning up in the psychiatric service.

Along the same lines you get the categories Psychopathy and Sociopathy which are the same thing really, and one called Borderline Personality Disorder (BPD), which is people who self-harm as a result of abuse, people who keep presenting at A&E departments wanting treatment. Generally, they are given very short shrift by the health services. They're not treated very well at all, although ways of managing people like that are beginning to be used which are better than they used to be. People who self-harm are a particular problem to GPs and nurses, because they are pushing their bodies to the limit, and nobody knows whether it's a medical or a psychiatric problem. You need people with a lot of experience of such behaviour to help manage them.

Cognitive Behavioural Therapy, and changes in the delivery of care

The big buzz for therapy is CBT - cognitive behavioural therapy. It seems to me to be what everybody with any sense always did, but with a few more forms to fill in. It can be all right, though. It's a matter of getting people to change the way they think. It's an educational exercise that works really well for some people, but it requires a level of commitment and intelligence from both the client and the worker because it isn't always so easy to appreciate that the way you think can change the way you behave. Especially if you've had a crap life, very bad early experiences, and now you're just told to think more positively. You need to be able to take it a step further back and work out why people think the negative ways that they do. Obviously, that can go on in CBT but it depends very much on who facilitates it - some are very skilled at it. Now it's reckoned that CBT should be used regularly in GPs' practices. It is certainly an advance on nothing but medication.

Counselling, psychotherapy and cognitive behavioural therapy have definitely increased in the last fifteen years or so. The movement out of the hospitals and into the community has seen a bit of a shift away from authoritarian medical structures, and in one way or another towards talking to people. There are all these fancy terms, labels and theories, but to me the biggest change is in the way care is delivered. The basic thing most clients need is care and management. Under the present organisation, as a nurse, nothing is very formal. I go in and talk to people and establish a relationship, and I talk through day-to-day difficulties, or past difficulties, or help people manage finances, housing, employment - all those things are vital. It's no good delving back into somebody's past if their

benefits are not coming through, or if they've got loan-sharks on the doorstep, or they haven't any food. We deal with all that. We bring in specialist help, or make the contacts to start getting things sorted out, we write to people owed money explaining that the person has a mental health problem, can they repay at a certain amount? And so on. A lot of places will write-off debts, especially catalogue companies. To re-establish some sort of peace of mind, those sorts of things are as vital as counselling. If you have a relationship with your clients they can ring you up and say they've got a letter from some authority or lender and they don't know what to do, and you can say you're coming tomorrow and we'll sort it out.

The people on our team don't have a complete consensus about how to do things, though I think they're all pretty committed. Some more committed to working outside the strict hours than others, of course. It shouldn't have to be like that but we're just not well-enough resourced. We're always chasing our tails, rushing round to see people just to keep an eye on things, and hoping nothing goes too badly wrong. It would be great to be able to spend a day with a client and really talk things through and try to help organise things better. But I don't have the time.

Normally my relationship to the client is one-to-one, but I might decide I want a support-worker involved, or a social worker. Several of my clients have really long-term needs and I can't see them enough, so the support-worker will go round and take them out, go shopping and for a coffee, or go to Welfare Rights or the Housing Department, or go and visit a relative, or supervise access to their children if they haven't got them with them. They can do anything they want, really. Some people go swimming - it depends what clients want to do and what seems to be the most beneficial at the time. People usually have very complicated lives with lots of things going on - people don't live in isolation, they have families, they have bereavements and upsetting life events.

Medication, the medicalisation of problems of living, and alternatives

I think some of the new medications have made a big difference. Some places don't even prescribe depots any more. Some doctors won't do it. Instead they give daily tablets. The newer medications aren't so heavy-duty in terms of side-effects. It does mean there is the problem of patients not taking them or forgetting, but people are much more inclined to take them. Especially if they have people from Community Care saying: 'Well, we can jiggle about with this. We can get you on the minimum dose. We can even get you off it if you want'. If you have proper education and care, people are much happier with the atypical anti-psychotics. They're sort of third generation, and very expensive. I don't know what they're like to take. No drug is free of side-effects.¹³

Anti-depressives vary. There are still two popular types, and it depends on the GP what is prescribed. Some GPs still favour the really old sort.¹⁴ There's an awful lot of medication being dished out just to make for social control, to keep people quiet medically. Somebody turns up with umpteen kids, too many abusive boyfriends, no money, debts, a horrible house on a horrible estate, and so on, and she's given medication. It's rubbish. She hasn't got an illness. She's got a lot of problems that need sorting out. There are lots of people like that who are given medication, as a standard GP response. Mind you, to be fair, people will go to GPs for a pill, even if it's just a sleeping pill. Then, once they start taking the pills they expect everything to suddenly get better. But of course they still have too many children, boyfriends who beat them up, a horrible house, no money *and* they still feel awful, even though they're on the tablets. The problem is that both GPs and the public seem to expect misery to be solved with a tablet, when in fact we all know that drugs can't do that. People on medication can sleep through their problems or be in a haze through them. Then, of course, they don't pay the bills, their children get taken off them, and so on...

13 See Chapter 6, above, in the section: Newer and better drugs? There are research indications that 'the atypicals' may have as many unwanted effects as previous generation anti-psychotics. But it will be some years before their utility or damage can be fully assessed.

14 The SSRIs (selective serotonin reuptake inhibitors) have largely replaced tricyclic antidepressants because they are thought to be safer. But see text to footnotes 10, 58, 59 and 63 in Chapter 6, which indicates that SSRIs are certainly not without their problems, which have yet to be fully assessed.

There's a huge expectation that a pill will be the answer to what in our team we call - it might sound very disrespectful but it isn't meant to be - what we call Crap Life Syndrome. We get lots of people referred to us who really need somebody just to sit down with them and begin to sort everything out when they've lost control of the money or the boyfriend or drink or kids, or just cannot manage and can't cope at all. I don't think people like that should have a 24-hour mental health team, unless there really is a big risk of serious breakdown, because it medicalises problems. What such people need is a case-worker who works Monday to Friday, 9 till 5, and can sit down with them, listen to things and help them to start sorting out their housing, children or whatever.

I think the 24-hour mental health team should be for severe problems that need immediate help. It should be either for people who display severe symptoms such as psychosis or suicidal tendencies or suchlike acute crises, where we could give them a lot of attention for say a couple of weeks, until it's sorted through. I don't think offering people medical help is necessarily a good idea, though. We do turn people down, but we refer them to other services - which doesn't mean they always get the service. We might refer to a local counselling service or the drug and alcohol service, or to a social worker or to Welfare Rights. It depends what we find when we assess people. We refer people on, and they don't get us on 24-hour call-out unless they become such a crisis that the GP re-refers.

For example, I had a girl referred the other day for assessment. She's twenty-two, she's got a kid, the kid's got a heart condition that's being investigated, she works in a shop for poor pay, her boyfriend's walked out, she had to move out of her home because the boyfriend went, her mum's really poorly, and so on. Just too much on her plate. There's no way that girl needs to be labelled mentally ill, though. She's having a really hard time in a very difficult situation, but she isn't mentally ill. It seemed to me that she was coping pretty well, considering how bad everything was. So we did some very brief immediate work on anxiety, because she was getting panic attacks, referred her back to the GP counsellor, referred her to Welfare Rights to get her some money as a single parent and to get time-out from work and that sort of thing, rang up her work, got her a sick-note, and that was it. She didn't need to be given a mental health nurse, though. She wasn't ill. She was just going through a lot at the time, and I can't understand why the GP thought she needed mental health care. He probably thought: 'I can't handle all this, I'll pass the problem over to them'. If you get somebody off a GP's back he loves you for ever. Under the current rules, they are the people with the money and power.

Anxiety management involves giving information about symptoms, advising about ways to cope, such as breathing exercises. We point out that anxiety is a physical condition that makes the heart race, makes you sweat and makes you feel as if you're about to die. Again, with people undergoing psychotic symptoms, explanations make a huge difference. It is also interesting how many people do really want to know. I think if you go into a situation with the right attitude you can do an awful lot of work with families, just helping people cope with whatever has been going on. And the families do usually want us to go in. If people live on their own and they're in an acute condition it's usually very difficult to manage it in their home because, obviously, you can't always be there with them. All the same, if there's somebody around them who can sort of act as your eyes and ears, then you can manage really very severe situations in the home.

What you do with people who are on their own depends how bad they are, really. If you think they might set themselves on fire, or something risky like that, you do have to think about getting them somewhere where there is more care, such as bringing them into hospital. If they refuse to go into hospital and they aren't sectionable, i.e. the risks to them or others are not that great, you've just got to hold your breath, cross your fingers, and go in to see them twice a day. We have a mobile phone which we take out every day. If I had a client I thought would ring if he got into a worse state, I'd give him the mobile so he could phone us and we could get straight round if he seemed to be getting into a state. Or, with the client's permission, we can ask the neighbours to keep an eye out and give us a ring if they're worried. Perhaps they could pop in to check.

People can turn up to our offices and get a cup of coffee and chat. One of the excellent things about our set-up is that we have a free taxi service - if clients want to go to a group or have to get somewhere we provide a free taxi. That means that people aren't stuck waiting for buses, so people

who aren't very motivated to go out can still do so. We have support workers who don't drive but who can go out in a taxi and pick people up and take them out. It's all a matter of costs. For example, doctors know that almost everybody will turn up to their appointments if a taxi picks them up, and so nobody wastes time waiting around for patients who are never going to turn up unless you help them get there. Our budget for taxis is about the same as another nurse's pay, but it's a good thing to do and does actually save a lot of messing about and waiting around. It makes the service much more responsive. It means that if somebody rings up in the middle of the night, freaking-out, we can ring for a taxi and they can be brought in. In the evening we only go out at least in pairs, for reasons of safety.

It's true that the big old hospitals did give some of the patients a sense of community, with plenty of things to do, and they were often set in lovely surroundings. That aspect of it is a loss. I don't think people should be removed from the community any more for the lengths of time that they used to be, though. If they hadn't been closed, would there still be many people in them? I think it's different for people with learning disabilities, which is a long-term thing. These days, though, a psychotic disorder shouldn't be regarded as something anybody has for ever. It can be episodic, and it can disappear. The presumption in the old hospitals was that it was for life. Now there is a massive need to give people something to do 'in the community'. You have people sat in front of the telly all day, no money, never going anywhere, nothing to do. It's just a nightmare. No wonder people break down. At least in the old hospitals there were people to say hello to, there were jobs to be done, you could sit around with people or walk about in the gardens.

Perhaps that is the next mental health challenge. There are schemes to get people into mental health employment but they're often pretty dire, the worst sorts of employment. It's been known for ever that a major problem is finding appropriate work - or any work at all - for people who have had a serious mental health diagnosis.¹⁵ I haven't got the time to sit down and get somebody back into any meaningful employment. I wish I did. Day centres suit some people but they tend to be very cliquey and not very imaginative in what they offer. A lot of people don't want to be herded together with a lot of other people with problems. Why should they, anyway? Smoking, coffee and bingo is not my idea of fun, either.

I think there's far too much casual medication. I work with one very good psychiatrist who doesn't like to put people on medication unless it seems really necessary. But he has an exceptional understanding of symptoms and is prepared to take risks. I think far too often medication is dished out just to get people to go away and be quiet, when, really, people are just suffering from a bad life. This 'crap life syndrome' is really a reference to the poverty, people living at the bottom of the social heap, with little education, the worst employment prospects, the worst pay, the biggest and most dysfunctional families, the worst housing and environment, ill-health all around them. They are the majority of the people seen at primary care because they are the people who go to the GP. There are not so many psychotics but there are millions of people suffering from anxiety and depression and drug and alcohol problems, and what would be called personality disorders. Some people end up in prison and some end up in mental health care. The people who end up in the mental health services usually get made worse by it because that medicalises the problem and takes away people's ability or will to manage their own lives. They become worse, become chronic and end up wanting to come to us all the time whenever anything goes wrong. It's a nightmare. That's why I don't think we should take everybody on for 24-hour care unless we are absolutely sure they couldn't cope without us.

I think what is needed is a wider political initiative of rebuilding communities and purposes in the inner cities. Meanwhile, what we as carers should do is really be allowed time with people in order to try to understand them in terms of where they are coming from and what they are going through. The ten minutes a GP might spend with a person before writing a prescription can't be enough. You really

15 One study found that at least 80% of those who had a mental health problem had given up looking for a job: '[People from all walks of life] had little in common except as soon as they received their diagnosis: not because of their condition, but because they had suddenly become different. They had become mad people.' Massow, I (1999) *Employment and the Mentally Ill*. London: Mind.

need to find out what's going on with people so you can advise them about what actually is possible, with our help, for them to achieve. People need to be helped to regain control over their lives.

There has to be far more political will than the Social Exclusion Unit that Blair's Government came up with. It was supposed to think of initiatives and help all the various agencies to co-operate to help people 'at the bottom of the heap' - the socially excluded. It didn't have a great impact on mental health care. (The Social Exclusion Unit was succeeded by the Social Exclusion Task Force (SETF), which was then abolished by the coalition Government.) Assertive Outreach Teams were introduced about ten years ago. This is a team which goes out and finds people who are hard to manage within the services - so it's the homeless, really. Some inner-city trusts have got those teams because there's a need for it. There's a different need in rural areas, a different alienation - isolation, not the drugs and alcohol of inner-city homeless. To me it looks a bit like social control rather than a good way to spend resources.

I think that alienation and anomie are the same thing as crap life syndrome, and to an extent the causes of psychosis. I do think that it's the lack of involvement, lack of meaning, lack of power, lack of respect, lack of community - everything that degrades people's lives. I don't want to sound like a technophobe, but if you have the television on all day and you compare that to your own poverty-stricken life, your whole view of things becomes more and more dislocated. People look at the fun world of television and they can't understand why they are so miserable. There's no activity, no energy in their lives. They get up and there's nothing to do except watch daytime tv. There's no sense of involvement - it all sounds a bit clichéd - but I do think that the lack of meaningful occupation is very bad. Also, working for low wages with bad conditions - if people can get the work - eating bad food, having a bad education. All those kinds of things lie behind the mental health problems that I see.

Serious mental problems are basically the product of political and economic forces. I don't think it's sufficient to talk about people's impoverished or messed-up family relationships. You have to try to help them deal with their real day-to-day problems - money, housing, child-care and so on. In a big city centre, you get mainly poor working class people, with very few middle class people. We're called a Family Care Team. We assess, we care and we refer without a waiting list and without having to see a doctor. That's what the GPs in our area wanted. GPs can refer over the phone, it doesn't have to be put in writing. We can see anyone within four hours. It doesn't have to be a doctor who refers. I'll take a referral off almost anybody. We don't have self-referrals but if it's somebody we've already dealt with we can just ring the GP and tell him, and he will probably OK it. We've taken referrals off somebody's mother, off midwives, youth workers, probation officers - anybody that's concerned can refer for assessment. GPs like it and I think it's good for clients. If I had a mental health problem, I think I'd appreciate being seen quickly. I think it is the way to go, even though the pressure on the team is huge. We just dread the phone going and getting another referral because it's a lot of work. Assessment takes for ever.

Everybody gets about twenty-nine clients at any one time. It's too many clients, far too many. In fact, I now manage 35 people on five shifts a week, and I have duty work. Strictly speaking, that's less than an hour you can devote to each case per week. It's very difficult. We are always plugging for more staff. There isn't the money, of course. So far our trust has been very good because it isn't a cheap service, although neither is it exceptionally expensive. Our team is in a Mental Health and Social Care Trust, which includes social workers, too. Getting involved with the team has shown me how bureaucratic and political it all is. Political commitment is crucial to the provision of decent services.

What is fairly standard throughout the country is for community mental health nurses to jog round their clients every three weeks giving them depot injections. Without the political will and financial commitment we would slip back into that sort of a service. I'm not saying I don't have one or two clients who are on depots - they come to us from previous treatment. I try not to do it myself, though. I really don't want to. Also, I try to encourage people to consider other ways of making themselves feel good rather than just getting medicated, going stiff, sleeping too much.

The provision of trained psychiatric nurses on duty in a Casualty Department is absolutely crucial. It was a novelty ten years ago, but it seems to be fairly general now - though only rarely 24/7. Again, it means that people don't have to wait around for ages, for days, but can be seen immediately at a busy Casualty Department. People who self-harm are then not treated in a prejudicial way, they aren't marginalised, they're dealt with respectfully, whereas before their treatment was almost always callous. We deal with a lot of self-harmers, people who regularly cut. They come in for stitching up at Casualty, or we just give them steristrips and let them get on with it. Nowadays you don't try to stop people doing it, you try to teach them to manage it in a reasonable way. I've got a couple of clients like that - they just cut when they have to. We don't bother with the doctor, they just sort themselves out. At least that stops the huge panic about self-harm when people go into hospital. It means people are only referred to the duty psychiatrists if the nurses feel they need admission. It reduces the fuss, it's cost-effective and it's actually better for the client as well. It's quicker for them, less stigmatising and they're not damaged so much by psychiatrists! You do need a nurse with some bottle to do it, though, because you get the relatives who want the authorities to take care of it all, and you're letting people just go home, with maybe the risk of them killing themselves. You've got to have some nerve to accept that they do self-harm and it is a risk. All the same, the risks, coming into hospital as a psychiatric case and becoming heavily medicated, institutionalised and stigmatised, are greater than the risk that by accident they might cut an artery or take too many tablets, or whatever.

There is now a huge emphasis on risk-management. The fear that clients might kill themselves is a big motivation - people want to cover their backs. In its turn, I think that risks over-treating and medicalising it all, and making people chronic. As it stands, whenever a client kills himself, people look to see who was to blame instead of saying: 'Well, did we do what we could?' I remember we had a guy who freaked out and just made more and more serious attempts on his life, got himself admitted for a while, apparently seemed to get himself more together, then went home, kept saying he was going to kill himself - and did. Now what do you do with somebody like that?

'Risk management' involves having to write down a risk assessment, such as demographic stuff, lists in terms of 'are they likely to kill themselves?' We have to do that for everybody, all the time: we list family history, their thoughts, troubles with their health. Theoretically this should keep us up to date with the risks. If you haven't done that and somebody kills himself, you're to blame. You might still be to blame even if the records are all up to date. I don't think multiplying the bureaucracy will reduce the number of people killing themselves. Suicide is one of those things that happens. It relates closely to economic circumstances. It seems to be an impulsive act, relating strongly to changes in people's lives, such as adolescence and youth, middle age or sudden changes in circumstances of life, or the economy. Most suicides haven't been near psychiatry. There are people under psychiatric care who are more likely to do it, but locking them up isn't really an answer. More people kill themselves on wards, anyway. You can still do it on a ward if you want to. It's a big thing, though, and a lot of people in the services are very scared of blame and litigation. Also, you do get a sense of failure about it - you do feel you should have done this or that. Yet until there is funding for much closer monitoring of people at risk, suicides will keep happening.¹⁶

I think it's an abuse of medicine just to give somebody a pill when they come to you for help. If you go to the doctor and he doesn't examine you or tell you what he thinks is up, and what he's giving you and why, then that is abusive. I think it's an abuse to tell somebody who goes into your surgery and says 'I feel terrible and I feel like killing myself': 'OK, take this, and in three weeks time you'll start to feel better'. Rather than saying: 'Well, I think it's probably because of this and this and this problem you have...' and so on.

¹⁶ By 2015 the innovative Detroit Program was able to report zero suicides for more than two-and-a-half years. This was down from 89 per 100,000 patients when the program began in 2001. The program specifically focuses on risks (mainly depression and substance abuse), has purposely trained staff, and works closely with at-risk patients and their families. See: Depression care program eliminates suicide (2015) www.henryford.com. The Detroit program is described in the text to footnote 46 in Chapter 25 (Volume 2).

The consultant I work with knows that I know far more than his student doctors. I've been around in psychiatry far longer than any of them. In their first five years, doctors do eight weeks of psychiatry. A lot of them just want to be GPs, so they then do six months or sometimes two lots of six months in psychiatry. The others specialise, normally for two years, as psychiatrists or whatever. I have a lot of experience and I can feel what's going on, as well as deal with people a lot easier than a junior doctor with very limited experience. A lot of psychiatrists don't like nurses doing assessments, though. They claim it isn't legitimately medically covered. If nurses can do assessments where does that leave doctors? It seems to me that the function of the psychiatrist should be to cover the strictly medical aspects of the case and, if drugs are to be given, to provide the bio-chemical knowledge that authorises their use.

They also have roles within the Care Programme Approach,¹⁷ which is the national structure we all have to work within with our clients. That means that people who are discharged either from wards to Community Teams or from out-patient appointments do get put on the Care Programme Approach, which is supposed to be a systematic way of making sure people don't fall through the net. If I have a client who is ready for discharge he would go on Level 0 or Level 1, which means: 'no follow-up' or 'follow-up through out-patient appointment' or 'through the GP'. Levels 2 or 3 mean: 'the person has complex needs and the follow-up will be done by me, a support-worker, a social worker or the doctor', according to a written plan of who does what and how often it's done. The idea of all this is that it's reviewed, and the client can say how often he wants it reviewed, and there's a maximum amount of time between reviews. If somebody is doing really well, for instance, it might be agreed that we all meet again in six months or a year. If somebody is struggling or things are a bit iffy, we might agree to meet in two or three months. The idea is that the client, the relatives, the doctor if there is one, the social worker and the nurse all meet together and sort out what's going on. This has been going on since the mid-1990s, supposedly nationally, but some authorities got it going quicker than others. Where I work there's a co-ordinator who organises the reviews to make sure they happen. I think it has its uses but it's by no means the answer to people 'slipping through the net', people disappearing, people not getting services.

Outreach, too, is supposed to pick up those who 'fall through the net', but I think the point of it is largely a propaganda one of picking up 'the mad people who are going to kill people'. It isn't about mad people who are suffering or haven't got any money. It's driven by the popular press and moral panics and people's irrational fears and everybody's wish to be able to predict the unpredictable nastiness that sometimes affects good citizens' lives. All you can say about somebody with a history of violence is that he has a history of violence. You can't predict when or where or if he'll ever do anything again. Perhaps they are thinking of monitoring such a person every four days rather than every four months. Really, the whole thing is a panic, because far more people are murdered by a supposedly sane member of their own family or by a close friend than by a psychotic on the loose. People seem to be quite happy to be murdered by someone from their family, but not by a complete stranger! Is it just media hype or the random nature of it that causes public panic? Nobody seems to understand how people behave when they're disturbed.

Meantime, I'm hoping, and fairly sure, that eventually the model will become less medicalised.

¹⁷ *Care Programme Approach* (1990) London: Department of Health; *Effective Care Co-ordination in Mental Health Services: Modernising the care programme approach* (1999) London: Department of Health.

Chapter 12: IS SCHIZOPHRENIA REALLY AN ILLNESS?

Schizophrenia cannot be understood without understanding despair... The experience and behaviour that gets labelled schizophrenic is a special strategy that a person invents in order to live in an unliveable situation.

RD Laing¹

At this point we begin to explore various crucial questions raised by the official management of individual irrationality being universally misinformed by the 'medical' fallacy. In this chapter we examine the notion of schizophrenia, and the pivotal role it plays in psychiatric ideology.

We open the argument by way of a review of a book by Professor FA Jenner and some colleagues: Schizophrenia: A disease or some ways of being human? This shows how the crucial concept of schizophrenia is employed in conventional psychiatric thinking, practice and research. Jenner's book also discusses the fundamental problems inherent in the medical approach to any kind of functional mental disorder. So as to closely follow important but more technical arguments about the invalid procedures and conclusions of most of the research into the alleged links between schizophrenia, biochemistry and genetics, the reader is referred to an Appendix to this chapter, which is a slightly revised and updated version of parts of Professor Jenner's book.

We then offer a critical summary of the position proposed by Jenner et al as an alternative to the medical model. From there, we develop an important part of the general argument of the present Volume: that, despite its best intentions, conventional psychiatry is not genuine medical theory and practice; rather, it is essentially a way of trying to control individual irrationality by means of persuasion or coercion.

This chapter concludes by broadly agreeing with the book under review: that the management and amelioration of functional mental disorder has to involve not so much medicine as an encounter between the distressed person and a team organised to offer him solidarity. This will include practical help, specifically (aside from material support), by helping him to interpret his symptoms and discover their cause; and the appropriate investigative approach is biographical or social-psychodynamic analysis.

Despite everyone's wishes, experience shows that there is no certain remedy for a mental disorder. Yet most professionals seem to be in denial. To the degree that their work is fraught with unknowns, to that extent doctors seem intent on representing themselves as undoubtedly the only competent authorities on mental disorder. Textbooks are written as if things are as clear and predictable in the mental health field as they often seem in general medicine. Changes in diagnostic categories and treatments are announced as refinements in an inevitable movement towards ever more scientific and technical precision, and more certain remedies. But this is a false impression. The turnover of psychiatric techniques and ideas owes much more to the vagaries of what psychiatrists wish, and with general fashions in ideology, than to what is actually discovered by research.

Soon after the middle of the 19th century, the methods of general medicine began to prove spectacularly successful. This was because they were at last based on methodical natural scientific experiments and discoveries. By implication, it seemed that a method for understanding and treating one form of personal malaise - identifiable organic illness - might extend to understanding and

¹ Laing, RD, op. cit. (n. 11, Ch 9) and Laing, RD (1967) *The Politics of Experience & The Bird of Paradise*. Harmondsworth: Penguin, Ch 5.

remedying another - worrying irrationality. The great successes of general medicine boosted the doctors' imperialist claims to administer the mad. Since the late-19th century, almost everybody has hoped that psychiatry would prove itself just as successful at diagnosis, prognosis and therapy as the general medicine in which each psychiatrist is first of all trained.

And yet what everyone might wish has failed to materialise. In reality, psychiatric practice is not supported by experimental science, nor even by the clear diagnosis of indisputable diseases. Doctors may refer to research findings and guidelines that are supposed to derive from well-founded medical science, but anybody practising psychiatric medicine actually 'learns the ropes' much more as an untheorised craft than as an experimentally proven science. Further, what passes for psychiatric theory only arises in an ad hoc manner in mental health workers' daily dealings with the patients who come before them, perhaps by reference to texts but certainly by relying on normally unquestioned, everyday, rule-of-thumb traditions of simply 'what seems to be the case' and 'what treatments seem to work'. While some psychiatric studies might proceed from more reflective hunches, we should beware that nowadays nearly all of the research is funded by drug companies. We cannot suppose those vested interests are going to employ researchers who might question the medical model of mental illness, or would happily publicise findings which disputed that ruling idea. Sometimes, in journals, magazines, seminars and books, there do appear less partisan, more considered and more rigorous ways of thinking about psychiatry. Criticism is rare, yet that is where, if anywhere, there may be found reasonable arguments about the presuppositions which underpin psychiatric practice.

A contributor to this book, Professor Alec Jenner, is also lead author of a book which discusses the science around the concept of schizophrenia; or, more accurately: the paucity of reputable science. This chapter revisits a review of his book.

We would do well to heed what Professor Jenner has to say about schizophrenia, and about mental disorder in general. He had a great deal of experience and expertise. After qualifying as a doctor, he was recruited to psychiatry for his work in research biochemistry. This made him almost unique amongst psychiatrists, and he proceeded to manage teams which carried out the first double-blind UK trials on Librium and Valium. In 1967, on appointment to the Chair of Psychiatry at Sheffield University, Alec found himself in charge of the psychiatric services for the whole of the Trent Region - a population of six million. At the same time, he was made Director of the UK's Medical Research Council Units for Chemical Pathology of Mental Disorders, and for Metabolic Studies in Psychiatry.

Clearly, Professor Jenner was highly qualified in research bio-chemistry, but he also had considerable 'hands on' psychiatric experience. A practical grasp of both psychology and bio-chemistry is unusual amongst psychiatrists. This was recognised by Alec's election to a fellowship at both the Royal College of Psychiatrists and the Royal College of Physicians. Like almost every other psychiatrist, when he began his career he believed in the medical model of mental illness. What set him apart from most of his peers, though, was that due to the accumulating evidence, and true to the spirit of science, his mind was changed. In the last half of his career Alec insisted that there is no evidence to support the medical model, but there is sufficient to give credence to the social-psychiatric view of the causes of functional mental disorder, and of the best ways to respond to it.

Our review of Professor Jenner's book is the beginning of a broad argument that leads through the next two chapters to a final chapter in which we summarise our critique of medical psychiatry. By reference to Alec's book, we are able to examine the hopeless confusions in the thinking and science that is supposed to guide psychiatric practice. Because it is so confused, the whole of orthodox psychiatry is revealed as inadequate to the real needs of the patients. It turns out that there are simply no genuine medical-scientific facts to support claims for a medical science of the functional mental disorders: there is no evidence for any of the so-said mental illnesses being caused by diseased, bio-chemically unbalanced or genetically flawed brains. On the contrary, in the field of mental health, the medical model is only a monolithic *ideology* - a persuasive kind of false and wishful reasoning.²

² By 'ideology' we mean a belief or set of beliefs proclaimed as true yet demonstrably unfounded; ideology is also motivated and partisan. The concept is further elucidated in the text to footnote 15, in Chapter 14, below.

The review below is presented in four parts making up one line of argument. Theorising - or hard thinking about fundamental concepts - is not a popular British pastime, and it was a few years before Professor Jenner's book was reviewed, even in *Asylum magazine*. This does not mean that the ideas are now out-dated and superseded, as they might be were the book a report from the frontiers of a science of objects, such as physics, chemistry or physical medicine. There have been no important discoveries in the field of psychiatric bio-chemical and genetic research since its publication. This is unsurprising since, as Jenner and his colleagues demonstrate, the urge to discover organic causes for the functional mental disorders only ever issues in impossible research projects based on hazy and unscientific concepts and elementary theoretical blunders.

A review of
Schizophrenia: A disease or some ways of being human?
 by Prof FA Jenner, ACD Monterio, JA Zagalo-Cardoso & JA Cunha-Oliveira³

1: The conventional diagnosis and prognosis

I am! Yet what I am who cares or knows?
 My friends forsake me like a memory lost.
 I am the self-consumer of my woes;
 They rise and vanish, an oblivious host,
 Shadows of life, whose very soul is lost.
 And yet I am - I live - though I am toss'd

Into the nothingness of scorn and noise,
 Into the living sea of waking dream,
 Where there is neither sense of life, nor joys,
 But the huge shipwreck of my own esteem
 And all that is dear. Even those I loved the best
 Are strange - nay, they are stranger than the rest.

I long for scenes where man has never trod -
 For scenes where a woman never smiled or wept -
 There to abide with my creator, God,
 And sleep as I in childhood sweetly slept,
 Full of high thoughts, unborn. So let me lie -
 The grass below; above, the vaulted sky.

John Clare⁴

Professor Jenner and his Portuguese colleagues explore the two most contentious and fraught topics in psychiatry: the so-called mental illness known as schizophrenia and, in general, the cause of any kind of functional mental disorder. They assess the assumptions, research methods and

³ Jenner, FA et al (1993) *Schizophrenia: A disease or some ways of being human?* Sheffield Academic Press. Review by Phil Virden. NB, reference to the authors is often abbreviated to the lead writer: 'Jenner'.

⁴ Bate, J (Ed) (2003) *I Am: The selected poetry of John Clare*. New York: Farrar, Straus & Giroux. These lines are from the poem *Written in Northampton County Asylum*. Clare was England's great peasant poet. He always felt isolated and different, and spent many years in an asylum.

therapeutic techniques of orthodox psychiatry, which until recently were never subjected to rigorous testing but simply taken for granted. The argument pursued by Jenner et al is sometimes couched in technical terms, but nonetheless it is clear enough to anyone with an interest in the genesis and resolution of distressing individual irrationality.

These authors do not lack scientific and medical credentials. Between them they have many decades of experience. Each has also proved himself a good ally to those who have fallen victim to the vicissitudes of mental disorder and psychiatric treatment. Each of these doctors also began his career by whole-heartedly believing that every functional mental disorder 'must have' an organic cause and requires a medical response; each had been happy to recommend medication, and each had participated enthusiastically in a variety of bio-chemical or genetic research projects. But the lack of evidence for an organic cause for any functional mental disorder now persuades them that their original assumptions were wrong.

As we mentioned, Professor Jenner was in the Sheffield research team which carried out the UK's first double-blind clinical studies of Librium and Valium. He was an active psychiatrist for nearly fifty years, and was always fascinated by the central and apparently intractable problem of schizophrenia. When he retired from full-time practice he wrote his book as something of a summary of his thinking on the matter. What he has to say is particularly interesting since he came into psychiatry as a high-flying bio-chemist, and pursued a successful career in psychiatric bio-chemical research. Functional mental disorders - commonly known as 'mental illnesses' - make up the great majority of the psychiatric case-load; however, within a couple of decades, Professor Jenner had concluded that there is not the slightest evidence that there is a bio-chemical or genetic cause for any of them - this in spite of more than a century of intensive research. True to the scientific method, Jenner turned to a different hypothesis: the social-psychological.

This review follows Professor Jenner's book as it describes the defining characteristics of schizophrenia, how it is conceived, and how it is researched in neurobiology and genetics. In his book, there are two chapters on the research (which is mainly funded by the drug companies), and the authors survey the significant findings to date. Those chapters ought to be essential reading for anyone concerned with problems of mental health: doctors, nurses, social workers, the public, as well as patients and ex-patients. The joint-authors address the question of whether or not the causes of those undesirable forms of behaviour that most of us view as the symptoms of a mental illness really are mysteriously elusive physical diseases, i.e., that they are due to bio-chemistry or genes. Unfortunately, anything more than a summary of their investigations would make the present chapter excessively detailed and long. Any reader who is sceptical of the argument, or is simply interested in the details of neurobiological and genetic psychiatric research, is referred to the Appendix to this chapter; it also contains extensive references to the research cited in this review.

After following Professor Jenner and his co-authors in their argument about what schizophrenia is *not*, and how *not* to treat it or research it, the review traces their discussion around a more useful approach. Though broadly agreeing with their conclusions, the review ends by trying to forestall some probable objections to what are, probably for want of space, the authors' rather terse proposals about the kind of therapy which might replace today's indiscriminate use of medication.

In this chapter, by following the arguments of Professor Jenner et al, we discuss the way the schizophrenia diagnosis is employed; we argue against its validity; and then we suggest an alternative explanation and therapy. In Chapter 14 we go on to explore the forgotten history - which is to say, the denied or repressed history - of the genesis of this crucial diagnostic category. We will see that the alleged discovery of a terrible mental illness was not at all a triumph of scientific medicine. Instead, the development of the idea of schizophrenia was finally decided by a *political* process inside the medical profession; and the belief that schizophrenia is a disease is based in unscientific, prejudiced and manifestly wishful thinking. In Chapter 14, under the sub-heading: The invention of schizophrenia, we describe the political and ideological process which determined the early history of this diagnosis and its poor prognosis.

A confused and confusing concept

Every extreme sign of madness which does not seem to fit any other diagnostic category is gathered together by psychiatry into the one syndrome: *schizophrenia*. In the orthodox narrative, the idea of this particular malady emerged gradually and inevitably due to the sound empirical processes of psychiatric medical science which, with ever increasing certainty, discerned a hitherto unknown disease.

In 1851, BA Morel identified a process of severe intellectual deterioration beginning at puberty. From the Latin, *demens* = out of one's mind (demented, dementia) and *praecox* = before fully ripened (precocious), he dubbed it *demence precoce*. The great psychiatric authority Kraepelin later refined this notion of a chronic degenerative disease. In 1893 he bracketed together the four recognised syndromes *demence precoce*, hebephrenia, catatonia and *dementia paranoides* as 'the psychological degeneration processes'. In 1899 he announced that together they comprise one disease. He thereby distinguished within the group of psychoses those with a good prognosis (tending to remission) which he called manic-depressive, and those which begin early in life, tend to progress and have a poor prognosis, which he called *dementia praecox*. Kraepelin described the signs of this condition vividly and exhaustively: characteristic apathy and/or busy but ineffective and grossly inappropriate volition and expression, delusions, hallucinations, the dereliction of the patient's social graces and personal hygiene, etc.⁵

In 1911, Eugen Bleuler proposed a group of mental disorders which shared some features and all showed a particular type of thinking, feeling and relating to the world that these days we call 'autistic'. In order to denote the 'splitting' of mental processes, characterised in one symptom-complex (or syndrome) for what he thought was one type of chronic degenerative illness, he called them 'the schizophrenias' (from the Greek: 'split mind'). During the next thirty years, psychiatrists came to favour the diagnostic category 'schizophrenia' rather than '*dementia praecox*'.⁶

The image of the most awful, chronic and generally incurable disease of schizophrenia has been taken for granted for decades - certainly since the 1950s, when Schneider's description of its clear signs or symptoms took on Biblical authority for world psychiatry.⁷ As we shall see, however, a schizophrenia diagnosis does not depend on the discovery of any biological or genetic abnormalities; therefore it has no causal-scientific status. Today, this is generally unrecognised, and protagonists for the medical model stoutly defend their belief in the existence of a disease called schizophrenia. Few psychiatric workers (let alone other officials or the general public) seem aware of the lack of bona fide scientific support for the reality of this so-said disease; nor, of course, are they aware of the once hotly contested political events within the profession, out of which emerged the decision to recognise *dementia praecox* (soon to be called schizophrenia) as an actual disease.

For, in the decade or so leading up to the First World War, there was a hot debate within the profession which decided the direction psychiatry would take, and the argument centred on the medical-scientific status of *dementia praecox*. At the moment of the proposal of the category, there were those who were strongly opposed to it, and for very good reasons.

...[Kraepelin] has brought together mania and melancholia as a single disorder under the title of manic-depressive insanity. This conception, vigorously attacked at first, has probably come to stay. It is otherwise with his creation of *dementia praecox*, which is still strongly objected to in many quarters, chiefly because it seems to be a sort of waste-basket into which is thrown all forms of mental disease which cannot be tagged with another name...

5 Kraepelin, E (1919) *Dementia Praecox and Paraphrenia*. Edinburgh: Livingstone.

6 Bleuler, E (1911/1950) *Dementia Praecox, or the Group of Schizophrenias*. New York: International Universities Press. See Hill, D, op. cit. (n. 86, Ch 1) and Boyle, M, op. cit. (n. 93, Ch 1), 42-118. Both make a thorough critical review of the development of the concept of schizophrenia, from its origins until its current formulation in 1980, in *DSM-III*. (The recent *DSM-5* only dispensed with the classification of subtypes.)

7 Schneider, K (1955/9) *Clinical Psychopathology*. New York: Grune & Stratton.

In following Kraepelin we find that he only offers us a general and superficial view of the disease... [He] makes no attempt to explain the senseless utterances and actions [of his patients]. In other words, whereas he gives us an accurate, almost photographic representation of the patient's general behaviour, he does not enter into his psychological productions. He contents himself with noting that the patient entertains such and such hallucinations and delusions, and such and such mannerisms, without examining the causal relations. [Yet t]hose who work among the insane know that no two cases of *dementia praecox* are alike; there is always a difference in the grouping and relationship of the symptoms, every case having its own individuality. Kraepelin, like his predecessors, totally ignores individual psychology, a thing absolutely essential for the understanding of the psychosis...⁸

There was no evidence of any real (organic) disease causing the symptoms grouped together in a syndrome that the most prominent psychiatrists were at first happy to call either *dementia praecox* or schizophrenia. In spite of this, they assumed that an organic cause would soon be found. And as soon as the notion of a definite organic cause had been elevated to the level of unquestionable dogma by those eminent medical authorities, the gates were thrown open to the 'discovery' - which is to say, invention - of any number of other so-said mental illnesses *for which there is also no organic evidence*. Thereafter, psychiatrists busied themselves with 'discovering' a host of apparently discrete clusters of types of aberrant emotion, ideation and behaviour. As a result, whereas a century ago doctors would recognise perhaps twenty or so apparently distinct types of mental disorder, the different kinds of mental illnesses are now numbered in their hundreds.

Meanwhile, on the face of it, it might seem true that there is a sort of psychosis, usually beginning in later adolescence or early maturity, in which some unfortunate individuals are seized by a particularly malignant kind of mental illness from which they do not often or easily recover. Furthermore, schizophrenic thought seems not only very irrational but also, in the technical sense, weirdly magical: the psychotic's ideas and feelings appear comprehensive and over-inclusive, as if he can no longer properly distinguish the boundaries between himself and the world.

Nevertheless, to this day (and especially between countries), there is no consensus by which the disorder can be exactly defined. Or is it best conceived as a number of disorders? For example, where does severe clinical depression end and schizophrenia begin? In the USA there has been a tendency to stretch the term 'schizophrenia' to cover many instances of what European psychiatrists would rather diagnose as psychotic depression or behavioural or personality and acute stress disorders. Never mind: most authorities agree that about 1% of the world's population suffers from a disease called schizophrenia. About one family in twenty-five is affected.

As the 20th century progressed, everyone became accustomed to the wonderful medical control of less socially disruptive forms of emotion and confusion, such as depression and anxiety. In the popular imagination, the generalised fear of insanity gave way to the fear of a specific bizarre and unpredictable bogeyman: the person suffering from that particularly irrational and unpredictable mental illness known as schizophrenia. Every now and then - especially in slow news weeks - if a diagnosed schizophrenic is released back into the community and then commits an act of violence, this is whipped-up into a moral panic by the popular media, and a politician is bound to call for more restrictions on the liberties of the mentally ill.

In fact, however, UK studies find that the proportion of homicides committed by those diagnosed with a mental disorder fell from 48% to 11% in the years from 1958 to 1995, and did not rise thereafter.⁹ The decline continued steadily throughout the decade or so when the big old asylums were closing down and care and treatment was largely moved 'into the community'. Few people diagnosed with schizophrenia are a danger to anyone except themselves. Murder victims are far more

8 Jung, CG (1909) *The Psychology of Dementia Praecox* (Trans Peterson, F & Brill, AA) New York: Journal of Mental & Nervous Diseases Publishing Co. Translators' Introduction, v-vi.

9 See Chapter 11, above: Murder rate by mentally ill falls, op. cit. (n. 8, Ch 11), and Large, M et al, op. cit. (n. 8 Ch 11). Available statistics go to 2008; there is no systematic audit and no very recent estimate.

likely to be closely related to an apparently sane assailant than attacked by a schizophrenic stranger. A president of The Royal College of Psychiatrists once pointed out: 'The people we should really worry about are the people who are drunk.'

Statistics notwithstanding, most psychiatrists seem as frightened or confused about schizophrenia as anyone else. Professor Jenner's book - a thorough critique of the confusion - contains a foreword which unwittingly expresses some of the typical conceptual tangles and anomalies. Dr Anthony Clare was a well-known and popular spokesman for compassionate psychiatry, but his preface is replete with signs of the muddle in psychiatric thinking. Although Clare is persuaded that Jenner makes a good case *against* such a supposition, he is still certain that:

[s]chizophrenia or the schizophrenias are...best categorised as diseases.¹⁰

Surely this means there is a discernible organic pathology? If so, Clare is quite wrong. Note also that he is not certain if schizophrenia is one or a number of diseases. Why not? In point of fact, as we shall see, there has never been *any* evidence for a disease called schizophrenia: there is only a set of 'symptoms', which are no more than various typical kinds of irrational ideation and behaviour. There is *no evidence* of an organic disease. Hence, the reason that Clare does not know if it is one or several diseases is because, as disease, in the medical-scientific meaning of the term, the whole construction - 'schizophrenia' - is a fiction. If there *were* a physical basis to schizophrenia - or, for that matter, for any of the functional mental disorders - diagnosis would not have to rely on vague and subjective criteria such as the presence of delusions or hallucinations, or inappropriate thoughts, bizarre behaviour, and so forth: the doctor would simply take a blood sample and send it off for a lab test. Thomas Szasz made this point decades ago.¹¹

Dr Clare continues:

...the ability to understand a patient's predicament, behaviour and utterances depends to a very great extent on psychiatrists' imaginative powers and on their commitments to their patients...¹²

This is very strange. Understanding, imagination and commitment are not the basic requirements of a doctor when he diagnoses a real illness. As part of his investigations, he is likely to interrogate the patient about his experiences, pains and circumstances, but he does not normally have to make a special effort to 'understand the patient's predicament', or employ his own 'imaginative powers', or to any remarkable degree 'be committed to the patient'. That would be absurd and quite inappropriate. Usually, a doctor is only required to investigate the condition of the patient's body by carrying out suitable physical or biological tests.

On the other hand, 'predicament' is an unpleasant and trying situation in which someone faces a difficult or impossible choice: the person may or may not have a *disease* but he certainly experiences *unease*. Words such as 'predicament', 'behaviour' and 'utterance' denote the patient's apparent problems as a subject, an actor, an agent - *not* as an object (perhaps a diseased brain) that requires technical assistance from a medical expert.

Of course, if understanding a person's predicament, behaviour and utterances requires the imaginative powers and commitment of the psychiatrist - which it surely does - we might all understand why those attributes may be in short supply in a health service which is hard-pressed in all its resources, including time. Under such circumstances, by far the easiest as well as the most obvious response is to hurry through the encounter with the patient who 'has a mental health problem' and prescribe a medical treatment which almost always *does have an effect*.¹³ and to justify the wholesale use of drugs (or failing that, electroshock) by maintaining - despite the lack of evidence - that every functional mental disorder 'simply must have' an organic cause.

10 Jenner, FA et al, op. cit. (n. 3), 7.

11 See Szasz, TS, op. cit. (ns. 1 and 12, Ch 3). This is not to suggest that people presenting such behaviours are not really in trouble and are not in need of care.

12 Jenner, FA et al, op. cit. (n. 3), 7.

13 Although as we saw in Chapter 6 above, the effect is not necessarily beneficial.

Indeed, Dr Clare seems to recognise some of this argument *yet he still clings to the disease theory of schizophrenia*. He continues:

...The subject matter must be a human being in toto, in the context of his or her life story. We get to know this subject matter only if we take the patient seriously and proceed with care towards an understanding of his or her condition. When we approach in this way those whose lives have gone badly, a psychiatric examination need not be a degradation ceremony.¹⁴

Medically, this is all very bizarre. What is the relevance of a patient's 'life story' when a doctor tries to discern the nature of a real disease? A medical history is always relevant but, faced with organic pathology, the patient's 'life story' is simply an irrelevant distraction. In addition, while every doctor should certainly be conscious of the possibility of offending patients when he examines them, Clare clearly implies that psychiatric examinations are *very often degrading*: he suggests that when a doctor deals with a patient who has a mental disorder he must be especially careful. This is not an anxiety about contagion, or about making the wrong diagnosis, or choosing the wrong medical intervention. It is concern that were the examining doctor to commit some or other crass social *faux pas*, some unnamed indiscretion, he would not be able to determine the nature of the illness, and that he would also risk degrading the patient.

How can 'taking the patient seriously' and 'understanding' his condition help to determine and thereby remedy his disease? How can talk and social interaction affect the success of a diagnosis or, for that matter, degrade the patient? Clare is obviously not talking about treating brain pathologies by means of the rigours of causal medical science. He advises psychiatrists to *listen* to their patients and to try to *interpret* what they say. Yet understanding a person is a completely different order of activity from investigating the condition of his body (or any part of it). What have any of Clare's concerns to do with real illnesses and real medicine? It appears that this orthodox psychiatrist, at least, is not at all clear about what he does when he practices his profession.

Unfortunately, Dr Clare's confusion is entirely representative. Few of his peers seem to have any clearer ideas about mental illness or its remedy. Clare likes to be seen as sympathetic and humane - and yet he wants to keep his medical model. This is a serious matter - sometimes, for the patients, deadly serious. When that kind of muddled thinking is embedded in fiercely defended institutional routines - which it is - many vulnerable people suffer needlessly by being subjected to unhelpful and damaging pseudo-medical treatments.

The management of extreme mental deviance

Jenner remarks that orthodox psychiatry always hopes to find the causes of mental disorders in genetic defects or birth-injury. Most psychiatrists seem to believe that damaged or defective brains are sensitive to interpersonal emotional intrusiveness, and that the major tranquilisers protect against schizophrenia. That is also the rationale for basing guesses about the genesis of mental illness on what psychiatrists suppose are the chemical effects of the drugs they use to alleviate symptoms.

But we have already seen how the movement for evidence-based practice (EBP) is beginning to call into question the whole ad hoc, rule-of-thumb and traditional nature of the application of every kind of medical treatment: EBP requires doctors only to use those treatments which prove their value in properly conducted tests. Psychiatry does not begin to measure up to this standard. The evidence for the efficacy of psychiatric medicine is poor, and drugs and shock treatment are at best double-edged tools - too often they cause unwanted psychological effects or organic harm - the notorious side-effects.¹⁵ Basing a theory of mental illness only on the alleged efficacy of psychiatric drugs is not scientifically convincing.

Nor is there evidence that any functional mental disorder is the result of a brain defect. This does not seem to matter: when psychiatrists talk about the organic causes of mental disorders, typically

14 Jenner, FA et al, op. cit. (n. 3), 7.

15 See Chapters 6 and 7, above.

they proclaim them as matters of fact, or at least as good enough theory. However, any authentic scientific theory proposes a hypothesis which may be meaningfully tested since its concepts refer to clearly defined objects, because it rigorously measures the factors involved, and because it holds constant all likely variables except that under investigation. How, then, do you test a hypothesis about someone's life? Manifestly, it is impossible to replicate the rigour of the natural sciences. By definition, the conditions of the laboratory are artificially separated from normal life, and it is impossible to measure or weigh 'the elements' of someone's life. Besides, how would one even begin to determine the relevant elements? By the time someone is identified as 'mentally ill' he has already lived a life replete with an extremely complex web of significations; the immediate problem is simply to determine what seem to be the most significant components to his biography, and arrange them into a coherent narrative. In other words, what is important in a person's life (or his mental disorder) is not a line of physical causation but *a matrix of psychological and social significance*.

Jenner and his co-authors recognise this. In their experience, interpersonal or situational factors matter a great deal. It is the details of the patient's life - and especially his anxieties - that require close scrutiny. It is then possible to make madness intelligible, and mad thought and behaviour is often revealed as not so far divorced from normal rational activity.

The authors suspect that

[m]any [normal] people see the madness of our institutions but live with effective complicity in the human socio-cultural context from which they know they cannot escape; some are blinded by it, others are content with it, and some see it as sacred and unalterable.¹⁶

...Those who seem to us [the sane] to act so strangely against their own interests, often with lack of guile, are the people likely to be diagnosed [with schizophrenia] especially if they declare ideas about their own special significance (worth or worthlessness), breaking the obvious rule of society that others must seem to matter. They will be called mad, too, if they report hallucinations, strange non-socially confirmable bases for perception. The diagnosis can also depend on their apparent perception that the world, that is, other people, is devious and against them.¹⁷

The question of whether or not schizophrenia is a disease is central to deciding the true nature of *all* the functional mental disorders, and an appropriate response. Are they really illnesses? Or, as with the prototypical mental illness - schizophrenia - is belief in the actuality of all the many types of mental illness simply a collective delusion, a figment of the poor psychiatric imagination, and consequently a distraction from patients' fundamental problems of living?

When we say 'schizophrenia', we collect under one rubric all the signs of 'the truly mad'. The schizophrenic is supposed to live in a mental space completely at odds with that of the sane. The bible of psychiatry, *The Diagnostic and Statistical Manual*, lists the symptoms: strange activity, lack of guile, ideas of one's own special significance (or special insignificance), disregard for others, reported hallucinations, paranoia, sometimes catatonia, etc.¹⁸

Professor Jenner reckons it must be a state of loneliness 'at least as undesirable as a broken body.' All the same, it is doubtful that schizophrenia is an illness best treated by medicine. Jenner suggests that when we see somebody showing those symptoms we should try to understand what he may be trying to *tell us* about 'the state of the world' [his world]. At the same time, though, it is an unfortunate fact that

...the mad and the bad, the dissident and the outsider have potentially disturbing power to affect our collective sanity or culture, and that affects our response to them... The madman...is construed by us in terms of his difference from the rest of us, so construing

16 Jenner, FA et al, op. cit. (n. 3), 16.

17 Jenner, FA et al, op. cit. (n. 3), 16.

18 See *DSM-5* op. cit. (n. 103, Ch 1), 87-89.

ourselves as well as him. The outsider is perceived as a challenge to our beliefs and perceptions, like an incurable sore on the otherwise serene face of our culture.¹⁹

A common response to personal mystery is to ignore it or shut it away, and - as with mental disorder - insist that it is the result of a disease. We must be careful, however, not to confuse mystery with mystification or bewilderment. In practice, the idea of 'schizophrenia' is used to pigeonhole people undergoing great stress. A secondary effect of this stigmatization is disengagement from the sufferer. Doctors provide us with a name for the condition and the means to avoid the scandal: seclusion and medication. Co-opting medicine to classify and manage undesirable behaviour spares us from having to confront the awkward question: What might this schizophrenic behaviour signify? The prescriptive label substitutes for an explanation, and terror and mystery are domesticated by drugging the patient.

In this perspective, psychiatry serves to domesticate madness - for the sake of all those who do not want to know, do not want to be involved, and do not want to accept any responsibility. Beginning with the diagnostic label, the medical intervention deflects and diminishes the potency of the human event. It focuses everyone's attention on the spectacular aspects of the whole event: the deviant mental and behavioural symptoms. In this way, the intentions of the person experiencing the emotional and mental turmoil are ignored, evaded or misunderstood. In 'the bad old days', psychiatry could only control mad people by confinement and violence. Nowadays, repression is interiorised by means of the chemicals we call 'medication'. This *gives the appearance* of progress.

A psychiatrist only establishes the health of brains in a cursory manner, if at all; quite rightly, this job is left to a neurologist. Rather, when called upon, and on behalf of society, the psychiatrist makes judgements about the motives and intentions of people who seem very disturbed.

Besides,

...[i]t is not so much that we need to perceive a motive as that we have to approve of it. This approval is the giving of a moral blessing. The morality is derived from religious dogma. The authority to impose it comes from those pillars of the state - the judiciary, the church, the professions, the hierarchical family and the authoritarian political party. This moral blessing is a disguised censorship... The purpose is to uphold the institutions wherein our collective sanity is supposed to be lodged. The social establishment of religion, politics, science and art makes censorship respectable in the eyes of the general public.²⁰

Madness is behaviour which appears to lack a reasonable motive. Foucault suggests that insanity is best defined by the presence of delusion. The root to the word 'delusion' is 'lira': a furrow; so madness is behaviour which is 'out of the furrow, out of the rut'. In effect, a mental disorder is any strange and inconvenient behaviour for which the person refuses to apologise: it is a discomforting challenge to the consensus that is busy ploughing the approved furrows.²¹

It seems to Jenner that the official response to delusion is 'to concretise the mystery of our being'. These days, we all expect a team of experts to come along and reduce any and every one of life's mysteries to a simple problem amenable to a quick technical fix. This simplification impacts on justice and civil liberties, however, if

...madness is the tyranny of inexpressible thought...which can, however, be made more meaningful and understandable... [The person's] madness may be in having constructed a world he cannot describe to us.²²

The first chapter of Jenner's book, setting the scene, was co-written with an artist. It is headed 'The Domestication of Art and Madness and the Difficulties for the Outsider', and it proposes that schizophrenia is closely related to art and rebellion. This echoes David Cooper's perception:

19 Jenner, FA et al, op. cit. (n. 3), 17-18.

20 Jenner, FA et al, op. cit. (n. 3), 20.

21 Foucault, M, op. cit. (n. 86, Ch 1).

22 Jenner, FA et al, op. cit. (n. 3), 24-25.

Madness exists as the delusion that consists in really uttering an unsayable truth in an unspeakable situation... The future of madness is its end, its transformation into a universal creativity which is the lost place where it came from in the first place.²³

The signs of schizophrenia

Psychiatrists have agreed since the late-1950s that schizophrenia is clearly signalled by the presence of one or more of Schneider's first rank symptoms. These are 1) hallucinations: auditory are by far the most frequently reported, but visual, tactile, olfactory and gustatory are also possible; 2) interference in thinking: ideas that other agencies are putting thoughts into the person's mind, or extracting or broadcasting his thoughts; 3) passivity experiences: strange bodily-feelings, and notions of invasion by alien objects, or that the subject's actions are not self-willed; and 4) delusions: bizarre non-consensual beliefs, generally including ideas of persecution.²⁴ Apart from these 'positive first rank symptoms', psychiatrists also refer to further criteria, a) thought disorder: attributed when the doctor cannot follow what the suspected schizophrenic is talking about; and b) catatonia: marked behavioural disorganisation.

During the last forty years or so, psychiatrists also became interested in 'the negative signs of schizophrenia' - with what seems to be missing from the personality, i.e., apparent deficiencies in emotional response, or other thought processes which make for reduced functional ability, a poor quality of life and an increased burden to others. 'Negative signs' include 1) blunted affect: an apparent lack or flatness of emotion; 2) poverty of speech: the subject says very little, or gives little away; and 3) lack of drive, sociability, pleasure or attention.²⁵ On the face of it, these 'negative symptoms' all seem equally applicable to someone who is simply depressed or apathetic. They may well be specific to certain situations, making them comprehensible as forms of fairly rational retreat from situations (or other people) that the person cannot otherwise avoid - such as oppressive members of the family or insistent psychiatric officials. Negative symptoms usually seem to emerge slowly; they also tend to fail to respond to neuroleptic drugging. By contrast, the positive signs generally emerge suddenly, and do sometimes abate with the use of neuroleptics; this is viewed as supporting the belief that they are the clear symptoms of a specific disease.

Can we make anything of this list of symptoms without necessarily accepting the medical model of psychopathology? Schizophrenic delusions are those irrational ideas which seem to descend on someone from out of the blue, and which are both unreachable by reason and inexplicable in terms of normal social or cultural beliefs.

In reality, things are not so clear-cut. Otherwise reasonable people *very often* hold some fairly bizarre views or ideas. When someone clings to an absurd belief, the rest of us may be quite used to understanding and 'explaining it away': it may be part of the person's different 'culture' or 'faith'; or it may simply be a misapprehension, or a defensive misunderstanding due to embarrassment or shame - perhaps concerning events in the person's past, or current personal problems.

It seems to Jenner that as long as the interlocutor is not perceived as a threat, many strange ideas which are not immediately and easily explained may be made intelligible by conversation.

We suspect that many so-called delusions are amenable to negotiation within the framework of a trusting interpersonal relationship.²⁶

Conventional psychiatry views psychosis as 'ego-alien': an absolute rupture with the patient's previous modes of thinking, feeling and perceiving. Even so, it makes more sense to suppose that any psychosis might have a developmental onset, emerging out of everyone's shared rationality (and, we would add, shared irrationality).²⁷

23 Cooper, D (1980) *The Language of Madness*. Harmondsworth: Pelican Books, 149.

24 Schneider, K (1974) Primary and secondary symptoms in schizophrenia. In Hirsch, SR & Shepherd, M (Eds) *Themes and Variations in European Psychiatry*. Bristol: J Wright; also see Schneider, K, op. cit. (n. 7).

25 For a discussion of these diagnostic categories, see Thomas, P, op. cit. (n. 11, Ch 6), 11-25.

26 Jenner, FA et al, op. cit. (n. 3), 63.

27 Psychiatric patients' delusions are often couched in terms of common religious or secular myths.

A diagnosed schizophrenic is characterised by his undeniable commitment to his own peculiar worldview. The psychotic often reaches crisis-point because he is caught on the horns of a dilemma: between the consensus and what he is driven to believe. In any case, just because we think we can identify the grounds for a patient's bizarre beliefs, that does not mean we can then easily persuade him to give them up. On the contrary, his bizarre beliefs may ultimately be dysfunctional - which is why the consensus calls them delusions - but any suggestion that he should abandon them is a threat to his precarious emotional and mental balance. This kind of dynamic is also *very often* true of those of us who are counted otherwise fully sane: in the face of reasonable arguments, and if it provides him with a sense of emotional security, it is not at all unusual for someone to cling to an unfounded belief.²⁸

First of all, then, the ability to understand schizophrenic delusions depends on the willingness to *try to do so*. There is a great need for rapport and rapprochement in psychiatry - instead of opposing any and all of the patient's delusions with what is supposed to be hard and cold rationality.

Again, imagination and fantasy figure prominently in almost any *normal* stream of consciousness: the symptoms of formal thought and language disorder - loose association, concreteness, over-inclusiveness, paralogical (illogical) thinking - are hardly confined to diagnosed schizophrenics. Psychiatrists over-estimate how calm, rational and sequential normal speech really is; in fact, it is *generally* fairly disorganised and littered with non sequiturs, redundancies and irrelevance. Furthermore, when someone is in a state of high emotion - for example, when he is anxious and agitated - the disorganisation of his speech increases so that loose associations, blocking, and gaps in communication all occur not as exceptions but *as a rule*.

It is therefore more productive to view the disorganisation of psychotic speech as intimately connected with emotional distress, and with the kinds of things which a distressed person feels compelled to express. With heightened concern for himself, someone suffering from distress and disorientation is quite likely to ponder or jabber about his own existential condition, as it seems to him. The overstatements and self-references of a diagnosed schizophrenic might be interpreted as signs of his agitated need to locate himself: they are the signs of his feeling dislocated. As well as this, a schizophrenic's characteristic movement towards specificity and over-statement could be interpreted as an attempt to counteract his fear of dissolution and chaos: he is over-anxious for his own integrity. This also manifests as his difficulties with social space, where he vacillates between feeling threatened by intimacy and fearing distance: at one moment he cuts-off from everyone and the next he tries to get too close. In short, under stressful circumstances many normal people express a variety of disordered thoughts and behaviours, but *acute* distress exacerbates those kinds of response.

And why do psychiatrists imagine that catatonia necessarily indicates a somatic basis for schizophrenia? There is no evidence for metabolic dysfunction; what the research actually indicates is that the more withdrawn the patient, the greater his somatic arousal. If we assume that psychosis is a response to intolerable circumstances, withdrawal from social life may be construed as a form of not entirely unreasonable self-protection: withdrawal, autism, emotional anaesthesia and catatonic retardation may all be plausibly viewed as varieties of the same essentially defensive posture towards a world perceived as threatening. In fact, catatonic patients often enter remission quite unaccountably and fairly rapidly. It therefore seems reasonable to view catatonic withdrawal as *a psychological defence*.

At other times, however, these patients cannot help discharging their pent-up emotions through what psychiatry calls 'catatonic excitement' or less dramatic 'acting out'. Similar alternations of

28 In Chapters 13 to 15, below, we argue that with regard to its own unfounded views on the genesis and treatment of the functional mental disorders, this is exactly the position of psychiatry. And psychiatry defines as a sub-culture or a sect (rather than mentally ill) any group of people greater than six who share a bizarre and unreasonable belief. By this token, when we have pursued to a conclusion our argument about the delusions of psychiatry, we might in all seriousness assert that *the psychiatric profession constitutes an extremely powerful and dangerous sect, and not a genuine medical-scientific community at all*.

immobility and uncontrollable agitation are often displayed by people who have survived a violent trauma. With schizophrenic catatonia, however,

...[t]he threat comes not from the world of natural elements but from inside the patient himself, mainly from the undesirable mental constructs through which he perceives reality and the intentions and qualities of his fellow men.²⁹

As a psychotic attempt to deal with the interplay of internal forces and external reality, deluded mental constructs and behaviours such as catatonia may act as restitutive symptoms. Conventional psychiatric interventions are no help: increased contacts with officials may well trigger an increase in the patient's established projections and delusions, and he becomes more agitated, more disorderly, more demanding, more suicidal.

What about hallucinations? These are representations experienced as perceptions, consequent to the individual's weakened ability to control his own thoughts (internal images and conversations) and engage in consensual activity. Once again, orthodox psychiatry assumes that there must be an organic basis, but there is no evidence to support this idea. Like the other symptoms, it makes more sense to interpret hallucination in terms of the patient's overall behaviour, experiences and psychological condition. Who has never experienced some kind of hallucination - and not generally dealt with it quite routinely and without undue anxiety? Research shows that hallucination is very common amongst women who have not attracted a psychiatric diagnosis but who were sexually abused during childhood. And in one study, almost half of a sample of widows not diagnosed with a mental illness nonetheless hallucinated their deceased husband; those who did so nearly all felt comforted by the experience, and were no more depressed than those who did not hallucinate.³⁰

Hallucination is a sudden, urgent and unbidden image. As a tactic of psychological defence, the translation of the image into verbalised meaning is blocked. All the same, the imagination is engaged, and the intensified vivacity, frequency, persistence and intrusiveness of the image persuades the emotionally disturbed person that he is (or might be) experiencing a genuine perception: the greater the emotional disturbance, the higher the imaginative arousal and the more powerful and more persistent the hallucination. This psychic phenomenon is best understood in the context of a person's life - the life of someone who is *currently* disposed to normally undesirable imaginings.

Orthodox psychiatric thinking gives this particular psychological problem a rather convoluted solution. Surprisingly, so do the authors of the book under review. Why not accept at face value someone's report of a hallucination? Jenner suggests that a hallucination is not experienced as vividly as perceptions which are true to exterior reality, and that we cannot trust patients' reports of hallucinations as much as we can trust anything else they say. Why not? The same argument for the cause of delusions and thought disorders surely holds for hallucinations.

Of course, the veritably sane are also susceptible to hallucinations when subjected to high emotion, stress or fatigue. All of us must surely have experienced 'seeing' or 'hearing' someone or something when objectively there is nothing there. For example, a hallucination may be the sound or sight of an emotionally significant expected event or of a significant but absent other (e.g., during a time of loss, abandonment or bereavement). Our common experience of hallucination accounts for the widespread willingness to give credence to ghosts: under stress, otherwise sane and sensible people really do see ghosts - or, strictly speaking, they really do hallucinate them.

In which case, it seems unnecessarily complicated to suggest, as does Jenner, that there is a socially-directed motive to hallucination (or to reporting it in all its bizarre details), i.e., that

...disturbing and undesirable as they may be, hallucinations can very well be regarded as special messages patients use to convey to their fellow human beings their statement of personal distress and emotional turmoil.³¹

29 Jenner, FA et al, op. cit. (n. 3), 69.

30 See Esink, B (1992) *Confusing Realities: A study on child sexual abuse and psychiatric symptoms*. Nashville: VU Press; also Rees, WD (1971) The hallucinations of widowhood. *British Medical Journal* 4 37-41. Cited in the discussion by Thomas, P, op. cit. (n. 11, Ch 6), 96-101.

31 Jenner, FA et al, op. cit. (n. 3), 75-76.

Rather, it makes more sense to suggest that the person who has a hallucination indeed suffers from overwhelming distress and emotional turmoil, and that is exactly *why* his body has reached such a degree of combined arousal and exhaustion that he is open to the auto-production of vivid images of significant events, terrors or other persons; and that this unbidden event is a kind of particularly striking, uncontrollable daydream which precisely may convey *to the person who experiences it* an unbidden message from the depths of what he might really know or fear, but wishes to repress. According to neurologist Suzanne O' Sullivan, EEGs can now show that a visual hallucination is accompanied by a seizure affecting the occipital lobe, a region of the brain controlling vision.³²

Jenner suggests that the patient's motivational system is involved in activating the imagery process that leads to hallucination, and also in the subsequent phase of evaluating and reporting the experience. This is surely the case. We have to assume that all behaviour is motivated, but this does not mean that it is conscious, wilful manipulation. Rather the reverse: the person who experiences hallucinations is subjected to his own runaway thoughts and imaginings. At this point, then, Jenner does not tell us anything particularly helpful - he rather implies that the person suffering the hallucinations is up to some kind of hoax.

Hallucination is amenable to interpretation. First of all, a better guess is that the motive which leads to the hallucination is suppressed and hidden: unsatisfied desire, fear, loss, shame, guilt. That is precisely why the repressed content only breaks through *as* hallucination and not as calm and reasonable thought: 'Oh yes, my husband has just died and I am extremely unhappy', or: 'My mother and father, who I need and love, always ridicule and blame me.' A repressed but preoccupying fear or desire is a ready trigger for hearing voices and seeing ghosts.

Secondly, an entirely rational motive for the wish to communicate a hallucination to others may be that a vivid and apparently real image presents itself to the person and he wishes to express what he sees or hears in order to confirm *or disconfirm* the event. Someone who experiences a hallucination may be well aware that in the normal nature of external reality what seems to be a perceptual event has no right to make an appearance. As a matter of fact, most diagnosed schizophrenics do not so much *report* their hallucinations as *respond to them* behaviourally: when a psychiatric patient talks back to his auditory hallucination - which is the most common kind - we surmise that he is hallucinating. Whether a patient reports hallucinations in order to bamboozle his psychiatrist is a different matter - perhaps that of the patient's resistance to social power - and tangential to the fact that hallucination is a vivid and actual experience.³³

Be that as it may, the authors of the book under review refer to a number of psychiatric studies which insist that hallucination is 'a distorted (and alienated) way of expressing one's human predicament to (more or less receptive and understanding) other people.'³⁴ They suggest that we could apply to schizophrenic symptoms a Freudian kind of understanding of hysterical motives and conflicts: the hysteric's failure to hear an actual sound is the equivalent but opposite of the schizophrenic's ability to hear an unreal one. This is true. Still, it seems most likely that the aural or visual hallucination appears in all its dread and persistence to tell the sufferer something, and not first of all, 'in an alienated sort of a way', to tell him to tell that something to somebody else. In Freud's view, hallucination is simply one kind of irruption into consciousness of an unconscious wish or fear. Like anything else reported by the patient, its significance may only be teased-out by means of sympathetic analysis.

Biochemical and genetic schizophrenia research

The alleged discovery of schizophrenia was not the result of medical research but only a highly motivated exercise in tautology. It was never more than the *proposition* of a syndrome: influential

32 O' Sullivan, S (2018) *Brainstorm: Detective stories from the world of neurology*. London, Chatto & Windus. To date, O'sullivan had found this for one subject.

33 In Chapters 26 and 27 (Volume 2), we discuss the problem of the inhibition of honesty in any psychiatric encounter due to the unavoidable intrusion of the psychiatrist's great power over the patient.

34 Jenner, FA et al, op. cit. (n. 3), 80.

psychiatrists gathered together the various signs and simply *asserted* that they constitute the symptoms of one particular disease. In fact, despite a century of determined investigations, no organic cause of schizophrenic behaviour has since come to light.

Jenner et al offer an excellent summary and critique of neurobiological and genetic research into psychiatry's 'holy grail': the organic cause of schizophrenia. The authors have backgrounds in various areas of psychiatric research - chemistry, electrophysiology and genetics. Like so many other medics, each tried to find a possible link between diagnosed schizophrenia and some or other organic aberration. No evidence for such a connection was ever forthcoming. This finally persuaded the authors that the key to understanding schizophrenia does *not* lie in those areas of research, which they now consider ill-conceived. This section summarises their reflections on the relevant studies.³⁵

There has been much research interest in brain chemistry and the more obvious clinical effects of pharmaceutical agents - the neuroleptic drugs. This is used to support the notion that there *must be* a biological origin to a disease that the doctors call schizophrenia. It is not that simple, however.

To begin with, any research into schizophrenia faces the fundamental conceptual problem of not really being sure about exactly what it measures.

The lack of reliable external criteria for the validation of the clinical diagnosis of schizophrenia has put research workers in the curious position of having to investigate the genetic basis of a disease without being certain about what they mean when they speak about the same disease.³⁶

Then, although it is true that there is *some* degree of agreement amongst clinicians and researchers with regard to the conventional definition of schizophrenia,

...these conventional entities are often taken for granted as real or objective things...³⁷

It is misleading to imply that the research deals with a clearly demarcated entity - as if, like measles, schizophrenia were a well-defined disease with its own unmistakable signs. In fact, all we have to go on is a rough-and-ready categorisation of a broad type of human behaviour about which any two diagnosticians are quite likely to disagree. This lack of definition for the diagnostic category unacceptably distorts measurements of statistical significance and the interpretation of research data.

What is more, psychiatrists tend to be naïve about the relationship between mind and brain. Like the general public (but they should know better), they want to conflate mental states into brain states. They maintain that only the brain is *really* real, and that one day electrical, chemical or genetic analysis will reveal the material cause of every mental state. Meanwhile, they refuse to allow the fundamental reality of mental or psychological states because it is impossible to measure and dissect those phenomena. And yet no-one has demonstrated how brain states correlate with mental events. Apart from that, it is doubtful that such a demonstration would ever be possible since the brain is a dynamic organ in constant feedback with its environment and itself, and vastly more complicated and rapid in its operations than any conceivable computer. The notion that mental states may be reduced to brain states is a nonsense which fails to help us understand how persons behave.

The research indicates that someone diagnosed with schizophrenia is in fact able to think just as well as anyone else about topics which he does not find particularly sensitive; this suggests the absence of brain dysfunction. However, as a self-defeating and undesirable form of life, and a form of miscommunication, schizophrenic behaviour always seems to occur under conditions of emotional distress and heightened concern for the self. Neural anomalies should be expected, just as they would with any normal person who goes through a painful experience; so should a pattern of physiological reactions to suggest a high level of central nervous system arousal. Drug intake, nutritional differences, phases of the menstrual cycle, the sexuality and personality type of the patient, levels of arousal and anxiety - all have their effects on what are supposed to be the neural markers of schizophrenia. It is now well established that many of the neurochemical anomalies that were thought

35 For full details of their review of the relevant research, see The Appendix to this chapter, below.

36 Jenner, FA et al, op. cit. (n. 3), 111

37 Jenner, FA et al, op. cit. (n. 3), 111.

to indicate schizophrenia are accounted for in terms of factors such as patients' diets, the drugs they are given, and even excessive coffee-drinking.³⁸

Research shows that those who have a religious faith are calmed by it when they are about to undergo general surgery. Likewise, the fixed delusions of the diagnosed schizophrenic appear to be a defence, a coping mechanism which reduces his anxiety. A delusion that has the immediate utility of reducing anxiety is all the same likely at some point to end up increasing it: the person removes himself further from reality when he commits himself fully to a delusion; this is likely to exacerbate his personal problems, and in turn increase his anxiety. Someone in the throes of a psychosis has entered a self-stroking somato-psychodynamic cycle. This would explain why the levels of stress and anxiety of a diagnosed schizophrenic usually *increase* when he contemplates giving up his delusions: typically, adrenalin counts increase when the patient is required to face up to reality. According to bio-chemical measures of organic arousal, someone beginning to recover from a psychotic episode appears 'even more ill' than when he was manifestly psychotic.

Anti-psychotic drugs seem to provide a slight benefit for all types of psychosis; they are not selective for schizophrenia. Knowledge of the effects of the actions of anti-psychotic and anti-depressant drugs has not led to the discovery of any underlying pathophysiological changes in the schizophrenic or bipolar (manic-depressive) disorders that are functionally opposite to the effects of the drugs in use. Anti-psychotic, anti-manic and anti-depressant drugs affect cortical, limbic, hypothalamic and brainstem processes which regulate arousal, consciousness, affect and autonomic functions. They can deliver useful clinical effects - for example, sedation - regardless of any fundamental cause of the mental disorder in question. Also, with schizophrenia, there is an average of three weeks between giving the supposedly appropriate drug and any signs of a therapeutic result. This poor temporal correlation between the somatic effects of the psychotropic drugs (which are rapid) and clinical or emotional-mental effects (which are slow) means that there must be secondary or indirect changes in the organism which mediate clinical actions - and these have yet to be elucidated. All that can be said is that the drugs seem to relieve anxiety, to an extent, and thereby decrease the pressure of the delusions, hallucinations and thought disorders. Alleviating a symptom tells us nothing about the cause: aspirin may relieve a pain but it does not indicate a cause.

The drugs only affect brain chemistry, either to stimulate or tranquilise, and cannot in any way deal with the causes of a patient's emotional distress and mental turmoil. Nor can a psychiatric drug repair or rid the brain of any 'abnormality' associated with a functional mental disorder - because no such abnormality has ever been discovered. Contrary to the wishes of the commercially-funded researchers, no drug has a single site of action. The wish for a drug which will precisely and exactly act on the one and only cause of a malaise is not supported by science: it resorts to the folk-belief in 'magic bullet' medicine. This is a misconception that is very convenient to those promoting the latest psychiatric drugs. Psychiatric researchers are supposed to be intelligent and well-trained scientists, yet most of them also seem to subscribe to that simple-minded folk belief. Most researchers, of course, have a vested interest: they are funded by a drug company. Countless research papers, careers and reputations have been devoted to the search for a psychiatric 'magic bullet', and the drug companies have poured huge amounts of cash into that particular bottomless pit.

Simply because the major tranquillisers seem to affect behaviour in a way which many people find desirable, it does not follow that this is proof that schizophrenia is a disease with an organic basis. Nearly all the positive research findings for treating diagnosed schizophrenics with specific drugs are mirrored for any other types of anxious patient. Psychiatry has worked itself into a reductionist corner: if there is such a thing as mental *illness*, then it *must have* an organic basis. Even if an abnormal chemical count were discovered, or if a form of management were found in a certain drug or a diet, that still leaves open the question of cause and effect. Take the common cold, for example: the anti-bodies and the mucous do not *cause* the illness - they are its effects.

As Thomas Szasz says,

38 See Jenner, FA et al, op. cit. (n. 3), 95-101. Evidence is provided below, in The Appendix to this chapter.

Although we have mountains of facts about neurochemistry and psychopharmacology, we have none about schizophrenia.³⁹

Jenner et al are just as critical of research into the possible genetic cause of schizophrenia. There have been studies of family trees, consanguinity, twins, adoption and linkage.

First of all, every family is not only a genetic transmission of traits: it also passes on a culture. Very few research projects acknowledge that typical behaviours or strategies for living always emerge *within a tradition*, and none have adequate controls for this factor. For example, twin studies might seem to show some increased genetic risk of schizophrenia. Yet these children are always raised under exceptional and often detrimental circumstances: separated twins in the studies either grow up in institutions or are taken by poor families or relations - they tend to get a worse deal in life *because* they are adopted. There are usually other fairly obvious physical, psychological and social reasons for the disadvantage of people who are later diagnosed with schizophrenia, and are supposed to have inherited the characteristic. For instance, a schizophrenic environment generally entails far higher than normal incidences of poverty, neglect, sociopathy and learning difficulties. This means that the offspring of hospitalised schizophrenics generally come from much worse circumstances than most other children; certainly, it is well known that malnutrition in pregnancy has marked ill-effects on the development of a child's vital organs, including the brain. Apart from this, those infants tend to get taken from their mothers for adoption at an early age. Hence, the physical and social disadvantages of the child of a mother diagnosed as schizophrenic are likely to produce greater psychological risks. Not least, the adopted child who trails a background of schizophrenia might easily spend his entire life with those around him watching for the onset of mental problems; this may then become a self-fulfilling prophecy.

Confusingly, studies indicate that, in general, the less the consanguinity (the less close the relationship by blood) *the greater* the effect. If schizophrenia has a genetic determination, that is very puzzling. It is true that monozygotic twins (mz, identical, from the same egg) do have some small significant shared propensity for schizophrenia. Non-psychiatric factors, such as obstetric difficulties and lower birth weights, also correlate higher with mz twins. But there is no telling that the slight tendency for mz twins to share a propensity for schizophrenia could not be due to their peculiar circumstances and lives. Consider the strange early lives of identical twins, usually reared side by side as a curious unit - 'the twins'. They are often dressed alike and mistaken for each other - even by their own family - and as infants they tend to turn in on each other and share a very similar and involuted life; they tend to develop their own private language before the native tongue; they also experience peculiar problems when developing a separate identity.

There are so many questions that disarm the case for geneticism. For example, researchers agree that they have discovered certain enzyme markers which correlate with schizophrenia. The production of enzyme, however, is conditioned by the responses of the body to the environment, not only by genetic structure. It is therefore not possible to tell whether the correlation is cause or effect - an effect of stress, the bio-chemical 'set' of someone who suffers from chronic anxiety. Some of the problems of geneticism could provide questions for a research effort that would take until the end of time. Is the hypothesis of causality single-factor, bi-factor or multi-factorial? Is there a collection of genetic errors? Perhaps any genes, or some, or all, or some particular combination of genes predispose a person to schizophrenia? Is the proposed genetic determination total or partial - and if partial, in what proportion? Such a wide field of research opportunities!

Despite the occasional announcement of 'a breakthrough', no clues pointing to a specific genetic determination of schizophrenia have ever been discovered. In 1988 the world's press announced the sensational 'Discovery of the Schizophrenia Gene'. The research paper which made this claim appeared in *Nature* - but it was accompanied by a study which disagreed with its findings and was given equal weight by that journal; and within a few months *Nature* reported another paper which

³⁹ Quoted in Jenner, FA et al, op. cit. (n. 3), 107.

also found no evidence to support the sensational ‘discovery’. Because neither refutation was newsworthy, the whole affair was quietly forgotten.⁴⁰

By 2008, a systematic review of the research - apparently the most recent - found no evidence of a genetic predisposition in anyone diagnosed with schizophrenia:

The most comprehensive genetic association of genes previously reported to contribute to the susceptibility to schizophrenia [found that] none of the polymorphisms were associated with schizophrenia at a reasonable threshold for statistical significance... The distribution of test statistics suggests nothing outside what would be expected by chance.⁴¹

Nor were the prodigious problems of finding genetic evidence for the cause of schizophrenia any nearer a solution by 2018.⁴² This is because fundamental misunderstandings and imprecisions have always plagued notions of how particular genetic markers and configurations are supposed to make (or help make) kinds of human behaviour, e.g., types of mental illness.

The same errors in reasoning and research are forever repeated in the argument concerning ‘race’ and the genetic determination of levels or kinds of ‘intelligence’. Since the millennium, a number of books by supposedly reputable academics have claimed to reveal the most up-to-date and precise evidence for such links, and with the political rise of ‘the alt right’ this has become more of a live issue. The controversy was recently aired in the pages of a newspaper,⁴³ and leading research geneticists stepped in to point out that, as usual, the neuropsychologists had got it quite wrong:

...[C]riticisms of attempts to demonstrate a robust association between surrogate measures of ill-defined concepts (‘race’ and ‘intelligence’) are to the point. However, the dogma underpinning these attempts - genetic determinism - is left unchallenged. This determinism asserts that sequences of nucleotides comprising our chromosomes specify the characteristics - in their entirety - of the individual.

Today, this reductionist approach to biology - and therefore to human biology - has been displaced by a more profound interpretation of the facts. ‘Systems biology’ sees an organism as comprising levels of relatively autonomous organisation, each interacting with their total environment. Critical features of each of these levels cannot be predicted from the sequences of the nucleotides. Genetic determinism is just plain wrong.

When it comes to the sensitivity of humans to their total environment, to their powers of reasoning about that environment, to their ‘intelligence’, the sources of variation in that sensitivity should be sought at the appropriate level of organisation of the individual. The best evidence points to the environment in which humans exist: cultural patrimony (including prejudices), education and economic status.... [N]ucleotides don’t come into it.⁴⁴

Originally, a gene was recognised by its effects on a characteristic that varied across a population (skin colour, size, cranial capacity, etc.), a view that harks back to Mendel in 1869. Since the 1960s, however, it has become clear that a gene is actually a piece of DNA that does something at a molecular level (e.g., coding for a protein or regulating its expression). The idea that there is a gene for intelligence, facial feature or any other characteristic is just plain wrong, as are the ideas put forward by race scientists.⁴⁵

40 Sherrington, R, et al (1988) Localisation of a susceptibility locus for schizophrenia on Chromosome 5. *Nature* 336 161-167; Kennedy, JL et al (1988) ‘Evidence against linkage of schizophrenia to markers on Chromosome 5 in a Northern Swedish Pedigree. *Nature* 336 167-170; Claire, DS et al (1989) No linkage of Chromosome 5q 11-q markers to schizophrenia in Scottish families. *Nature* 339 305-309.

41 Hamilton, SP (2008) Schizophrenia genes: Are we really coming up blank? *American Journal of Psychiatry* 165 420-423.

42 See Mukherjee, S (2017) *The Gene: An intimate history*. London: Vintage, especially 446-450.

43 Evans, G (2018) The unwelcome revival of ‘race science’. *The Guardian* March 2, 6.

44 Yuille, M (2018) ‘Race science’ depends on dubious genetics (letter). *The Guardian* March 9, 6.

45 Bard, J (2018) ‘Race science’ depends on dubious genetics (letter). *The Guardian* March 9, 6.

Apply this reasoning to the field of psychiatric disorders and it accords with the arguments and evidence sifted years ago by Jenner and his colleagues, when it seemed to them that
 ...the evidence of a genetically sufficient explanation of schizophrenia [is] unlikely and therefore there is something political or projective about the effort put into looking for it, as distinct from other factors.⁴⁶

Never mind the lack of evidence, psychiatry still worries the idea like a dog with a bone. Standard textbooks continue to declare that there are ‘genetic predispositions’ or ‘tendencies’ to schizophrenia; or they speak of ‘vulnerabilities’, by which they also seem to mean inherited semi-determinations. This credo is far from the scientific truth: it is no more than wishful thinking. Worse, the psychiatric prejudice rationalised by this dogma is irresponsible and untherapeutic. It is pejorative of those who suffer distressing emotional and mental turmoil, and it burdens them with a further stigma which they are never permitted to escape. By identifying a psychosis as schizophrenia, and claiming that there is a genetic basis to the disorder, the patient is inevitably viewed as inherently inferior and less than fully human.

In view of there being no evidence to support the idea of a biological cause, it is more helpful to view the symptoms of schizophrenia as signs of chronic and overwhelming stress: the florid symptoms are the result of trying to cope. Studies show a certain correlation between creativity and schizophrenia. People assessed as ‘creative’ are more likely to have a first-degree relative diagnosed with schizophrenia; and vice versa, people diagnosed with schizophrenia are more likely to have more first-degree relatives who are generally recognised as creative. This still says nothing about the role of any genetic cause: as well as genes, the members of a family share an environment and a culture. But it might say something about habits of imaginative expression: the generic schizophrenic is famous for his vivid imagination.

Besides, even if a genetically inherited condition or predisposition were suddenly discovered, this would not mean that the disease would inevitably develop, nor that it would be incurable. Some inherited diseases can be remedied and others may be much modified by environmental factors such as diet, exercise and education. Inheritance does not necessarily mean ‘chronic’ or ‘incurable’.

During the first half of the 20th century, however, most psychiatrists were very pessimistic about the prognosis for severe insanity. This encouraged some of them to separate out certain mental patients for eugenic measures, and eugenic pseudo-science was the rationale for the organised murder of at least a quarter of a million ‘incurable’ mental patients during the Third Reich.⁴⁷ With the demise of Nazism, eugenics thankfully fell into disrepute. Still, there are always those waiting in the wings to revive it. In spite of decades of determined research, the supposition that there ‘must be’ a genetic cause to schizophrenia finds no scientific support. That so many psychiatrists refuse to accept this fact, and instead continue to proclaim the dogma of a genetic cause, puts them only one step away from lending legitimacy to a possible eugenic ‘solution’ to mental disorder in the future. That is not a good place for a caring profession to be.

Could schizophrenia be caused by infection?

As we saw in Chapter 1, the medical aspirations of psychiatrists were boosted in 1905 when it was discovered that general paralysis of the insane (GPI) was due to infection by the spirochetal bacteria, *Treponema pallidum*, which causes syphilis. Soon after, a remedy, of sorts, was discovered: arsenic.⁴⁸ Various infectious agents (bacteria or viruses) have since been proposed as possible causes for mental illness - and especially for schizophrenia.

At the moment, the most popular candidate is Toxoplasmosis. This is a disease caused by the protozoan parasite *Toxoplasma gondii*; this affects any warm-blooded animal but is especially carried

46 Jenner, FA et al, op. cit. (n. 3), 118.

47 See text to footnote 93 in Chapter 1, above.

48 See the text to footnote 94 in Chapter 1; also see Chapter 14 below, in the section: The invention of schizophrenia.

by cats, and often transmitted by them to people. Whether active or dormant, an estimated one-third of the world's human population carries a toxoplasma infection (22% of the UK's population).

Research shows that infection by this parasite changes the behaviour of its host. Most notably, infected rats and mice become less fearful of cats: in fact, some infected rats seek areas marked out by cats with their urine. This strange effect is advantageous to the parasite, which is able to proliferate due to cats eating infected rodents and then producing infected kittens. The mechanism for the rodents' behavioural change is not fully understood, but in mice toxoplasmosis infection correlates with raised dopamine levels.

These findings lead some researchers to speculate that toxoplasma may have comparable effects in humans, even in the latent phase which was previously considered asymptomatic. Every human body is host to a multitude of parasites; some are symbiotic or essential to its functioning, but toxoplasma could well be detrimental. Behavioural changes due to infection are most likely the results of low-grade encephalitis, marked by the presence of cysts in the brain. These may produce or induce production of a neurotransmitter (possibly dopamine) thereby acting similarly to the dopamine reuptake inhibitor type of antidepressants or stimulants.

Studies indicate that the toxoplasmosis parasite may affect behaviour and may present as, or be a causative or contributory factor in, various psychiatric disorders such as depression, anxiety and schizophrenia.⁴⁹ In eleven out of 19 studies, *Toxoplasma gondii* antibody levels were significantly higher in individuals affected by first-incidence schizophrenia than in unaffected people. Diagnosed schizophrenics are also more likely to have a clinical history of toxoplasmosis than the general population. It has recently been found that this particular parasite produces an enzyme with tyrosine hydroxylase and phenylalanine hydroxylase activity. This enzyme may contribute to the behavioural changes observed in toxoplasmosis by altering the production of dopamine, a neurotransmitter affecting patterns of mood, sociability, attention, motivation and sleep. And schizophrenia has long been linked to dopamine dysregulation.

As an example of a behavioural effect, studies show that toxoplasmosis associates with an increased rate of causing car accidents for people with Rh-negative blood: relative to uninfected subjects, the chance of causing such an accident increases 2.6 times. This may be due to slowed reaction times associated with infection. Globally, this might mean that about a million people a year die in road accidents due to toxoplasma infection. Studies show that this risk decreases with the length of time since infection, but that the decrease is not due to aging itself. On the other hand, the European Multicentre Study on Congenital Toxoplasmosis is more cautious: these findings could be due purely to chance, or to social and cultural factors associated with toxoplasma infection.

Other studies suggest that the parasite may influence not only reaction-times but also personality traits. Various studies show correlations between latent toxoplasma infection and various cognitive, motivational and moral characteristics: not only slower reactions but decreased novelty-seeking behaviour, lower rule-consciousness, and more jealousy in men; and more moralistic behaviour, greater warmth and conscientiousness in women. One study suggests that male carriers have shorter attention spans, a greater likelihood of breaking rules and taking risks, and (compared to the control sample) are more independent, anti-social, suspicious, jealous and morose; it also suggests that women find these men less attractive. Compared with non-infected controls, women carriers appear more outgoing, friendly and promiscuous, and are considered more attractive to men. There is some speculation that, if any of these effects are genuine, the prevalence of toxoplasmosis in a society could be a major determinant of cultural differences.

The evidence for behavioural effects in humans is controversial and not fully consistent, however. To date no prospective research has been done on the topic, i.e., testing subjects prior to infection, to see whether the proposed behaviour emerges only afterwards. Some researchers find potentially important associations with toxoplasma, but the causal relationship (if any) is unknown; perhaps these associations simply reflect factors which predispose certain kinds of people to infection. At any

49 For references to this research literature, see *Toxoplasmosis* (2015) *Wikipedia* April.

rate, it is interesting that many of the neurobehavioural symptoms postulated as due to toxoplasmosis correspond to the general function of dopamine in the human brain. The fact that toxoplasma encodes the dopamine synthetic enzyme tyrosine hydroxylase does seem to make it possible that neuro-behavioural symptoms might result from infection.

There are also claims that those infected by toxoplasma are more susceptible to schizophrenia and bipolar disorder. This possibility has been researched since 1953, but it attracted little attention until publicised in a review of the literature in 2003.⁵⁰ To that year, almost every study found that diagnosed schizophrenics have elevated rates of toxoplasma infection. There are also reports that acute toxoplasma infection sometimes leads to psychotic symptoms ‘not unlike schizophrenia’: compared to the general population, several studies found significantly higher levels of toxoplasma antibodies in diagnosed schizophrenics.⁵¹ Toxoplasma infection causes damage to astrocytes in the brain, and that damage is also sometimes seen with schizophrenia.

These studies might be suggestive, but none is able to confirm a causal relationship: diagnosed schizophrenics may have an increased exposure to toxoplasma infection, rather than the reverse. Besides, more than 75% of some human populations carry the toxoplasma infection. Due to their predilection for lightly-cooked meat, which carries the parasite, this includes the French, the Belgians and the Germans - and yet there is no evidence of a higher incidence of schizophrenia for those countries. If the evidence were ever to ‘harden’ into definitely supporting a causal link between such an infection and diagnosed schizophrenia (whether in some or every instance), that would be a remarkable scientific breakthrough: it would make schizophrenia (or one kind of schizophrenia) an organic (brain) disease rather than a functional mental disorder (a mental illness). At the moment, though, this is simply not the case.

Schizophrenia, medical dogma and the self-fulfilling prophecy

Ever since the time of Kraepelin, Bleuler and Freud, psychiatry has generally given anyone diagnosed with schizophrenia little cause for hope. All the same, there are a number of statistical studies which refute a poor prognosis. By the 1980s, every study anywhere in the world which had followed diagnosed schizophrenics for at least twenty-five years had discovered that, by any criteria, about 35% fully recover and another 35% function independently and are self-supporting but with some residual symptoms.⁵² Nor is this a result of modern medications: in Switzerland, where the diagnosis of schizophrenia was first used and where there are accurate population records, this generally benign course of the malaise has been true since the diagnostic category was devised, around 1900.

A bad prognosis too easily becomes a self-fulfilling prophecy. Far from helping, the official response mainly obstructs recovery. No good is expected of the patient and only stigma, prejudice and inappropriate or inadequate therapy is on offer. As far as Szasz is concerned, what is chronic is not the fictional disease but certain social expectations - especially those of families, doctors and psychiatric workers. There is plenty of cogent sociological argument and some enterprising social research to indicate that, because everyone’s expectations are set like stone in the institutional arrangements of psychiatry, once someone is embarked on a career as a psychiatric patient it is very difficult for him to disembark.⁵³

The section on genetic research in Jenner’s book is headed by a quote by F Jacob:

50 Torrey, EF & Yolken, RH (2003) Toxoplasma gondii and schizophrenia. *Emerging Infectious Diseases* 9 11 1375-1380.

51 Wang, H et al (2006) Prevalence of Toxoplasma infection in first-episode schizophrenia and comparison between Toxoplasma-seropositive and Toxoplasma-seronegative schizophrenia. *Acta Psychiatrica Scandinavica* 114 1 40-48.

52 See Karon, BP, in Modrow, op. cit. (n. 35, Ch 2), xi.

53 This is discussed in Chapter 15, below.

To attribute part of our totality to heredity and the rest to the environment doesn't make sense. It is like asking how much of the affection of Romeo and Juliet has a genetic and how much a cultural origin.⁵⁴

As against genetic or biochemical determination, we should not ignore the great plasticity of the human being. In fact, the outcome of all the twin studies is that the concordance for schizophrenia is more or less the same as that for patients who only suffer from a neurosis. In every study, similarities in social and cultural environments, the effects of being raised in orphanages or with relatives of the biological parents, and in unsatisfactory economic conditions, etc., are quite sufficient to account for the levels of statistical significance in correlations. So far as the purely genetic bases for schizophrenia are concerned, it seems to Jenner et al that the best-conducted studies fail to come to any conclusions.

Notwithstanding this damning critique of biologism and geneticism, it appears that the sheer weight of professional dogma overwhelms the objectivity of nearly everyone working in psychiatry, including some of its most incisive critics. While dismantling the rickety case for a genetic cause of a disease called schizophrenia, in what reads like a sop thrown to the prevailing psychiatric ideology these authors nevertheless conclude that

...we think it is reasonable to regard (at least for the time being) the genetic basis of schizophrenia as a relatively weak and non-specific polygenic disposition, allowing for considerable (and in the end much more relevant from a heuristic viewpoint) environmental influence...⁵⁵

Here, whether under the pressure of their own previously long-held prejudices or that of wishing not to offend the great majority of psychiatrists so completely, Jenner and his co-authors fall into exactly the same trap of making a 'reasonable' assumption which is quite unsupported by any evidence: i.e., the supposition of 'a relatively weak and non-specific polygenic disposition'.

These psychiatrists clearly demonstrate that there is not the slightest evidence for an organic cause of a disease called schizophrenia. But if there are no physiological indicators for an illness, what exactly is going on with someone who suffers from that particular kind of mental disorder? Further, there is the question of why the enigma of that particular kind of dysfunctional behaviour should generate such a high degree of emotional heat, confusion, muddled thinking, motivated research, professional evasion and downright dishonesty.

2: An alternative to the medical model of mental disorder

Difficult for man on earth to 'scape the snares of delusion -
All wrong, the thought process screamed at
from Infancy,

The Self built with myriad thoughts
from football to I Am What I Am,
Difficult to stop breathing factory smoke,
Difficult to step out of clothes,
hard to forget the green parka -
Trees scream & drop
bright leaves,
Yea, Trees scream & drop bright leaves,
Difficult to get out of bed in the morning
in the slums -
Even sex happiness a long drawn-out scheme

54 Quoted in Jenner, FA et al, op. cit. (n. 3), 109.

55 Jenner, FA et al, op. cit. (n. 3), 122.

To keep the mind moving ...

...The body's a big beast,
 The mind gets confused:
 I thought I was my body the last 4 years,
 and everytime I had a headache, God dealt me
 Ace of Spades -
 I thought I was mind-consciousness 10 years before that,
 and everytime I went to the Dentist the Kosmos disappeared,
 Now I don't know who I am -
 I wake up in the morning surrounded
 by meat and wires,
 pile-drivers crashing thru the bedroom floor,
 War images rayed thru Television apartments,
 Machine chaos on Earth,
 Too many bodies, mouths bleeding on every Continent,
 my own wall plaster cracked,
 What kind of prophecy
 for this Nation...

Allen Ginsberg⁵⁶

Detecting an illness or understanding the person?

Just over a hundred years ago, Eugen Bleuler proposed the diagnostic category 'schizophrenia' as a refinement of Kraepelin's syndrome, *dementia praecox*: early onset dementia. Bleuler focused on the aspect of psychopathic 'splitting', and more carefully defined the primary symptoms. Forty years later, Schneider suggested a clearer inventory of signs or symptoms. This is still in use.

In practice, however, a patient is usually said to be schizophrenic or 'have schizophrenia' when he is perceived as particularly and unacceptably unintelligible and does not obviously fit any other diagnostic category. Moreover, as we have seen, the diagnosis entirely depends on a number of behavioural symptoms and does not indicate any organic cause: it is only ever *supposed* that there is a disease. Also, unlike the signs of most actual diseases, symptoms of schizophrenia can never lead unambiguously to an indisputable categorical diagnosis.

Therefore, and as opposed to the mainstream, Jenner contends that

...[d]elusions, hallucinations, formal thought disorders and catatonic symptoms are striking and unusual to most of us, but they are perhaps susceptible to meaningful interpretations within the context of the patients' life histories... To understand or not to understand is an alternative very often decided not by the nature of the illness but by the power struggles fought amongst mental health professionals and between them and their patients. Time, concern and intellectual interest in our patients' problems are precious commodities which professionals have in short supply... The ability to understand depends to a great extent on the psychiatrists' imaginative powers and also on their commitment to the patient.⁵⁷

The psychiatric consensus, unchanged since the days of Kraepelin and Bleuler, maintains that schizophrenic speech and behaviour is devoid of meaning, nothing more than incomprehensible gibberish, irrelevant to remedying the disorder. This attitude both issues from and endorses the dogma of a purported biochemical or genetic cause. Much research and theoretical use is made of statistical variations, even though the classification of the various mental disorders is rough-and-ready and the probability that any two psychiatrists will agree on the diagnosis of any one patient is not high. This is quite different from what happens when separate doctors diagnose most real diseases: physical tests usually deliver high levels of agreement. Surely this ought to suggest that

⁵⁶ Ginsberg, A (1984) Autumn gold: New England Fall. *Collected Poems*. New York: Viking. Allen Ginsberg had been diagnosed with schizophrenia and was forcibly hospitalised and treated.

⁵⁷ Jenner, FA et al, op. cit. (n. 3), 29-30.

schizophrenia - or any other functional mental disorder - is not really an illness at all. Instead, it is a condition that calls for a completely different, non-medical mode of analysis, explanation and response.

Undeterred by evidence or argument, orthodox psychiatrists proceed as if they can easily enough distinguish between irrationality resulting from comprehensible personal problems and that requiring a scientific-medical explanation since it is based in a peculiar kind of illness with no physiological signs and no known cause.

...[T]he concept of schizophrenia depends on accepting that some things can be understood and other things cannot, although we cannot quantify and objectify them statistically.⁵⁸

Those subscribing to the medical model of mental illness seem to assume that we will never be able to understand some people who say and do things which do not *immediately* appear to make sense. In those cases, though, we could try examining some of the details of the patient's life so as to construct a biography which might help us begin to see the drift of his beliefs and behaviour. Jenner suggests that this would make psychiatry more akin to teasing out the meaning of a poem than finding determinative causes of behaviour which follow the laws of nature. Certainly, we often only catch glimpses of other people's motives and experiences, and any interpretation is bound to be biased. What Jenner calls 'the ideographic approach' nonetheless gives us a much more useful picture of the patient than one which simply assigns him to a category by adding up the number of his behavioural symptoms.

Of course, if psychiatrists do not believe in the possibility of understanding what a particular patient says or does, they will simply try to gather what they see in advance as the relevant symptoms, in terms of the main nosological entities defined by the diagnostic code with which they agree. They will [then simply] confirm their own prophecies.⁵⁹

Psychiatric labelling only gives the illusion of an explanation. Taxonomy no doubt has its uses, but the first duty of a doctor is to help his patient. He should therefore try to *understand* the patient's behaviour, engage him in a discussion, and take him seriously as someone who tries to communicate something - or perhaps tries *to avoid* communicating something.

Anyhow, it seems to Jenner that the psychiatrist should not hold back from offering the patient his own theory about the patient's ideas.

We hope this exchange of worldviews (and the demonstration of our understanding and concern) will eventually lead to a kind of negotiation between us and the patients, and even perhaps to a more or less profound and lasting modification of patients' beliefs and lifestyles.⁶⁰

As against naïve anti-psychiatry, Jenner won't indulge in romantic notions about the patient's heroic voyage into a more lucid inner space. What is necessary is to reduce the distance between the psychiatrist and the patient by means of human contact; this may be achieved through conversation, which in turn will hopefully lead to mutual understanding. This approach opposes the so-said objective-scientific view of the patient which renders him *essentially alien* due to his being diagnosed with the worst of all mental illnesses. The medical perspective tries in vain to 'explain' pathology by 'natural causes' that inflict themselves on certain unfortunate people - organic causes that it can never discover but only ever surmise. And authentic human contact and dialogue is ruled out by the idea that the psychiatrist can only properly deal with the patient in a 'clinical', 'detached', 'objective' and 'scientific' manner.

When psychiatry imagines it is scientific and medical - which it does, as a matter of routine - this is a myth. Furthermore, psychiatrists seem to be ignorant of developments in contemporary medicine and science. For example, it is a century since Heisenberg recognised that an observed object or system inevitably interacts with its observer. It is time psychiatry recognised that it is in a similar

58 Jenner, FA et al, op. cit. (n. 3), 37.

59 Jenner, FA et al, op. cit. (n. 3), 38.

60 Jenner, FA et al, op. cit. (n. 3), 39.

position with respect to its topic: the patient. The pseudo-medical language of psychiatry is not therapeutic, it simply fossilises patient and psychiatrist in a ritual which mainly serves to confirm the dominant politics and ideology. There must surely be very powerful emotional and political reasons for this allegedly medical-scientific approach.⁶¹

Those who suffer from a psychosis have not been well served by the authorities who shaped modern psychiatry. It is true that when someone is in the throes of a psychosis he may appear well beyond the reach of reason. Freud was pessimistic about the possibility of ever helping a psychotic individual; he maintained that his own analytic technique would work with subjects only so ill as to suffer from a neurosis, that is, only with people who could admit they had a mental disorder and would seek help. Freud worked outside of the official structure of psychiatry, however. In the inter-war years the existentialist philosopher and psychiatrist Karl Jaspers had just as much influence as Freud, but he also endorsed the idea that empathy with a schizophrenic is impossible.⁶²

All the same, a crucial lever to understanding any kind of functional mental disorder is provided by Freud's notion of the fragmented and self-contradictory nature of the personality, to a degree alienated from its own experience. It struck Freud that *everything* that a person says or does must have a meaning, however bizarre it may immediately appear. In his view, neurotic and psychotic behaviour is the censored or masked expression of repressed experience and memory, blocked from open expression and recognition because it is too painful for the patient to admit.⁶³

If this is so, no matter how deviant it may at first appear, it makes sense to view very irrational speech and behaviour not as senseless and irrelevant but meaningful - in fact, *replete with meaning*. Jenner is optimistic about discovering this meaning. If we look at the personal world of the patient - at the circumstances of his life - we are less likely to consider that what he says and does is absolutely alien and incomprehensible. The psychiatrist should attend to the possible meanings of the patient's beliefs and behaviour - its symbolism, for example - not simply ignore what he says just because at the moment he is confused and distressed.

Unfortunately, despite good reasons for psychological interpretation rather than pseudo-medical diagnosis, mainstream psychiatry refuses to view patients' bizarre beliefs or behaviour as motivated; it is all discounted as 'only the symptoms of a mental illness'. Why are psychiatrists so reluctant to abandon their medical perspective? Well, as a normal matter of daily life everybody interprets intentions, so if doctors were to begin to try to interpret the meaning of bizarre and dysfunctional behaviour they would immediately be exposed to the judgement of the public. How could they then claim special expertise? Another reason for sticking with the medical model is that quick and easy solutions rarely emerge out of listening to very distressed people, and trying to interpret what they say. Doctors are able to hide behind a smokescreen of psychiatric jargon - hide from the patients, the public, from other professionals, and not least themselves: jargon allows them to neatly sidestep every difficult psychological and social question posed by the patient. It is tempting to view any human problem as an illness, and then to use unchallenged medical power to decide the patient's fate - simply by shuffling him into a category which indicates a certain kind of pre-arranged, generalised and impersonal processing.

'Proper scientific standards' are defences [psychiatrists] use to avoid getting involved with... patients in a dialogue bound to be coloured by [the psychiatrists'] and [the patients'] world-views.⁶⁴

61 These reasons are hardly mentioned in Jenner's book. However, they are crucial to understanding the strange potency of the myth of mental illness, and the fanatic resistance of the doctors to a properly rational conceptualisation of mental disorder and the psychiatric project. This is why we devote Chapters 13 and 14 of this book to a discussion of the emotional, political, conceptual and institutional barriers to clear thinking about functional mental disorder and appropriate forms of response.

62 Jaspers, K (1913/68) *General Psychopathology*. Manchester: Manchester University Press.

63 This is Freud's 'law' of the inevitable return of the repressed.

64 Jenner, FA et al, op. cit. (n. 3), 85.

The allegedly medical concepts and routines of psychiatry constitute a form of scientism - an ideology which *appears* scientific but which is not devised to carry out scientifically precise medicine so much as to *persuade everybody* that this is what is going on. Psychiatrists are trapped in a cage of their own medical education and language.

When Schneider devised a more rigorous definition of schizophrenia, he was also careful to emphasise that the concept is *not* a proven disease entity: it is simply a conventional categorical device, and should be cautiously used as such. All subsequent psychiatric thinking and research stems from his work, but his caveat was immediately ignored and his technical language fetishised. Ever since, the 'syndrome of schizophrenia' has been used to settle dogmatically every question of cause which still awaits its proper scientific solution.

Educated people should by now know that a disease generally consists of multi-factor changes in biological processes, but when it comes to the cause of mental disorder what is in everyone's mind is the image of a well-defined, unchanging, single caused 'thing' which inflicts itself on the human organism. This folk image of disease is based in a primal paranoid delusion: each of us fears imperceptible and uncontrollable invasion of the body by a powerful and wily alien force that is surreptitiously 'out to get us'. This notion is no less concrete than the belief held by uneducated Eskimos who 'brush' or 'blow away' their illnesses. In spite of years of scientific and medical training, most psychiatrists also subscribe to a very simplistic view of illness.⁶⁵

The idea that an adequate explanation of human behaviour can only issue from the scientific analysis of the material body is itself a folk myth, a belief constructed on the recognition of genuine medical advances. Doctors have been developing better ways of seeing deeper beneath the surface of life for four hundred years. During the last century the focus narrowed progressively from cells to micro-biology to genetic structure. Clinical medicine no longer perceives illness as something descending on the body but as developing within it - perhaps by invasion, perhaps not. Few doctors nowadays give much consideration to living relationships that lie beyond the boundaries of the human body. In spite of a general medical indifference to external influences and human agency, it could still be argued that such factors are in fact the most important determinants of health and disease. After all, it was not clinical medicine but improvements in sanitation and diet - changes in political-economy - that in the last century-and-a-half so improved the general health of the population.⁶⁶ In practice, if they cannot think of a medical prescription, physicians pretty much leave the physically sick to their own devices. At least that is consistent with an appreciation of the limits of their expertise.

Of course, every psychiatrist is first of all thoroughly trained in medicine. They are not primarily interested in removing the environmental influences in which abnormal behaviour develops. It 'stands to reason' to a doctor that a neuroleptic medication must be the appropriate treatment for the disease called schizophrenia. Nevertheless, it would be useful to compare schizophrenic with normal populations: we need an epidemiology, but as sensitive as possible to social nuances.

Developments in general social and political awareness have forced psychiatrists to acknowledge that stressful environmental factors do play a part in the onset of the condition they call schizophrenic illness. This is only an afterthought, however, and not one that is integrated into the dominant medical model. Due to medical indoctrination, psychiatrists employ the wrong concepts and ask the wrong questions about the schizophrenic patient. Why assume that there *must be* an organic cause for his condition? Why such a naïve, one-dimensional, causal approach? Is there any kind of human behaviour that is generally the result of only one measurable cause? Why the obsession with genetic or bio-chemical guesswork? The orthodox psychiatric perspective is simply inadequate to the

65 We suggest that it is a combination of professional paranoia and the public's profound wish for a medical remedy for all psychological and interactional ills that gives rise to the scientific ideology which pervades psychiatry. See Chapters 13 and 14, below.

66 This is probably just as true today. People now seem to be waking up to the idea that the epidemic of diseases caused by obesity has socio-economic and psychological causes.

richness of the human condition. It would be far more helpful to reflect on biography and the meanings and motives that are surely encoded in schizophrenic speech and behaviour.

Extremely fraught response to extremely troubling circumstances

There is no disputing that chemicals have their effects on the production of psychotic symptoms - generally by lobotomising the patient. However, the human body is a complex dynamic biochemical feedback system, responsive not just to medication but to every aspect of its environment. And it is the vehicle for *the person*. What do we know about personality, and the context in which it develops?

First of all, no-one grows up outside of society. Every person's development is in the context of a complex history and culture. The optimal environment is nurturing and loving, protective and permissive, but each of us has also to learn self-restraint so as to adapt to the conditions in which we find ourselves: we are all more or less subject to social control and have to live with more or less frustration and anxiety. Happily, in most of our waking life the higher centres of the brain suppress aspects of the automatic activity of the central nervous system such that the cortex is generally kept from over-arousal by fears and frustrations. Jenner suggests it is likely that when frustration and fear is chronic and extreme it cannot always be managed without producing schizophrenic kinds of symptoms, and that the behaviour which characterises the condition is due to excessive dopamine activity. Research has already established that 'environmental factors' - which is to say, social relationships - have a big influence on the levels of patients' agitation.

In fact, nobody has been able to demonstrate that Schneider's set of defining symptoms apply only and exclusively to that particular group of patients diagnosed with schizophrenia: 'first rank symptoms' are also found in patients suffering from other types of psychosis. All we can safely say is that an individual attracts the diagnosis of schizophrenia when he displays certain signs, is referred to a doctor and is also

...a highly sensitive person living in a more or less permanent state of emotional turmoil, especially when interacting with people he sees as threatening...⁶⁷

Over the last sixty years, evidence from numerous studies shows that the psychiatric process itself influences behaviour. For instance, research indicates that maintenance phenothiazines are little better than placebo when employed in a hospital but have significant effects on out-patients: schizophrenics not on medication and living in the community relapse at a higher rate. This suggests that the hospital acts as a shield from the stresses the patient faces at home or 'in the community'.⁶⁸

In principle, the effects of social context, the environment, personal crises and life changes *are* recognised by mainstream psychiatry. However, doctors usually only suppose that they play '...an accessory role...in the overall context of the officially accepted aetiopathogenic theory of schizophrenia.'⁶⁹

The medical model assumes that the mental illness causes problems in the home and the community - that the disease generates the social problems. Yet we could just as well assume that it is the social problems which cause the condition. Anyone who genuinely tries to get to the root of the matter would investigate both possibilities, and it stretches credulity to postulate an entirely hypothetical disease to account for the behaviour and mental states of diagnosed schizophrenics. On the other hand, it makes more sense to interpret 'schizophrenic' symptoms as most likely the person's over-stressed reaction to his overwhelmingly difficult life.

Cross-cultural studies may throw a light on this matter. The prognosis for schizophrenia is usually significantly more favourable in 'undeveloped' countries than in 'developed' ones. In Mauritius, for example, there are much higher rates of return to normality (i.e., for symptoms to disappear) and less relapse for mild schizophrenia than in the UK. (Although there are no differences for severe schizophrenia: in both countries there is little improvement.) Similar variations are found between Tongan and Australian patients.

67 Jenner, FA et al, op. cit. (n. 3), 83.

68 See research quoted in Jenner, FA et al, op. cit. (n. 3), 83-84.

69 Jenner, FA et al, op. cit. (n. 3), 86.

The popular explanation for these differences is that the social or cultural conditions are better suited to recovery - that more rural and traditional societies are less stressful, there is less competition and more social stability, and the population tends to be allocated social roles rather than each person having to spend a lifetime making his own decisions about who to be and what to do. This may or may not be the case; what is certain is that distressed and confused people are not so often identified as 'having a mental illness', and therefore co-opted into the sick role. Rather, the onset of a mental disorder is often explained in terms of locally approved beliefs about 'possession' by an outside force; the person exhibiting the condition is permitted to inhabit a culturally defined role which embraces his strange ideas and behaviour, and he is also helped to return to his old self by means of exorcism or other rituals. By contrast, in modern urban-industrial societies everyone believes that schizophrenia (and any other form of serious irrationality) is a kind of illness *intrinsic to the person*. This implies that 'the illness might enter remission', rather than that the person's problems might find their ritual resolution. This difference in presuppositions - and hence in the kinds of response - is bound to influence the nature of psychotic episodes in different cultures.

Jenner suggests investigating the phenomenon of so-said schizophrenia by supposing that it consists of a person's *activity in his world*, rather than assuming that the problem is confined to one discrete and dysfunctional brain - an object for medicine to work on. He proposes an

...ideographic approach to schizophrenic patients' behaviour, and the writing of biography as a means of understanding their acts and experiences. This implies that schizophrenia is more akin to some varieties of life processes than a specific kind of disease.⁷⁰

He quotes the authority of the younger Bleuler:

...[S]chizophrenics flounder under the same difficulties with which all of us struggle all our lives. In spite of our own inner discords, or ambivalences, and our ambitemencies, all of us must find ways and means for establishing an awareness of our own 'egos' and for confronting the world with our own wills. As long as we recognise the schizophrenic as a fellow sufferer and a comrade-in-arms, he remains one of us. But when we see in him someone whom a pathological heritage or a degenerate brain has rendered inaccessible, inhuman, different or strange, we involuntarily turn away from him. Yet it is so very beneficial to the schizophrenic for us to stay close to him!

...[E]ven in healthy people there is some disposition in the direction of a schizophrenic psychic life and...such disposition might be a normal part of human nature. This, indeed, has been proved by research into the psychology of the healthy; beneath the surface of healthy psychic life enabling us to adapt to others and to the real world there is hidden in every man a chaotic inner life which goes on without consideration of reality. This chaotic and illogical inner life cannot be distinguished from the schizophrenic way of thinking, imagining and living...⁷¹

Jenner also rejects Eugen Bleuler's pessimistic conclusion that the chaotic and illogical features of the schizophrenic patient's inner life are wholly inexplicable and have nothing to do with his real experience. That is how the old psychiatric orthodoxy used to see it. Why not assume, however, that there is method in the madness, and that we can perhaps tease out the meaning, if only we give it a chance to emerge?

There is now a solid body of evidence to indicate that the psychiatric consensus which insists on a poor prognosis for schizophrenia is factually wrong: most patients with the diagnosis do get better. Schizophrenia is therefore better viewed as a life process, open to a great variety of influences and outcomes, rather than a physical (brain) illness with a specific and uniformly awful progression. Psychiatrists might have more success were they to focus less on the diagnosed 'illness' than on taking into account the person and his unique set of problems.

What attitude should psychiatry take towards this patient-as-person, rather than patient-as-carrier-of-illness? If a diagnosed schizophrenic has not actually fallen ill, neither is he simply the passive

70 Jenner, FA et al, op. cit. (n. 3), 125.

71 Manfred Bleuler, quoted in Jenner, FA et al, op. cit. (n. 3), 125.

victim of a complex of morbid social factors. Rather, he is the active protagonist of a history and a destiny. Therapy has to involve discussions with the patient concerning his personal responsibility vis-à-vis not only his past and present misery but also the making of his future mental balance and happiness. An appropriate intervention recognises

...the patient's own participation in the incubation, emergence and course of his psychiatric illness...⁷²

Moreover, the patient's own judgements, projections, decisions and choices *already do have an effect* on his career as a mentally abnormal person.

This attitude towards the patient makes restraint or sedation perhaps occasionally necessary but entirely secondary to a meaningful relationship of one person to another: the mental health official to the person in crisis. Jenner and his colleagues argue that too often medical treatment or unnecessary sedation immediately obscures the real issues by persuading the patient that there is nothing he can do to help himself because his brain is diseased and he needs medical treatment. Instead, if it is to be therapeutic, the relationship between the psychiatric official and the patient must become a dialogue. Not simply the old ritual of supposedly detached clinical observation, it must become a kind of negotiation involving compromise and disclosure of the worldview of the carer or therapist. When the patient usually guesses them anyway, why try to hide the doctor's views about the patient's self-destructive behaviour?

A psychotic is essentially someone who is so insecure that he fails to handle chaos except with the aid of a system of pathological beliefs: fantasy makes everything clear to him - but fantastically clear, not actually clear. Psychosis or schizophrenia should be seen as

...the price men must pay for being thrown into a world where they have to find and make their own way without the help of any concrete set of norms, valid for all times and places...⁷³

In the experience of the authors, schizophrenic patients are as sensitive as they are mistaken, and they become less disturbed and less suspicious if they can be persuaded that they are able to act and think as responsible and socially effective people who still have plenty of time to make good sense of their lives. Or as Laing put it:

A good deal of the skill of psychotherapy lies in the ability to appeal to the freedom of the patient...⁷⁴

No doubt there are risks in adopting this humanist position. First of all, it enters the ideological fray between the protagonists of neurophysiology and psychodynamics, between biochemists, social workers, civil liberties agencies, neighbours, relatives, friends, nurses, policemen and judges. Psychiatrists bear a responsibility towards the patients, however. By simply assuming that the symptoms indicate some unknown and yet to be discovered disease, it was they who foisted the diagnosis of schizophrenia on people who display certain behavioural signs. Jaspers bears much of the responsibility for establishing the unhelpful idea that the onset of this kind of irrationality is entirely inexplicable and independent of a person's life history and the meaning of significant events within it.

Instead, Jenner views schizophrenia as a 'nascent state' - a new state of mind, in the process of being born. 'The world of the marvellous' is experienced by artists, by lovers, by religious mystics - and by schizophrenics. The new state of mind questions the routines of established institutional life. An important function of every institution, of course - every family, community, school, church, psychiatric facility - is precisely to neutralise or domesticate any emerging nascent state, since it threatens the status quo. Psychiatrists are expected to define the schizophrenic's vision as invalid - nothing more than aberrant ideation resulting from a disease for which no-one is responsible. So-said medical science is employed ideologically so as to depict the schizophrenic patient as intrinsically defective, whereas really he is often the visionary of a social norm which he contests because he

72 Jenner, FA et al, op. cit. (n. 3), 127.

73 Jenner, FA et al, op. cit. (n. 3), 127.

74 Quoted in Jenner, FA et al, op. cit. (n. 3), 129.

experiences *society* as defective. It seemed to Franco Basaglia that schizophrenia is the most individual and least contagious nascent state.

Meanwhile, the notion of mental illness polarises ‘us and them’, and only the accused is stigmatised, never his accusers. This polarisation means that a person loses his full humanity as soon as he is diagnosed with a mental illness, and especially if he is said to be schizophrenic: the schizophrenic, in particular, inhabits an absurd, nightmarish, Kafkaesque world where he may be denounced by any accomplice to the status quo.

Unfortunately, it is normal for people not only to tolerate power but to take its side against powerless and demonised enemies. Throughout his career, Thomas Szasz spoke against this tendency in psychiatry. He contended that in our modern and supposedly enlightened world, and in the name of care and cure, Reason arrogantly persecutes Unreason. Management of mental deviance has become a mass medical movement which has supplanted the mass religious movements of days gone by; harassment of those who are extremely distressed and mentally disturbed has replaced the persecution of heretics; everybody believes that any serious mental health condition must surely originate in a genetic error, a biochemical fault or a viral infection - that the individual is less than fully human. Medical Science has replaced Theology, doctors have replaced the Inquisition, and mental patients substitute for witches.

The big problem, obviously, is that any nascent state tends to release conflicts, instabilities and unforeseen consequences. It upsets every other insecure person - which means almost everyone - and often it just as much frightens the officials who stand between the public and what it most fears. ‘Science’ is used to legitimate that rational modernity which is supposed to hold all the threatening chaos at bay. We all expect Science to know and be able to control everything that ever occurs, including social and psychological conflict: we wish medicine would cure every ill. Consequently, psychiatric medicine is enlisted to regulate all those conflicts generated or inflamed by the presence of nascent states. Nowadays, most people seem to take it for granted that biochemistry and genetics will provide us with a technical fix and re-establish nice and tidy identikit conformity.

All this amounts to wishful thinking which flies in the face of reality. Since we all live in constant tension with our own and other people’s needs and emotional and mental states, few of us ever get to feel very secure. Besides, our ‘common sense’ ideas are all rather precarious - ideas about social time, space and matter, God and morality, freedom and responsibility, self and society, etc. Hence, anyone who upsets the fragile consensus is likely to be subjected to public opprobrium. Not so long ago heretics were burnt at the stake for suggesting that the earth circled the sun, and the Church forced Galileo to stop announcing such an upsetting idea.

As regards schizophrenic dissent, Jenner suggests that

[s]trange ideas tend to develop when beliefs begin to fail, when interpretation is not rewarded, when one is socially and personally stranded and alone in a strange world and perhaps angry and hurt. The attempt to go it alone can then lead to a spiral of rejection, to isolation, to false perceptions and/or experiences and segregation and diagnosis. Worse still, one cannot escape. There is nowhere to get away from the social nexus and the reality in which one’s emotions are so intimately and inevitably enmeshed...

The formidable task of being alone and struggling to produce a new language with which to speak to nobody and yet to blame everybody else for one’s discomfort produces unbearable tensions. One wishes to be very special but one is not. In order to be secure, core constructs are tenaciously, almost randomly, sought and maintained. What is face-saving in one’s mind, which is damaging to one’s image in others, seems essential. What follows is vacillation and thrashing around in a rough sea, grabbing hold of this or that plank of belief...in order to survive and breathe freely. Everything makes everything worse, especially those who think they are helping.⁷⁵

75 Jenner, FA et al, op. cit. (n. 3), 138.

Naturally, if someone starts to speak or act very bizarrely, people trying to live quiet and predictable lives find him insufferable and perhaps frightening: they welcome the psychiatric intervention. If it is to help the individual, though, rather than simply to control and contain him for the sake of the social peace, psychiatry must come to understand that behaviour which it currently diagnoses as a disease - 'schizophrenia' - is an intelligible way of being human.

3: Psychiatry as a form of social control

As soon as you're born they make you feel small
By giving you no time instead of it all
Til the pain is so big you feel nothing at all.

They hurt you at home and they hit you at school
They hate you if you're clever and they despise a fool
Til you're so fucking crazy you can't follow their rules.

When they've tortured and scared you for twenty odd years
Then they expect you to pick a career
When you can't really function, you're so full of fear.

John Lennon.⁷⁶

Conflicting perspectives within psychiatry

Early in the 20th century BL Whorf worked as fire prevention assessor for an insurance company, but an interest in language was his ticket to a successful academic career. At the time, gasoline (petrol) was pumped out of free-standing drums, not stored in vented underground tanks. With the rapid increase in the number of automobiles there had been a worrying rise in the number of fires caused by these gasoline drums exploding. Whorf described a workplace in which the full drums were stored in one room and the used ones in another. Workers were careful not to bring a flame or electrical appliance into the room with the full drums, but they were casual with the used drums and smoked cigarettes around them. It occurred to Whorf that everyone said the used drums were 'empty', whereas for safety's sake they should have recognised they were over-flowing with highly flammable vapour: people were getting blown-up due to a bad linguistic habit.

Subsequent studies of a variety of languages led Whorf to conclude that

[w]e dissect nature along lines laid down by our native language... Language is not simply a reporting device for experience but a framework for defining it.⁷⁷

Only when we think we know a thing can we act in relation to it. However, a conception of objects or events is not simply formed by the world 'out there' impinging on our senses - there is interplay between the sensory inputs and our imaginative or theoretical constructs. And since thought is mediated by speech, every language is a reservoir of received and habitual 'common sense' conceptions and assumptions. This is to an extent unique to each language since they emerge historically in response to the particular problems met by each speech community. Every language or conceptual scheme therefore has its biases. Consequently, if we are to understand the world and act rationally in it, we have to examine the key terms by which we conceive of things.

Psychiatrists are not much given to examining their own concepts or figures of speech. To begin with, they say 'mental illness' when there is no illness but only apparently obdurate irrationality. And

⁷⁶ Lennon, J (1970) Working class hero. *John Lennon*. London: Apple. Given up by his mother when he was very young, Lennon was notoriously 'moody'.

⁷⁷ Whorf, BL (1964) Thinking in primitive communities. In Lenneberg, EH (Ed) *New Directions in the Study of Language*. Cambridge, Mass: MIT Press.

whereas the incapacity may only be temporary, partial or depending on events or context, with a psychosis they tend to assume that the loss of reason is absolute. But perhaps they would do better to view such a person as full or overflowing with pent-up, potentially 'volatile' reasons which he has difficulty articulating: perhaps his swirling, aberrant ideas are agitated by great emotional heat. Of course, it is true that this agitation - the person's desperate response to internal strife, perceived by others as a mental disorder - contrasts starkly with the better-organised cool, calm and collected, explicit and sequential reasoning of rational discourse. Just the same, it might prove fruitful to put a psychotherapeutic construction on the famous comment on Hamlet's madness:

Though this be madness, yet there is method in't.⁷⁸

If psychiatrists would recognise this possibility, a way might open up for the negotiation of psychoses - a way to comprehend the methods of madness.

Jenner thoroughly criticises the pretensions and suppositions of orthodox psychiatric theory and research: he demonstrates that it is not based in sound scientific medicine.⁷⁹ He then suggests 'an ideographic' approach. It is unfortunate, however, that the book tends to be compact and dense in its argument, and also that it employs the technical terms of orthodox psychiatry without fully purging them of their medical connotations. It is also a pity that no space is given to illustrate the argument by reference to any case histories.⁸⁰

As well as these shortcomings, a number of important issues are raised and left unresolved. On the grounds of these gaps, anyone who defends a view that he fondly imagines is genuinely scientific and medical might still object to Jenner's idea of an alternative, 'humane' psychiatry.

First of all, someone said to be suffering from schizophrenia is defined by Jenner as 'unacceptably unintelligible', as having problems establishing his 'ego' [his conscious, thinking self] and asserting himself in the world. At the same time, though - and usually that aspect of the whole event which calls down the psychiatric response - there is a visible breakdown in the person's ability to negotiate his way in life: in the absence of any apparent organic cause, or of any socially acceptable reasons or motives, serious mental disorder is distinguished by the individual's *loss of autonomy*.

Secondly, the notion that psychosis is a kind of nascent state - 'a new state of mind in the process of being born' - is fine, so long as this is qualified. When the patient 'contests a social norm', that is not a particularly heroic activity, nor necessarily how he sees it. Psychosis is a form of suffering in which, to some degree, the person loses contact with reality. Usually, it is easy to differentiate madness from artistic, political or other reasonable or reasoned activities. In 1922, psychiatrist Hans Prinzhorn published an appreciation of his collection of patients' art, and pointed out:

Alienation from the world of appearances is imposed in the case of the schizophrenic 'as a gruesome, inescapable lot against which he often struggles for some time until he submits and slowly begins to feel at home in his autistic world, which is enriched by his delusions.'

In contrast, the 'alienation' of the modern artist 'occurs because of painful self-analysis'.⁸¹

Third, psychiatry is itself an institution, a set of norms arranged around a social function, i.e., managing very disturbed individuals, and trying to rectify their deviance. If psychiatrists were to view psychosis as 'a nascent state contesting a social norm', the consequences for their theory, research and practice would be profound. Jenner et al do not really address this issue. In fact, 'nascent state' is the view of psychosis from one side of those battle lines which have been drawn up within psychiatry ever since it emerged as a separate profession. This is the divide between the advocates of psychology or medicine, i.e., between those who wish to engage the patient in conversation so as to help him to better understand and negotiate his world, and those who believe it is necessary to carry

78 William Shakespeare. *Hamlet*, Act 2: scene 2.

79 For more details of their critique, see The Appendix to this chapter, below.

80 The examples in Chapter 2 are analysed and interpreted in Chapters 18 and 19 (Volume 2); there we demonstrate that argued understanding is more fruitful than any wished for but unproven 'causal explanation'.

81 Rhodes, C (2000) *Outsider Art: Spontaneous alternatives*. London: Thames & Hudson, 82; quoting from Prinzhorn, H (1922/72) *Artistry of the Mentally Ill: A contribution to the psychology and psychopathology of configuration*. New York: Springer-Verlag.

out technical work on the patient's brain, to some extent irrespective of what it does to his body or spirit, as long as it controls the symptoms of his madness. Nowadays, at least in theory, psychiatry attempts both projects at once. This contradictory practice is celebrated as 'pragmatic' and 'eclectic', but it tends to generate muddle and confusion.

There are other unresolved issues. Jenner's book begins by pointing out similarities between psychotic and artistic behaviour. This might seem to romanticise psychosis. As well as this, however, we are told that psychoses are 'the price men must pay for being thrown into a world where they have to find, and make their own way without the help of any concrete set of norms, valid for all times and places.' This makes it sound as if there is an existential dilemma which will one day rear up and smack each of us in the face, but that those who respond to it with schizophrenic symptoms are, for some reason, too insecure to handle the anxiety without the crutch of a pathological belief system. Well, perhaps. But this only begs the question: Why, in the first place, is the potential schizophrenic more insecure than other people?

There is a tradition which suggests that at the root of *pathological* doubt and confusion is not some kind of universal existential determination but a particular emotional trauma. What predisposes someone to psychotic breakdown is not being born and growing up and having to face dilemmas, but *having to survive exceptionally pathogenic events*. In this perspective, psychotic speech and behaviour are the signs of a *personal or social predicament* towards which the individual can no longer orient himself rationally, and which he is only able to express in a coded manner that appears bizarre to the rest of us. These authors do insist that the investigation of the patient's case should be biographical; they also mention his subjection to adverse social conditions. Unfortunately, these points are not elucidated.

With respect to any serious mental disorder, the crucial products of any psychotherapy are likely to be hitherto confused, unspoken or literally unspeakable. If the patient is to be helped and his condition remedied, it is essential to carry out a sympathetic *social-psychological analysis*. Otherwise it is impossible to decipher the code of the patient's 'bizarre' speech and behaviour so as to render it a coherent and significant narrative. Freud was wary of applying his techniques to psychosis, but this is the tradition that stems from his ideas.⁸²

Psychiatric ideology

If sense is to be made of the management of mental disorder, it is first of all necessary to cast a critical eye on the presuppositions taken for granted by the professionals. It seems that doctors need to be reminded that it is because *there is no discernible organic cause*, and to differentiate them from those who really do have an organic brain disease, that the majority of their patients are said to suffer from a *functional* mental disorder. Certainly, each psychiatric patient should be given a physical examination - real illnesses do sometimes cause bizarre behaviour and ideation. What about the part played by personal problems in the genesis of mental disorders, however? Few psychiatrists allow them much weight. Instead, they routinely allege that there is an organic cause for every kind of serious mental disorder, and a medical remedy or palliative for all of them. In the meantime, almost the entire research effort is concentrated on discovering an organic cause or new medications. This prejudice is due to an irrational but apparently unshakeable faith in assumptions for which there is no evidence: despite protesting its medical-scientific credentials, it is clear that today's psychiatry is not based in well-founded scientific findings but only in naïve wishes and irrational beliefs.

Psychiatric ideology is encapsulated in the idea of 'the mental illnesses' which, during the 20th century, replaced a motley collection of less specific terms such as 'madness', 'lunacy', 'insanity', 'melancholia' and 'mania'. Those terms were originally employed in a purely descriptive manner: they simply denoted irrationality (or very broad kinds of irrationality) as a kind of possession or pathological obsession and preoccupation. None of the old vocabulary necessarily implied illness, nor did it favour any particular kind of explanation. Intelligent observers without the medical prejudice

82 Freudian theory and psychotherapy are discussed in Chapters 21, 22 and 26 (Volume 2).

have never been oblivious to the role of personal and social processes in the genesis of madness. Any disinterested layperson is well aware that people may be driven mad by events in their lives, and probably most often by extreme anxieties concerning oppressive or fraught relations with significant others. The pathogenic impact of such relations on a character's life and mind is a major theme in drama and literature.

The word 'illness' implies an organic cause; and as soon as someone is handed a mental illness diagnosis, *anything* he does or says is likely to be interpreted as a symptom of the illness from which he is supposed to suffer. Not being scientific, but thinking and declaring that it is, reductionist psychiatry creates a self-fulfilling prophecy: its prejudice makes it view the psychiatric patient as a passive, non-reflective, reactive object - a kind of vessel containing a mysteriously undetectable disease process. Consequently it can never encounter or discover him as an active, thoughtful subject who, just like us, the sane majority, inhabits a world of meaning.

To claim that someone's mind has contracted or developed an illness - a mental illness - is to commit an elementary logical blunder. This misconception of the psychiatric topic and its appropriate treatment is based in a category mistake. For 'mind' is an abstraction with no physical location: it is an attribute of persons that only emerges by way of symbolic interaction. Correctly or incorrectly - depending on the evidence - sickness may be attributed to a body or to a specific organ, e.g., the brain. But logic does not permit us to attribute illness to an abstraction. Just as it is no more than a colourful political metaphor to speak of a 'sick society', so it is only metaphorical to speak of 'a sick mind' or 'mental illness'. Nevertheless, this literalism or concrete way of thinking was by the end of the 19th century firmly entrenched in the psychiatric discourse. By which time, managing the mad had been more or less definitively appropriated by the medical profession, and *the wish* to find an organic determination for every psychopathological condition could be authorised by the doctors' monopoly of the management of the insane.

It is simply not possible to locate mental events in the brain. Mind is the consciousness of meaning. It is convincingly defined by GH Mead as consisting in

...a consciousness of attitude on the part of the individual, over and against the object with which he is about to react... The feeling of readiness to take up a book...is the stuff out of which arises a sense of meaning of the book.⁸³

Mind cannot be explained as a set of 'things' or events bottled up separately in each person's brain - perhaps a bio-electro-chemical process. Intention and meaning do not inhabit some discrete part or parts of the brain; they are attributes of the whole response of the person. More than this, intention is a process of social interaction mediated by shared symbols; it is the way people negotiate their worlds with each other. Marx and Engels point out that what goes on 'in the mind' is inevitably a social production.⁸⁴ Mead clarifies the issue: social interaction proceeds by means of a vast and ceaseless series of gestures. This includes speech, which is internalised by the developing child, such that

...the mechanism of thought, in so far as thought uses symbols which are used in social intercourse, is but an inner conversation.⁸⁵

As we mentioned, the medical profession established its control of the management of madness largely by riding the great success of general medicine which, around the middle of the 19th century, discovered and began to apply the notion that all illness is tissue damage. After millennia of trial-and-error guesswork, this was the first undoubtedly successful application of scientific remedial medicine, and a spectacular one.⁸⁶ Nonetheless, it is simply wishful thinking to believe that *all* forms of mental deviance are 'due to a mental illness' - are due to a mysteriously elusive, yet-to-be-discovered

83 Mead, GH (1922) A behaviourist account of the significant symbol. *The Journal of Philosophy* XIX 160; see also Mead, GH (1934/62) *Mind, Self and Society: From the standpoint of a social behaviourist*. Chicago: Chicago University Press.

84 Marx, K & Engels, F, op. cit. (n. 46, Ch 3).

85 Mead, GH (1913) The social self. *Journal of Philosophy, Psychology, and Scientific Methods* 10 376-377.

86 See Chapter 1, above, in the section: A brief history of the management of madness.

organic cause. This wish only has any credibility because of the kudos of general medicine. Whereas it is sound science to identify sickness in a body or brain, the same cannot be said of a mind: a case may be made for someone's confusion, error, mental aberration or perversity, but not for his 'having a mental illness'. In addition, it is impossible to make much sense of any of the person's ideas and behaviour, whether rational or irrational, except by reference to his biography and social context.

Regardless of this logic, the law encourages psychiatry to subsist as a hermetically sealed system: sufficient only to itself, the pseudo-medical practice and discourse is permitted to gyrate in a closed ideological loop. Because they are a power unto themselves, psychiatrists' discussions only ever employ the false categories of what is touted as a sub-set of scientific medicine. Psychiatry may be said to consist in assistance to individuals who struggle desperately with their autonomy. Were this true, however, it would include listening to patients and taking their lives seriously: cure as help with personal problems, which first of all have to be talked out. Instead, the first object of conventional psychiatry is to contain and domesticate mad behaviour: cure as the alleviation or obliteration of symptoms. In effect, psychiatry's 'scientific medicine' is the alibi for a repressive agenda.

The psychological perspective is radically at odds with the medical. Every now and then an argument based in psychodynamic theory or in research findings which contradict the medical model is hurled against the walls of the psychiatric fortress. But there is nothing to force the professionals to account for themselves, and they simply ignore the argument and dig in deeper behind their false assumptions. It therefore seems clear enough that, in response to everybody's deep-seated fears, one important function of psychiatry is to ratify wishful thinking about madness and despair. As long as psychiatry also fulfils its political role by more or less containing a certain type of troublemaker, and as long as it does not offend any important political constituency, it is largely left to its own devices. After all, somebody has to do the job, and psychiatry *appears* effective. Since they are agents of the social consensus, it is unsurprising that most psychiatrists are happy with an ideology which falsely attributes sickness to discrete vulnerable individuals, and never to social arrangements which facilitate cruelty and exploitation, and hence emotional and psychological trauma. Best not rock the boat by considering interpersonal dynamics: it might reveal neglect, abuse, persecution or confusion perpetrated by supposedly normal citizens.

We do not suggest that psychiatric officials consciously disregard the psychological and social circumstances of mental disorder, and cynically assert a false view of emotional distress and mental disorder. Every psychiatrist is an authorised healer who has undergone years of medical training which, from our perspective, is also a process of indoctrination; and this is why doctors imagine that the causes and cures for all mental disorders *must* be found by means of scientific medicine and not by means of any wishy-washy, speculative chit-chat with patients or the members of their families. If the law requires all psychiatrists to have a full medical training, then surely it is their duty to supply medical treatment. By the same token, research inevitably focuses on discovering medical cures or the physiological, biochemical or genetic differences between those individuals who are supposed to 'have a mental illness' and everybody else who appears 'normal'.

Despite all the certainties paraded by the textbooks, psychiatry has never been able to claim unqualified medical successes. Rather, the history of its technical innovations during the 'scientific' era - psychosurgery, electroshock, coma therapy and the great variety of drugs - is more a series of high hopes followed by disappointments. This may explain why the arbiters of the profession almost invariably adopt a defensive-aggressive posture and are fanatically intolerant of any arguments that raise normative, aesthetic, social, political or (perversely) even psychological questions about the problem of individual irrationality. And yet all human life is emotional and social and expressed in symbols, and everyone's development inextricably interweaves the genetic and the bio-chemical with the social and psychological. Each of us is moved by what we perceive as the *significance* of the situations we encounter, and not necessarily by any physical cause: a person lives and acts in a world of meaning, and it can only be said that he is 'caused' (like any other object) when his body is physically moved or he responds to the workings of the body's autonomic system. Otherwise - and more to the psychological point - mind always intervenes between stimulus and response: whether he

is right or wrong, a person acts in response to how he construes the situation. Having spent so much time and energy chasing the chimera of physical-causal psychology, and utterly failed to establish a scientific basis for the pursuit, it is high time for a change of direction: time to encourage biographical narrative and compassionate interrogation by means of psychotherapy.

Whatever their intentions, it seems to us that the stubborn refusal of the psychiatrists ever to entertain any non-medical arguments has the whiff of totalitarian eugenics rather than the fragrance of genuine therapy. Moreover, by supporting the unrestricted growth of the psycho-pharmaceutical industry - which is nowadays huge, highly profitable and most influential - the medical ideology re-enforces its own rationalisations. Why would the drugs companies not boost the conceit of mental illness and its medical remedy rather than ever admit (or research) the social-psychological reality of the misery and confusion generated by significant problems of living?

Mental health treatment as a modern kind of magic

Psychiatry is only one element in a general movement of secularisation which has progressively removed spiritual authority from religious leaders and delivered it to scientists and technicians - *or to those who persuade themselves and everybody else that they act according to the precepts of science*. So far in this Volume we have demonstrated that psychiatry is far from being conducted in a manner which conforms to the principles of science, with clearly defined hypotheses and adequate tests so as to determine evidence-based practices. If 'magic' is the power of apparently influencing events by using mysterious or supernatural forces, it can surely be argued that mental health provision is largely a matter of magical beliefs and rituals.

Freud recognises that the original of all symbolic systems is language, and that first of all it is a mode of sensual expression. Only later does language succumb to the domination of the reality principle, i.e., become rational and pragmatic. This is not a precise and final achievement, however - a precise match of language to objective reality; our emotions often 'run away with us', to the extent of making us lose sight of what is real. Freud gives this universal fact its psychological expression: since everyone is to an extent neurotic, language begins as play and becomes disease; that is to say, it becomes neurosis, and there is always secret and motivated bias. Hence, when Freud discusses magic and the omnipotence of thought, he sees more to it than simply the *random* or *arbitrary* attribution of a cause, due only to the absence of fully developed science. Rather, there is always a positive commitment to magic based in the omnipotence of wishful thinking; and belief in the omnipotence of thought is characteristic of the narcissistic phase of infantile development: *magic is neurotic play*. Adults in pre-modern communities may preserve a high degree of that narcissistic orientation, but modern people should not kid themselves that they do not also have a strong tendency to revert to narcissism whenever their emotions are aroused.⁸⁷ With magic, only the talismans, terminology and forms of the rituals change across time and space, depending on differences in physical, technical and social environments.

That being so, for anyone subjected to its ceremonies - known as medical routines and techniques - the problem of psychiatry and the entire mental health system is that of the institutionalisation of a contemporary neurotic belief. They should know better about the limits of their expertise, yet doctors continue to act as the agents of a misguided social consensus. Not so long ago, the neurotic solution to any apparently intractable personal problem was an appeal to God, mediated by a priest. The spectacular technical successes ostensibly delivered by the rise of scientific medicine have in the meantime marginalised religion as the first resort for problems with the soul. For most practical purposes, technicians, experts and state officials have taken over from priests, and the only certainties in a desacralised world are those supposedly confirmed by Science: nowadays, most people believe in the wizardry of science and technology. The urge to medicalise every problematic personal or interpersonal dynamic is predicated on the neurotic belief that the truth about the matter, and its efficient

⁸⁷ Freud, S (1913/38) Totem and Taboo. *The Basic Writings of Sigmund Freud* (Ed Brill, AA) New York: The Modern Library. Also see Brown, NO (1959) *Life Against Death: The psychoanalytic meaning of history*. Middletown: Wesleyan University Press, 71-72.

management, can only possibly issue from scientific work on individual brains, rationally explained in terms of predictable quantities of material causes and effects. Accordingly, since mental health technicians lack any adequately theorised, proven or useful understanding of the relations between brain processes and psychological states, medicalised care and treatment is only magical thinking dressed up in the latest apparently scientific fashion.

Certainly, psychiatry appears eminently reasonable and benign compared to the old dispensation, which was carried on by means of restraint, torture and terror, by proto-medical guesswork, or under the auspices of religious faith. Under the old regime, the mad were often considered little better than Godless animals. This permitted them to be chained-up in filthy dungeons, subjected to exorcism, cut and bled, have holes drilled in their heads to let out vapours and demons, subjected to ducking or freezing baths, swung round in centrifuges, and so forth. The more discrete methods of drugging and electroshock have replaced routine physical restraint and the instruments of deliberate punishment or torture. Concurrently, 'possession by demons' has only been displaced in psychiatry (and in the public imagination) by a fantasy of possession by 'bad genes' and 'chemical imbalances' which, with just a bit more research, will at last be discovered and forced to submit to precise medical remedies.

Any crisis in which a person succumbs to a mental disorder is likely to provoke anxiety and an emotional reaction amongst family and friends. Everyone wishes for a quick fix, and anxiety and ignorance conspire to encourage the social response to take the form of magical rituals. The routinised liturgy of psychiatric interrogation has replaced the old religious rituals of exorcism which depended on theologies replete with precise details of Godhead and spirituality, the soul and its travails, and questions such as how many angels are able to dance on a pinhead. Now we have secular and apparently scientific categories of the brain, a multitude of esoterically named parts, neurochemistry, brain-electrics, references to genetics, to polysyllabically-named medications, and so on. Even so, no-one really knows how brain-chemistry, brain-electrics or genes correlate with ways of thinking, whether apparently normal or by consensus abnormal. Nor is it certain that the medical techniques are beneficial to the patients. All the jargonised diagnostic labels, the bio-chemical-genetic 'theories', and all the potions and techniques only amount to a pseudo-science consisting of a mumbo-jumbo of modernistic formulae chanted in up-to-date ceremonies, i.e., the normal routines and techniques used to process and persuade mental health patients that they are certainly ill, and that some or other psychiatric technique will definitely help them get better. The psychiatrist is a modern high priest who administers medical-looking sacraments of drugs, electricity and surgery; he is identified by specialised vestments and demeanour - the business suit, his calm assurance, his allegedly detached, objective, scientific-medical attitude. By medication and electricity (and occasionally surgery or electrode implants), this modern priesthood attempts to perform magic once tried by holy water and the laying on of hands. Instead of driving out demons by holy presence and incantation, drugs are now administered so as to inject the correct, 'scientifically calculated' dose of 'good medicine' as an antidote to whatever is supposed to be 'bad' in the brain (the chemical imbalance, the faulty gene), or the mental illness is supposed to be blasted out by electricity, or cut-or burned-out by leucotomy.

Meanwhile, as we saw in Chapters 6 and 7, all this dosing, blasting and cutting is so much guesswork and hokum, quite as magical to everybody concerned - doctors, patients and relatives - as any holy relics and rituals. This explains the powerful placebo effect, well-attested for both inactive pills and switched-off ECT machines (see Chapter 8, above).

In an authentic science of the psyche, rather than a magically conceived one, some of the responsibility for responding to worrying emotional distress and mental disorder would devolve on the person and those around him. As it is, though, a general neurosis is always with us - and we call it 'normality'. The widespread desire for salvation is rooted in deep-seated anxieties. Whereas the Church used to answer to all forms of otherwise incomprehensible personal malaise, mental health officials now serve to articulate an ideology of scientific and technical remedy which at first supplemented and has by now largely replaced religious faith. Medicine promises to fulfil the

widespread wish for a separated, quick and relatively painless technical fix for any and all of life's personal problems.

But this is a promise our medicine can never fulfil since

[s]cience in the service of capital, the commodity and the spectacle is capitalised knowledge, a fetishism of idea and method, an alienated image of reasonable thought. Pseudo-greatness of Man, its passive knowledge of a mediocre reality is the magical justification of a race of slaves [or neurotics]. Like religion in the Middle Ages, science compensates people's daily stupidity with its eternal specialist intelligence. It sings in numerals of the grandeur of the human race, but is only the organised sum of man's limitations and alienations.

Mercenary of separate thought, science works for [neurotic] survival and so it cannot conceive of life except as a mechanical or moral formula. It does not conceive of man as subject, nor thought as action, and for this reason it is ignorant of history as deliberate activity and it makes people 'patient(s)' in its hospitals.

Founded on the essential deceptiveness of its function, science can do nothing but lie to itself. And its pretentious mercenaries have preserved from their ancestor priests the taste and necessity for mystery. A dynamic element in the justification of the State, the scientific profession guards its laws and secrets with interminable research and jargon, of which the illegible handwriting of the doctors - those repairmen of labour power - is only the most mundane sign.⁸⁸

Specifically, regarding this particular diagnosis, as David Cooper points out,

[s]chizophrenia has no existence but that of an exploitable fiction.⁸⁹

As yet there is little indication that psychiatry is soon likely to become more rational, or that management of mental disorder is about to be wrested from the hands of the medical profession. Most of us *want* a doctor to deal with those kinds of problems. Change is unlikely so long as most of us would rather rely on *someone else* to solve every personal problem - some expert, some official.

Could psychiatry change?

Before any radically different sort of psychiatry could take root, it would have to overcome problems of public perception, of the current medical monopoly, and of the great imbalance in power between the individuals in crisis and those organised to manage them. The universal belief in the medical model is founded in neurotic fears, and any irrational idea that rationalises a neurosis is defended with fierce energy: the deeper the anxiety, the greater the resistance - the neurosis is expressed in the institutional inertia of normal everyday routines. There is a history of victimising heretics to psychiatric orthodoxy. Colleagues might simply become unpleasant and uncooperative, but more powerful professionals tend to defend the status quo unscrupulously - dissidents who speak out risk reputation, career and livelihood.

In direct proportion to its uncertainty (which it won't admit), mainstream psychiatry is firmly committed to a self-image of its fully adequate expertise. Otherwise the psychiatric official would have to admit to having little more to offer than just another opinion - and what would that do for the doctor's ego, status, power, privilege and salary? Naturally, the psychiatric profession insists on its members' medical-scientific standing, and that they alone are able to act with proper objectivity. Yet to the degree that they believe in their own myth of technical efficiency, to that extent the professionals act in a hopelessly biased manner and fail to engage with the essence of any psychiatric problem - the psychological and social realities of the patient. Added to which, as David Cooper points out, under these conditions a psychiatric patient is *always* faced with having to make one of three equally impossible responses to the power that holds him and can do with him whatever it wishes: If he expresses socially unacceptable truths he will be 'destroyed by all the techniques

88 Rothe, R (1969) Science under capitalism. *The International Situationist 12*.

89 Cooper, D (Ed) (1967) *Psychiatry and Anti-Psychiatry*. London: Paladin, 149.

available' for doing so; if he lies he colludes with psychiatry and society, betrays his own experience and sense of reality, and remains in conflict and distress; if he remains silent he will be called catatonic and paranoid and 'be forced to chatter acceptable nonsense'.⁹⁰

Whereas orthodox psychiatrists seem to imagine that they practice a kind of 'hard' science, Jenner and his colleagues show that what they actually do is act out a parody of Newtonian physics. The professionals are desperate for measurable, determinate causes so as to deliver a predictive technique for definitively modifying the behaviour of aberrant persons. And yet some modern sciences - such as quantum physics - are happy to settle for probabilities since only that is possible. This happens to accord with everyday experience: when we negotiate normal psychological and social events, and when we think about them reasonably, we are all happy enough to estimate *probable* motives, developments and futures. Of course, the outcome of most social interaction is not usually as unpredictable as that generated by a situation in which one party is unable to control the signs of his high emotion and mental turmoil. Uncertainty and hazard increases everybody's anxiety and fuels the desire for certainty, that is, for an expert to step in with an apparently painless solution.

Jenner suggests that psychotherapy is the best treatment for anyone diagnosed with schizophrenia, and that doctor and patient should 'exchange world-views'. This seems to propose a kind of one-to-one tutorial, with the topic: human existence. The patient is 'an active agent of his own history and destiny... Discussions should be opened up with [him] about his personal responsibility vis-à-vis his past and present misery and the making of his future.' Moreover, '...his own choices, decisions, projections and value judgements have an effect on his career as a mentally abnormal person.' Therapy as re-education.

This is a good idea, but unfortunately the conventional wisdom and the nature of the problem - psychotic detachment from reality - conspire to undermine this ideal. Leaving aside for the moment the problem of psychosis precluding communication, medical power is absolute and the medical model is dominant, and so, even were it possible, any kind of therapy-as-education would be likely to degenerate rapidly into behaviourist conditioning (coercion) or temporary faith-healing due to the persuasive magic of the apparently authoritative medicine-man. The idea of therapy as education poses two major questions which urgently need addressing: psychotherapy is stifled by the medical monopoly of the management of individual irrationality, and psychiatrists can legally compel a person to submit to management and treatment.

Supposing the power of the doctors were one day successfully contested, at last the truth of any psychopathological event might reasonably be triangulated by juxtaposing a full variety of witnesses' accounts, theories, investigations and interpretations. This process would probably disclose a host of different and often opposing conceptions and meanings attributed by the various parties and witnesses to the crisis, and of course any achieved truth would always be provisional. In the medical model, however, the psychiatric patient is not respected as a fellow human - an equal who happens to be extremely troubled - so much as simply another case of one or other kind of mental illness; consequently, and as a matter of course, any point of view he may try to articulate is not normally deemed relevant, except perhaps as a sign of his illness or recovery (reinstated conformity). From the psychotherapeutic standpoint, however, the psychiatric patient must be fully included in conversations about the nature of the crisis and possibilities for its resolution, and whatever he feels should be taken seriously. Even a speechless or catatonic huddle of a person signifies a certain attitude towards the world, and a commentary on it. Anyhow, most patients do communicate, and by no means always unreasonably. It is scandalous that the pseudo-medical practices of psychiatry cavalierly disregard all those intentions of the patient which do not immediately accord with the officials' own wishes - that whatever the patient feels or says is so easily discounted as irrelevant nonsense, merely another symptom of the illness.

The medical model reads no intentions in mental disorders, and officials tend to be perpetually surprised that patients do not always express themselves with cool and clear rationality. This seems to

90 Cooper, D, op. cit. (n. 89), 148-149.

miss the point of the psychiatric intervention: it was because the individual had become irrational. Orthodox psychiatry maintains that if the patient says something which seems bizarre or is uncomfortable or undesirable to the officials, it must be nonsense, simply a meaningless symptom of the illness. All the same, this is not a proposition which is ever argued, and it seems most likely to Jenner et al that a patient's problematic behaviour and beliefs signify something important to him. They observe that communication is fundamental to human being, and that meaning always inheres in what anyone says and does. Rather than assume that a patient's aberrant behaviour is intrinsically senseless, there is good reason to believe precisely the opposite: that *everything in which psychiatry should take an interest is signified by the symptoms of the disorder*. A person ends up in psychiatric care due to the signs of his overwhelming distress, and taking those signs seriously, assuming that they are significant, is exactly the starting-point for psychotherapy.

Let us suppose that psychiatric officials could be urged to recognise psychotic behaviour as a kind of communication, and to believe that it is often possible to engage patients in dialogue. The next problem is the absolute differences of power and anxiety between the two parties to the encounter. As it stands, once he has been referred and unless he can escape, the patient *must* submit to the demands of psychiatry if he is to regain his freedom, and with as little pain or discomfort as possible. It is possible that the patient finds he is managed by a sympathetic psychiatrist and other officials willing and able to tolerate and encourage free dialogue. The present system, however, based as it is in the medical model, does not routinely encourage this happy circumstance. Rather, medical authority is so entrenched and unaccountable that it only encourages a monologue of power in which any patient might be best advised to engage in damage limitation by appearing to submit passively to any official demand. In Chapter 4 (above), we saw that this occurs even though psychiatry may *pose* as a dialogue and even *imagines itself* as such.

Just as great an obstacle to successful psychotherapy is psychosis itself. A person is subjected to psychiatric management precisely because it seems that, due to his irrationality, he cannot be left to run his own life. Jenner does not explain how someone manages to make the journey from psychotic unreason back to responsible self-activity - including the ability to conduct himself reasonably in conversations about his life. What is proposed sounds entirely voluntaristic: it reads as if the atomised individual - the psychiatric patient, the person who has collapsed under the pressures of running his life - ought to take sole responsibility for his own misery. Whereas the hypothesis of social psychiatry is that psychological trauma leaves the individual so distressed and confused that he is incapacitated, it is not clear from Jenner's text that the patient is not held fully responsible for his activity or inactivity. In addition, a diagnosed schizophrenic is supposed to be extremely sensitive, fraught and cognitively disturbed, and it is not clear how he may work himself into a position where he is able to take back his life into his own hands. Surely it is not what is intended, yet at this point the authors' ideas sound uncomfortably close to those of the Pull-Your-Socks-Up Brigade.

There are other niggling loose ends. Rather than refer simply to 'mental disorders', and since it denotes an incapacity that is in some respects *like* an illness, the authors seem to accept at face value the notion of mental illness. Yet using the term 'illness', without qualification or comment, gives too much ground to the all-powerful medical establishment, and it is confusing.

Again, these authors seem to suggest that psychopathology is a failed response to the immutable and inevitable condition of human existence: to be born is to live under alienation, to be human is to suffer existential angst, and some unfortunate people buckle under the strain. There is not much we can do about 'the human condition', however - we can hardly refuse it, except by suicide. The question is: why do some people succumb to mental disorder and others not? Each of us may at times experience a nebulous kind of existential doubt, but the more unfortunate amongst us are faced with urgent practical and psychological problems triggered by a relentless struggle with very onerous circumstances. Although there are well-known differentials in the social distribution of the types and incidence of mental disorder, the authors do not discuss social aetiology.

The authors' generalised, 'existential' gloss also risks romanticising the problem of the psychiatric patient's loss of autonomy. They recognise that madness sometimes exhibits a certain

interesting intellectual originality, and the first chapter of their book likens psychosis to artistic sensibility. Be that as it may, even if it is couched in mystery, metaphor or metaphysics, mad expression is always anguished and tragic: it is anxiety, raw and exposed. The borderline between 'bizarre' and 'pathological' is generally clear enough: serious emotional distress and mental disorder appears definitely as 'lost' expression, the speech and behaviour of those who are lost, and who have definitely 'lost it'. This is why the person is consigned to psychiatric care rather than directed to a patron of the arts.

Just the same, the analogy is interesting since it suggests an entry into interpreting the bizarre speech and behaviour of psychosis. The meaning of an event is considered irrelevant to any expert who considers himself medical, scientific and objective: conventional psychiatry imagines that it works only with scientific information, only with quantities of material causes and effects. But whereas a scientist or a reporter delivers factual information, the artist does not so much inform as enlighten and inspire. Jenner suggests that doing psychotherapy is 'like interpreting a poem'. It is subjective and psychological components which determine the hierarchies of significance and value that concern any psychiatric patient. At the moment, the doctors try to understand and manage mental disorder by applying to the patient's body and behaviour inappropriate causal and quantitative categories, techniques and procedures; and when they imagine that they practice medical science, this only compounds the patient's problems because everything subjective and psychological is dismissed out of hand. Consequently, in the very attempt to assist or cure the patient, this faux medical science only further oppresses and alienates him. To cap it all, medical psychiatry often introduces new problems in the shape of harmful somatic and psychological treatment effects.

In previous chapters we have seen that the apparently scientific procedures of psychiatry *may* help some patients to adjust to their circumstances, but only by overloading their bodies with toxins or substituting one unreasonable belief for another.⁹¹ There is sometimes benefit from the more informal psychiatric processes of asylum, retreat and the common decencies of those staff who help to create a caring environment. Consequently, the first and easiest reform of psychiatry would be to increase those best features and reduce the amount of coercion and intimidation.

There remains the problem of communicating with someone in the throes of a psychotic crisis. Psychosis is by definition loss of reason, and it is not usually suddenly and miraculously amenable to cold reason. Genuine psychotherapy achieves communication because it is grounded in trust; in turn, this is only established through the patient's experience of non-judgemental care. When a patient distrusts his therapist - and he may be wise to do so, considering the realities of psychiatric power - he remains anxious and committed to his psychotic defences, thereby making reasonable dialogue impossible.

Some sequences in a documentary about RD Laing were filmed in 1972, when he was at the height of his fame. We see him on a North American speaking tour, addressing a packed lecture theatre. Afterwards some fellow psychiatrists express their scepticism, and they take him to see a patient who they say has been catatonic ever since taken into care. A door is opened, and in the gloom, huddled on the floor in the opposite corner of the cell, we see a dishevelled young woman. What would the great Dr Laing suggest? Laing enters the cell, crouches down next to the woman, and begins to talk to her. He speaks softly - we cannot make out what he says - but within minutes the patient begins to respond.⁹² This demonstrates that it is possible to persuade a very psychotic person to venture out of her private universe. Clearly, it did not take much for Laing to persuade this particular patient that she was welcome in the world of those normal people (the neurotics) who are prepared to give and take as they try to engage in a reasonable dialogue about the problems which seem to confront them.

What should be the content of the therapeutic encounter? Jenner and his colleagues seem to favour a kind of philosophy tutorial, discussing a sort of muscular existentialism. Well, perhaps. But there is a century-long tradition of therapeutic dialogue: psychoanalysis. In analysis, the patient is

91 See Chapters 5 to 8, above.

92 Tougas, K & Shandel, T (1989) *Did You Used to be RD Laing?* London: Third Mind Productions.

encouraged to utter whatever ‘comes to mind’. What he says is then subjected to scrutiny, focussing on perceived areas of conflict in the patient’s psychological and personal life; and unless he comprehends and faces up to those conflicts, as soon as he leaves the consultation he cannot but sink back into his psychopathology. Rather than a general kind of philosophising about life, this is therapy as the expression and exegesis of a particular biography and psychodynamic. As for universal existential fears, in the analytic perspective these are like any other anxiety: symptoms of underlying personal developmental trauma, of conflicts and insecurities which the patient needs to understand and overcome before he can hope to feel and get better..⁹³

4: Conclusion: social psychology and therapeutic interpretation

Democracy don’t rule the world, you’d better get that in your head,
This world is ruled by violence, but I guess that’s best left unsaid...

Bob Dylan⁹⁴

Psychotherapy

There is no doubt that someone who becomes psychotic is made vulnerable by demoralisation and the radical disorder of his perceptions and beliefs. And yet there were always some psychiatrists who maintained that if there is a condition we could usefully call schizophrenia, it is not inevitably permanent and hopeless..⁹⁵ Sympathetic therapists have found that if his trust can be gained it is usually possible to engage a diagnosed psychotic in helpful conversation.

How should the parties to that encounter deal with the material it produces? Does the patient’s re-entry into the community of the sane consist in the reasonable dialogue itself, perhaps along with other signs of recuperation? Is therapeutic success assured by the patient recovering his self-esteem and the ability to act with responsible autonomy? Or is something else required? Jenner’s book does not address these questions. Case histories might have shed light on them.

Psychotherapy surely has to aim at generating reasonable feelings of personal integrity and self-esteem. There is more to it than that, though. Jenner talks of *interpreting* the material which emerges in the dialogue. Besides, any movement from psychosis to sanity must surely consist in a shift from incapacity and incoherence towards coherence and competence. Jenner talks about an ‘exchange of worldviews’. This is rather a bald proposal. It is not clear that he means that information about the reason for the psychosis emerges during therapy - perhaps evidence of an emotional trauma that drives the development of the psychopathology. Or that information is elicited which is necessary for constructing a new and less confusing and troubling picture of the patient’s past and present identity, and of his place and prospects in the world. As for ‘interpretation’, surely this can only proceed in terms of a coherent theory of the genesis of the particular mental disorder and recovery from it?

Instead of medical therapy, Jenner and his colleagues seem to offer two different ideas about ‘talking therapy’. First, they seem to hold a sort of muscular existentialist-philosophical view: to exist is to suffer emotional pain and mental torments, and we must all be persuaded to accept that fact. Then they suggest a kind of developmental social-psychological or psychoanalytic approach: that delusions, hallucinations and thought and speech disorders demand sympathetic interpretation with respect to ‘the context of the patient’s life history’. In either case, they offer no therapeutic rules or procedures.

93 Freud views the therapeutic session as a place where rational discourse is focussed on exposing irrationality. In his opinion, it is only possible to carry out analysis with a willing and fairly reasonable neurotic, and never with a deluded psychotic. This important point is addressed in Chapters 25, 26 and 27 (Volume 2), below.

94 Dylan, B (1983) *Sundown on the Union*. *Infidels*. New York: Columbia.

95 One of the first to publish dissenting evidence and argument was Sullivan. See Sullivan, HS (1924/35) *Schizophrenia as a Human Process*. New York: Norton.

It would be most helpful to go with the second idea, which seems to agree with the normal analytic-therapeutic approach: that the real science of the person begins with encouraging the subject to express himself freely, followed by sympathetic but sceptical interrogation of what he says and does, especially his accounts and motives. However, the century-long pursuit of social-psychological, interpretative analysis was long ago pushed to the margins of official mental health therapy by the dominant medical model.⁹⁶ Unfortunately, Jenner et al barely mention the rich Freudian tradition.

Still, if orthodox psychiatry claims there is a material cause for mental illness (a brain deficit), and asserts its so-said detachment and objectivity, these authors do appear to stand fairly close to the polar opposite of subjective engagement in practical philosophy, biography, history, sociology and psychological analysis. The interpretative approach brings its own problems, of course - issues of subjective bias, motivated censorship, conflicting interpretations. All the same, the impossibility of discovering material evidence for any particular psychological state means that those who yearn for the certainties of the natural sciences will be forever disappointed. Personal life is a matter of too many secrets and unknowns, intangibles and possibilities; better to settle for a provisional hypothesis. Most psychiatrists refuse to entertain legitimate arguments from any other perspective than the medical model, and at the same time they refuse to reflect critically on their own practice and theory. This is far from the systematic doubt of genuine science: it is the sign of an ideology whose proponents dare not face up to reasonable questions for fear of what they might find. At least the social-psychological perspective anticipates problems of interpretation.

Why would the irrational beliefs of a psychotic take the particular bizarre form that they do, rather than any other? Jenner writes that ‘the core [mental] constructs’ are ‘almost randomly sought and maintained [by the schizophrenic patient]’.⁹⁷ However, this simply reiterates a major diagnostic criterion: along with being a nuisance or potentially a danger, a person is taken into psychiatric care precisely because significant elements in his construction of reality or ‘world-view’ are apparently random, i.e., bizarre. But the interpretative attitude has the therapist attend imaginatively to what the patient says and does. Psychotherapy begins with the hypothesis that, although on the face of it they may seem utterly random, a psychotic person’s ‘core constructs’ are vital elements in a system of psychological defence that is not necessarily incomprehensible, either in principle or in practice; it assumes that however confused or strange the psychotic ideas may at first appear, it should be possible to discover a certain logic to the person’s beliefs and behaviour. The task of interpretation is precisely to discover the method in the madness, the latent order within the manifest disorder of the patient’s ideas and actions. Nonetheless, any attempt to discern underlying reasons for a mental disorder cannot proceed without at least a provisional notion of how mental states tend to correspond to the contexts in which they develop: no interpretation can proceed without reference to some sort of explanatory scheme which proposes a coherent articulation of the psyche to its environment, which is to say, *the person’s relations with others*.

There is a long tradition of interpretative sociology and social psychology that operates from the first assumption or working hypothesis that when thought is demonstrably out of kilter, it is the product of a covert material interest. This view was formulated by Karl Marx;⁹⁸ following Freud, the first hypothesis would be that a mental disorder is a psychological accommodation to a traumatic

⁹⁶ It often surprises people that it is not NHS psychiatric policy to provide psychological therapy. In fact, it has only recently been offered, in a limited manner, by the primary mental health service, i.e., to patients who are not very seriously disturbed. Moreover, cognitive behavioural therapy (CBT) is the favoured method, a type of ‘talking therapy’ which forbids social or psychological analysis. See *Improving Access to Psychological Therapies (IAPT)*, op. cit. (n. 80, Ch 1). We describe CBT, and offer evidence and arguments for and against it, in the text to footnotes 35 to 42 in Chapter 27, and to footnotes 9 and 10 in Chapter 28 (Volume 2).

⁹⁷ Jenner, FA et al, op. cit. (n. 3), 138.

⁹⁸ See Marx, K & Engels, F, op. cit. (n. 46, Ch 3).

event during the subject's personal development.⁹⁹ A good first bet is that the confused 'core constructs' of any particular mental disorder articulate the person's desperate attempts to make sense of those confusing, threatening or exploitative social arrangements in which he finds himself trapped.

Nobody can avoid the vicissitudes of fate - pain, frustration, terror, insignificance and, finally, death. Existence confronts us all with terrors and angst. In principle, on the other hand, much can be done about a person inhabiting a particular psychopathogenic social space: that is why there is a welfare system, in which psychiatry is supposed to play its part. However, until they might be rescued, some individuals are compelled to inhabit a milieu in which they are subjected to burdens of stress, terror, conflict, exploitation, cruelty and confusion - sometimes relentlessly, unremittingly and without many compensating rewards. This is reflected in marked social differentials in the chances for a mental illness diagnosis: the risk skews significantly towards the poor, ethnic minorities and women, i.e., the social distribution of diagnosed mental disorder correlates inversely to the distribution of wealth, privilege and power. It is therefore not fanciful to suggest that any particular person's distressing emotional or mental condition might be traced to its origin in specific pernicious relations of power and dependency. As participants in wealth, privilege and power, this is not a perspective which many psychiatrists are readily able to conceive or acknowledge.

Contrary to the medical model, a psychodynamic interpretation makes sense of psychotic speech and behaviour: it is coded reference to the distressing and confusing world which the patient inhabits. How is the elective psychiatric patient to utter the truth of his experience rationally and explicitly if to do so is to risk losing that little love and affirmation he wishes for - risks denial or actual abuse? How is he to speak coherently about his experience if he is confused by what has gone on around him, or has been done to him, perhaps since infancy, ever since he became conscious of anything at all? Jenner quotes heroic humanist literati in support of the idea that we must accept the chaos that is life. However, it is one thing to have an intellectual appreciation of the problems of freedom, choice and loneliness while having enjoyed a secure and supportive upbringing and material security, and quite another for someone to have to face a life bereft of opportunities or hope when he is overwhelmed, confused and paralysed by preoccupations brought on by anxieties rooted in psychological trauma.

A child is not expected to take full responsibility for his own life. Perhaps at the root of any schizophrenic breakdown is the arrival in a disturbed young person's life of an inescapable demand to make a choice, to act as a responsible adult; perhaps the psychosis develops when he approaches a threshold, and is expected to make an important decision. This could explain why schizophrenia typically onsets in late adolescence or early adulthood. If an individual had an emotionally traumatic upbringing, he would be likely to suffer from insecurity, self-doubt and confusion; since he might be overwhelmed by fears which he is unable to announce coherently, even to himself, he would be rendered incapable of making significant choices. His anxiety and confusion would feed on each other, and he might then build psychic defences against the accumulating anxiety and mental turmoil: 'bizarre mental constructs'; and those misconstructions of reality would manifest to the community at large as delusions, hallucinations and speech and thought disorders. Essentially, the truth of the young person's life would be so distressing that it is impossible for him to think or talk about it in a fully rational or coherent manner; often it might be so awful that it is only possible for him to survive by pushing it from consciousness, by denying reality, by retreating into fantasy. Of course, this is in conflict with the imperative to engage with reality, so his anxiety would increase, and he would be likely to retreat further from reality and deeper into fantasy.

Psychotherapy cannot hope to solve the conundrum of a patient's incapacitating distress and confusion unless it addresses particular biographical issues; it explores the connections between the individual's pathological beliefs and behaviour and his anxieties and actual problems. Any therapeutic interrogation must therefore be a subtle and sympathetic process in which the patient is not made to feel threatened. Probably for want of space, Jenner rushes the discussion of this issue.

⁹⁹ See almost any of the items in *The Complete Psychological Works of Sigmund Freud: Standard Edition*. (1953-74) Strachey, J, et al (Trans and ed) London: Hogarth Press. We discuss Freud's ideas in Chapters 21 and 22 (Volume 2).

Unlike the rational beliefs of the consensus, schizophrenic 'mental constructs' are not the deliberate products of the person's will. A web of delusions may be the result of conscious activity - and most often obsessive private ruminations - but its manifest and bizarre deformations point to their origins in fantasy and denial. It is therefore not possible to make any sense of a delusional system without reference to what the patient does *not* say, what he seems to *repress from awareness*. This may only be discovered by coaxing the patient to reveal himself, by interpretative activity, and by some kind of investigation of the circumstances of the patient's life. Analysis discloses the secret conflicts that determine the confusions in consciousness. The implicit is made explicit: interpretation explicates the 'almost random' constructs, and offers their synthesis as a significant pattern. Nor is it the case that bizarre schizophrenic ideas or behaviour 'seem' essential to the person in crisis. Rather, we must work from the hypothesis that the particular forms taken by the bizarre thoughts and behaviours constitute the components of a stance - albeit fantastic - which has a certain internal consistency which gives comfort to the patient, even if everybody else views him as nothing but a locus of crisis, chaos and delusion.

Actually, delusion is not so very uncommon; it is only noteworthy when it governs a person's life and separates him from his competent autonomy. Any neurotic or psychotic strategy begins as a form of psychological defence and reassurance; however, since it separates the individual from a realistic appreciation of significant aspects of his world, it also incapacitates him. Neurosis or psychosis is a kind of addiction which provides only fragile relief: the addict feels less anxious when made insensible by his drug, but at the same time his real problems are likely to increase.

In the psychoanalytic perspective, whatever appears bizarre or random in someone's ideas or behaviour is a rationalisation which, at the same time, cannot help being a coded expression of the real concerns which he is unable to express due to overwhelming anxiety and confusion. Whether it lasts a matter of hours, days, weeks or decades, a psychotic episode is the manifestation of a conflict between the suppression and realisation of a dreadful truth; this is bound to refer not only to the self but also to significant others on whom the person depends. The emotional crisis translates into misery, confusion and psychotic preoccupation - and from there into personal dysfunction and danger or intolerable social nuisance.

In any case, the psychotic is not empty of reason. Analogous to Whorf's gasoline barrels, he overflows with a repressed truth and urgent reasons which can find their expression only in a burst of strange, coded constructions. The schizophrenic is only able to communicate elliptically: for fear of whatever great anxieties and confusions drive him beyond his wit's end, he is unable to announce rationally his truth and his reasons. (In this perspective, catatonia is demoralisation so complete as to result in an absolute retreat from communication.)

Interpreting deranged symptoms as a response to deranging circumstances

Whether or not it seems strange or mad, behaviour is always intentional. We have to assume that the psychotic clings tenaciously to his bizarre worldview because it affords him some kind of peace of mind. At the same time, it seems to Freud that however much we may try to hide it, we cannot avoid giving clues about what troubles us. Hence, to an intelligent observer, the confusion in what the neurotic or psychotic patient says and does is perhaps unwittingly revealing: his bizarre constructions and irrational behaviours are coded references to the anxieties which overwhelm his rationality. In which case, interpretation can only proceed by careful attention to *whatever* the patient says and does. The question is: why that (pathological) worldview rather than another? Interpretation begins by remarking the specific choices in what the patient says and does, and by noting how they might bear upon what is otherwise known about his life.

A functional mental disorder is defined precisely by the absence of any discernible organic disease: in spite of the orthodox dogma, there is no real disease which *causes* the symptoms of the disorder. The patient may be wrong, wrong-headed, a danger or a nuisance, but he does not have a mental *illness*. It follows that the cognitive and behavioural symptoms of a mental disorder should not be neglected as only the random, irrelevant and uninteresting epiphenomena of an actual disease.

On the contrary, *the psychosis is the sum of its symptoms, and the bizarre behaviour and beliefs are signs of the patient's anxieties.*

The intimate and wider social groups within which each of us develops are simultaneously more or less nurturing and more or less oppressive. A person may grow up less provided with unconditional love and a sense of security, and more terrorised and confused, than can be easily sustained. Psychological trauma may be caused by unforeseen accidents, yet personality is primarily formed *and deformed* within the family. In any family, power is privately wielded over the weak, the less able and the uncomprehending; and if a child is terrorised or abused, it is likely that he will suffer deleterious emotional and mental consequences. Whereas biography is irrelevant to the psychiatric medical model, in the psychotherapeutic perspective it provides essential information about the way the patient connects to his world: a person's construction of reality is bound to be conditioned by his experiences. It is clear that unless he is able to situate him by means of sufficient biographical information, a therapist could hardly begin to comprehend any patient's 'symptoms', or his bizarre 'worldview', or likely reasons for the development of his mental disorder.

It seemed to Freud that any mental disorder is an attempt to accommodate a particular set of repressed fears. However, the privileged and complaisant professionals who wield power within the psychiatric system refuse to acknowledge that exploitative relationships of power and dependency have any bearing on the genesis of mental disorder; they refuse to contemplate the insecurity, terror, violence and general misery and anxiety experienced by significant numbers of the least powerful and most disadvantaged members of society; they will not admit that the deprived and the exploited are more likely to succumb to their experiences of physical, emotional and mental duress; and they will not allow that those individuals are made to become victims twice over when they are stigmatised as mentally ill, and inappropriately administered drugs, shock treatment and behavioural psychology.

It is difficult to comprehend the full extent of the vulnerability of the dependent child. In the USA in the early 1960s, a group of sociologists carried out an unobtrusive study of the lives of a sample of normal suburban children in their natural settings. The research interest was the extent to which children's lives are influenced or determined by adults or older children. Including admonishments and gentle and stern advice, harsh demands, screamed threats, physical compulsion and various degrees of violence, the *average* number of controlling incidents for a five-year-old child was more than 700 per day - the equivalent of one every minute of his waking life.¹⁰⁰ Meanwhile, the UK's Children's Act (2004) permits parents to defend themselves against prosecution for assaulting their own children by pleading 'reasonable chastisement' in the form of 'mild smacking'; fewer than fifty Labour MPs voted against this formula. A few years before, a Gallup Poll found that 80% of British adults recommended violence (smacking) as 'discipline' for their children. This belief gives licence to all manner of physical assaults on children. In 1998 a Children's Help phone-line was set up and publicised in an English city of half a million people. In the first week there were 20,000 calls, representing at least 20% of the target child population. Supposing half the calls were frivolous, that is still a sizeable number of aggrieved children who do not feel that they can discuss their fears with any adult they know.¹⁰¹

Domestic privacy hides from public view the most intimate, pervasive and formative social interactions. Who can tell the full breadth and depth of the persecution and exploitation, the cruelty and abuse suffered by the vulnerable, and especially children? Emotional and mental cruelty, and even physical and sexual abuse, is often justified by perpetrators as love or righteous discipline. Abuse is carried out at the whim of a frustrated perpetrator - a more powerful neurotic, a closet psychotic, a sexual pervert or an incipient psychopath. Awareness of the routine, everyday impact of

100 Schoggen, P (1963) Environmental forces in the everyday lives of children. In Barker, RG (Ed) *The Stream of Behavior: Explorations of its structure and content*. New York: Appleton-Century-Crofts, 42-69.

101 See *Childline: 30 years of listening to children* (2016) London: NSPCC; polls and studies concerning the extent of child abuse and widespread adult approval of smacking as a normal form of 'discipline' are discussed in the section: The conditions for the development of mental abnormality, in Chapter 23 (Volume 2), below.

'normal' neurotic and perverted irrationality ought to be at the heart of psychiatric theory, and yet it is not anything which the psychiatrists wish to acknowledge, let alone integrate into their theory.

Freud's initial psychopathological hypothesis attributed the cause of repression and consequent neurosis to sexual abuse during childhood. He quickly dropped the idea when it was greeted with outrage by his fellow professionals. Instead, he worked-up a theory of the inevitable repression of any child's appetites and wishes, and the psychological conflicts this causes as he grows up having to come to terms with the demands of society. In other words, Freud changed the emphasis of his theory from the identification of a particular trauma at the hands of a specific perpetrator, to the need to adjust to generalised, existential trauma.¹⁰² Only recently have we come to recognise the great extent of the secret abuse of children. At the turn of the millennium, a national survey for the NSPCC suggested that 10% of all children (and mainly girls) experience sexual abuse - at the hands of brothers, step-brothers, step-parents or fathers (in decreasing order of incidence). Also, 7% of the sample showed signs of serious physical abuse - nearly half by their mothers.¹⁰³ If there is so much serious abuse - which is under a taboo - when smacking is endorsed by the consensus as a legitimate form of punishment, there is likely to be a much greater amount of 'low level', habitual physical and emotional cruelty.

It recently became clear that most violent and sexual abuse of children is perpetrated by those who suffered such abuse when they themselves were children. Also, most abusers are members of the family, or close friends or acquaintances. The oppression of children by those expected to protect them is a self-perpetuating cycle. In a competitive social system there is bound to be a high degree of frustration vented on the vulnerable. Are we to suppose that the intimidation or abuse of a child causes him no long-term psychological harm?

Subjected to rewards and punishments, to gratifications and frustrations bestowed on us by those who have us in their power, all of us grow up to some extent repressed and neurotic. In a context of love and security, a neurotic disability may be restricted and not so noticeable. In Freud's later formulation, neurosis is the inevitable result of the conflicts aroused within us when we are forced to submit to the demands of the community and, in order to survive, efface our own egotistic desires. Emergence of the more completely disabling condition of a psychosis may be viewed as a sign of over-repression - of oppression so threatening, confusing and cruel that (in the absence of sufficient compensating emotional support) the person who must bear it experiences a cognitive dislocation under the weight of his hopeless misery. Many people suffer from unremitting and extreme socially-induced anxiety; this is the source of their crippling levels of neurosis, and one more stressful event topples them into psychosis.

Since the publication of Jenner's book, a number of studies have focussed on the relationship between adverse childhood experiences and the later emergence of a serious mental disorder. The research identifies traumatising childhood factors such as sexual, physical or emotional abuse, abandonment or serious neglect, death of a parent or sibling, and living with a parent who is alcoholic, an addict or seriously mentally disturbed. In 2005, a global research review found that large-scale general population studies indicate a high correlation between symptoms of schizophrenia or psychosis (especially hallucinations) and childhood abuse and neglect, and that the relationship is causal and has a 'dose' effect, i.e., where an individual experiences more and more severe kinds of adversity, there is an increased risk of psychosis.¹⁰⁴ In one study with a sample of more than 8,500 adult subjects, those who had experienced three types of adverse childhood events during childhood were eighteen-times more likely to have suffered a psychosis than those with no such experiences,

102 Freud's changing ideas are discussed in some detail throughout Chapters 21 and 22 (Volume 2), below.

103 *Child Maltreatment in the United Kingdom* (2000) London: NSPCC; reported by Carvel, J (2000) Survey reveals widespread child abuse. *The Guardian* 20 Nov. Later surveys indicate no substantial changes; see the section: The conditions for the development of mental abnormality, in Chapter 23 (Volume 2), below.

104 Read, J et al (2005) Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica* 112 330-350.

while those who had experienced each of that study's five types of adverse events were 193 times as likely.¹⁰⁵

If psychosis is not regarded as an end-state - and why should it be? - in principle there is no reason why the particular determinations of each case cannot be discovered by attention to what the patient says and does, and with regard to the contexts from which he emerges. Freud was pessimistic about psychosis, but others therapists offer grounds for optimism: a psychosis is very often the result of a particular moment of crisis, and in favourable circumstances it can be little more than a very unpleasant phase the person has to pass through.¹⁰⁶

In order to discover the truth of a mental disorder, a therapist has to be willing to empathise with the patient and interpret his puzzling beliefs and behaviours by paying close and dispassionate attention to them. This immediately runs up against the problem that a neurosis or a psychosis develops precisely so as to mask an unutterable truth: it may not be easy to admit what one desires or what actually happened in one's life - for example, how unloved one really was (or is). Nor, when a person's energy is committed to defending a neurotic or psychotic worldview, and from a position of very low self-esteem, is it easy to face up to the responsibility of reconstructing one's own coherence and then to go on to live one's own life. It is well-known that the closer analysis approaches the source of a neurosis, the more the patient resists. This has a use: the analyst questions the patient's resistance. Nevertheless, it might be hard to steer a psychiatric patient towards a plausible analytic interpretation, as against his own compulsions and delusions.

Prospects for interpretative psychiatry

Therapy is only likely to be successful if the patient sees a definite benefit to renouncing his psychopathological defences: he must feel genuinely included in the human community. If this can be achieved, there remains one seemingly insurmountable barrier to interpretative therapy: the organised inertia of medical power, which apparently cannot be brought to account.

The public face of psychiatry is that of medical efficiency and guarded optimism '...as long as the patient keeps taking his medication...' At the end of the 20th century, the Royal College of Psychiatry remained bitterly opposed to all forms of interpretative psychology.¹⁰⁷ Just as history is written by the victors, psychiatric case-notes, research studies and textbooks are written by successful social actors - or at least, those able to make their way as competent functionaries. Psychiatrists are most unlikely to have lived through contexts that bear much resemblance to the milieu inhabited by most of their patients, and there is no requirement for them to take a close interest in any patient's biography. After all, they are medics, not sociologists, reporters or writers looking for a story. Furthermore, nobody can force them to be concerned with the misery endured by that significant section of the population who, usually long before they become psychiatric patients, are emotionally traumatised and psychologically disturbed by having to endure overbearing oppressions. Individual psychiatrists may sometimes comprehend the desperate lives of some of their patients (as summarised in case-notes) but psychiatric theory, research and practice is *systematically* organised by reference to the medical model, which only recognises so-said mental illnesses. As a result, even though it is traumatising social relations and events which most often generate the misery which presents to

105 Shevlin, M et al (2007) The distribution of positive psychosis-like symptoms in the population: A latent class analysis of the National Co-morbidity Survey. *Schizophrenia Bulletin* 89 101-109; Shevlin, M et al (2008) Cumulative traumas and psychosis: An analysis of the National Comorbidity Survey and the British Psychiatric Morbidity Survey. *Schizophrenia Bulletin* 34 193-199. More evidence of the correlation between psychological trauma during childhood and serious adult mental disorders is provided in the section: The incidence of child abuse and its association with adult mental disorder: research findings, in Chapter 23 (Volume 2).

106 Sullivan, HS, op. cit. (n. 95), was one of the first psychiatrists to view the career of the schizophrenic in this light. Soon after the formulation of the diagnostic category, he and a few others dissented from the consensus of a very poor prognosis, on the grounds that many schizophrenics did in fact recover.

107 See Temple, N, op. cit. (n. 14, Ch 1). Except in primary care, where there is now some, there is still no routine provision of psychotherapy.

psychiatry, if a doctor regards those factors as interesting it is usually only as colour to an off-duty anecdote.

As if psychiatry were nothing more than just another branch of general medicine, the medical model also obstructs clarity and therapy by endorsing the fiction of a contract between the patient and the doctor. Nowadays, psychiatric patients are generally known as 'clients' or 'service users'. Most often this is a public relations deceit. The terms 'client' and 'user' imply free entry into a contract, yet as soon as there is an official response to his irrationality, the elective psychiatric patient is no longer a free agent. Those who actually engage the services of psychiatry are the police, social workers, members of the patient's family and occasionally members of the public. Some patients do genuinely volunteer for care and treatment, but it is a strange kind of client who may at any moment be compulsorily detained and administered drugs or shock treatment against his will.

Rather than wishing for psychotherapy, doctors and families might share an interest in believing in the medical model. That ideology suits the purposes of those families of the seriously disturbed who wish to avoid questions about the part they might have played (and perhaps continue to play) in the genesis of the emotional and intellectual breakdown of one of their own. As a defence against their own neuroses, family members are likely to welcome a medical explanation for the crisis. When it is defined as an unfortunate illness which can only properly be managed under medical guidance, nobody has to take any responsibility for the genesis of the mental disorder and only medical experts are responsible for its remedy. Everyone can then imagine that the patient is simply so unlucky as to have been 'born with a genetic fault' or - just like catching a cold or developing diabetes - to have 'developed' schizophrenia (or any other mental disorder). Besides, it might be difficult for a parent to acknowledge that mental disorder is a response to psychological trauma, and families are not always able to control traumatising events.

On the other hand, the family or some of its members may sometimes be aware of the trauma which precipitated the mental disorder, and cannot get anyone in the mental health service to recognise it because every official believes in the twin myths of mental illness and the efficacy of medical treatment.

That mental illness is a misconception which serves certain powerful interests is not a novel idea.¹⁰⁸ Fifty years ago it was advocated by a tendency within psychiatry which was hailed by some but reviled by most established psychiatrists: Anti-Psychiatry.

Some persons regarded as schizophrenic, whom I have known, seemed to describe during their 'illness', with symbols, their social situations, past and present. The more I learned of their lives, the more truth I could see in what they were saying. Their families, however, would dismiss their words as signs or symptoms of illness and therefore as invalid. Their doctors, unfamiliar with the social world in which the 'illness' occurred, would too. The idea that someone is mentally ill makes it easy to call what he says invalid.¹⁰⁹

We argue that the proper topic of psychiatry is not the brain but persons and their relationships, as investigated by way of social and psychological analysis; that a serious mental disorder may be traced to a traumatic event (or events) in the individual's personal history. And yet, even supposing that medical power could be reined in, that psychiatric officials were educated in social psychiatry, and drugging were largely replaced by counselling or psychotherapy, undoubted practical difficulties would remain.

For example, on the face of it Freud's pessimism about psychotherapy for psychosis seems reasonable: the grip of a neurosis produces a resistance to analysis, but at least the neurotic offers himself for therapy; if the neurotic won't easily give up his rationalisations, how much more fiercely will the psychotic cling to his delusions? Yet it seems to us that this misconceives the nature of psychosis by viewing it, once achieved, as a total and permanent condition. In reality, the seemingly impenetrable force-field of a psychosis waxes and wanes, depending on the degree of the individual's

108 A discussion of the philosophical-logical and sociological critiques of orthodox psychiatry can be found in the first section of Chapter 15, below: The classic critique: Anti-psychiatry.

109 Schatzman, M (1973) *Soul Murder*. Harmondsworth: Penguin Books, 1.

anxiety and panic, the degree of his psychosomatic arousal. There have always been more optimistic psychiatrists who understood that any developed mental disorder responds particularly to the situation *as the subject sees it*; and if the circumstances really do change, so too can the individual's response. In fact, ever since the idea of the awful terminal disease of schizophrenia came into vogue, evidence from practice has steadily accumulated to support the social-psychiatric view of the matter: under more favourable conditions a patient is less anxious, conversations with a therapist may begin, psychotherapy can be effective, and today's psychotic may *very often* become tomorrow's less disturbed and much better functioning neurotic - or even much less neurotic than before the psychiatric crisis. From HS Sullivan to RD Laing and beyond, this is affirmed by a number of experienced psychiatrists.¹¹⁰ In other words, if action is taken to allay his or her feelings of insecurity, a patient in the throes of a psychotic crisis can more often than not be induced to re-engage as a reasonably sane member of the community.

An interpretative approach attempts to comprehend the individual by listening to what he says and relating it to the context from which he emerges. Obviously, it cannot proceed without developing a clear sense of the patient's biography. Whatever else, this might permit responsible officials to discover and try to remedy what it is in the individual's life that causes him anxiety, and not in an off-hand manner simply send him back to the circumstances in which his mental disorder emerged. Of course, 'the environment', 'the social context' or the patient's 'world' very often denotes members of the family, and they are often likely to resist interpretative psychiatry - after all, any family is a group of neurotics likely to wish to guard their own particular secrets.

Obviously, the interpretative approach is no magic wand. We have mentioned the possibility of the patient's profound irrationality and resistance. The priority is to establish trust and reduce his anxiety, by means of genuine care. But perhaps the patient has no wish to begin psychotherapy. And how does the interpreter gauge the quality or veracity of what the patient says? How can he tell if or when the patient is dishonest? Again, how can he tell when or if the patient's emotional life is *really* 'on the mend', or whether apparent progress is only subterfuge? Most damning of all, sceptics argue, psychotherapy is never anything more than supposedly healthy subjectivity intervening in allegedly unhealthy subjectivity: Where is the empirical proof for *any* of the conclusions which anyone might reach about *any* of the material elicited in therapy?

These might seem weighty problems, but interpretation is the only option. After all, it is not some strange, fraught and new-fangled therapeutic device, some preposterous trick that liberals try to pull on the decent hard-working folk who make up normal families and the psychiatric workforce. It is how we all have to deal with the interpersonal problems of everyday life. Certainly, an interpretation can be deficient, or it can fail. When that happens, the best we can do is pick up the pieces of the problem at hand and start again, search for more clues and perhaps pay closer attention to signs we may at first have overlooked or ignored - and then make a further interpretation. Without interpretation, there is no connection between any two people, between any two subjectivities: no social life, no individuals, no humankind. That we are routinely able to interpret motives and intentions is proved by the very existence of mind and society.

It is also true that where there is memory there must be imagination. But it is only possible to estimate a false memory against a background of generally reliable memory and reconstruction. Only a fool accepts the first version he hears about any contentious event. Why would the interpreting psychiatrist accept only the patient's word for the events he speaks about? Like any detective, the psychiatrist should get to the scene of the crisis, interview members of the patient's social network, weigh account against account and motive against motive, and not ignore any other evidence or witnesses. Many judgements about human events are problematic, but the legal process does not grind to a halt just because some witnesses lie or let their imaginations run away with them. Besides, establishing legal facts is usually a matter of considerable teamwork. It should not be left to one official to do all the fact-finding, interpretation and decision-making. The doctor is often the official

110 We explore this in Chapters 25-27 (Volume 2), below.

who sees the patient more briefly than others, and psychiatry is best practiced by a team. There should be collective discussions of evidence and interpretations. Of course, this is in fact most often the case: it is a myth that only the doctor's medical diagnosis discerns the state of the patient's mental health, its cause and an appropriate remedy.

Whatever seems best to account for any patient's psychiatric condition will only be a provisional hypothesis. This is not so strange; it is the essence of both science and justice. A legal case or a scientific problem is always sent back for review if new evidence emerges and appears to contradict whatever version of events previously convinced the interested parties. Those shouting the loudest against interpretative psychotherapy are the apologists for entrenched medical power, including organisations which represent the interests of some of the relatives of diagnosed mental patients. The motives of both groups are suspect. Both protest the provisional nature of the conclusions reached by psychotherapy or counselling; both demand an impossible level of certainty - as if real science or law were not provisional, and often explicitly based in probabilities. Apologists for orthodox psychiatry hope that one day their shoddy research will deliver the certainty that they crave; in the meantime, they pretend it already does so. Most of all, they must find psychotherapeutic interpretation distasteful since what is revealed is that the patient's mythical illness is not, in fact, the unfortunate, random development of an organic pathology. Rather, the malaise is plausibly the product of an 'unhealthy' social matrix in which members of the family and psychiatrists too often play a part. This makes remedy not medical treatment but justice and realignment of the social relations.

This is not to suggest that it would be at all helpful to employ interpretative analysis simply to apportion blame. Families, or certain members of families, might certainly suspect this motive - after all, wittingly or unwittingly, some of them may have played a part in traumatising one of their own. To some degree, everyone's life is a chronicle of frustrations, stresses, conflicts and suffering, and a consistent psychodynamic approach recognises that perpetrators respond to the urges of their own miserable neuroses, psychoses or perversions. Clearly, anyone's neurosis or perversion is bound to have a more or less deleterious impact on those who live within his orbit. Who is to blame for what? If it appears that a psychotic patient's behaviour responds to previously hidden cruelty or exploitation at the hands of a more powerful person (or persons), then we have to find out which individuals did exactly what, when and why. But not primarily in order to cast blame. Rather, it is to advance the project of deconstructing a pathological frame of mind and reconstructing a better one.

Finally, we must point out that Professor Jenner and his colleagues seem to subscribe to that conventional social-psychiatric view of the causes of mental disorder which was established by liberals in the profession during the 1940s and 1950s, and is still very much current today. If a mental health official does not subscribe to the medical model of mental illness - or hedges his bets - he tends to believe the crisis in hand is the product of quite 'normal' (i.e., by implication, inevitable) developmental stresses and strains coupled with 'normal' social pressures, family misunderstandings and conflicts. However, this does not begin to explain why a significant minority of young people develop worrying psychological conditions, of various intensities, while most do not - even if apparently subject to similar social conditions. Despite this lacuna, the standard social-psychological view attained the status of 'liberal' professional dogma many years ago; it was recently exemplified by the complacent comments of a psychotherapist in an advice piece for an 'intelligent' newspaper:

Three-quarters of mental illnesses appear before the age of 24: depression, anxiety, eating disorders, schizophrenia. [Adolescence] is a period of vulnerability. Changes are happening at the same time, a perfect storm: hormonal changes, neural changes, social changes and the pressures of life suddenly increase. The changes in the brain mean it is particularly plastic and susceptible to environmental stress. The pressure of schools and exams is increasing. As an adolescent your mind and cognitive capacity is developing so you're able to reflect on life, the future and your place in the social hierarchy in a more

sophisticated way. You're starting to look like an adult. People expect you to behave like an adult, too..¹¹¹

All this is true, but wholly inadequate. That formulation takes the social relations as unquestioned givens, and while it may help to explain neurosis it does not begin to explain psychosis; neither does it account for some young people developing a mental disorder when most do not. And whereas the information really ought to be known by every 'expert' in the field (since it has been accumulating for two decades and more) there is no mention of childhood trauma and the fact that cruel but secret oppression and exploitation is by far the most likely trigger for the subsequent emergence of psychological conditions of incapacitating mental anguish and confusion. In a recent large-scale UK survey of those between the ages of 16 and 59, people were asked about their childhood experiences of abuse by adults: 9% reported psychological abuse, 7% physical abuse, 7% sexual assault, and 8% witnessed violence or abuse in the home. This confirmed the findings of previous studies, and equates to an English and Welsh total of 567,000 adult women and 102,000 adult men within that age range..¹¹² Meanwhile, as we mentioned towards the end of the previous section, general population studies indicate that the relationship between symptoms of schizophrenia or psychosis (and especially hallucinations) is strongly related to childhood abuse and neglect, and that the relationship is causal and with a 'dose' effect - that is, the more and the more severe the kinds of maltreatment experienced, the greater the risk of psychosis..¹¹³ In one big study, subjects who had experienced three types of adversity and abuse during childhood were eighteen-times more likely to have suffered a psychosis than non-abused people, while those who had experienced each of that study's five types of abuse - neglect, mental cruelty, alcoholism, addiction or mental disorder in the family, physical and sexual assault - were a staggering 193-times as likely..¹¹⁴

The new knowledge of the true and shocking extent of child abuse has profound implications for psychotherapy. Away with prior beliefs and theories! In the absence of reliable evidence to the contrary, any mental health official, counsellor or therapist ought to display a genuine willingness to listen to patients and to believe them when they speak of the horrors they have had to endure (and often still have to) and which have driven them to their present states of distraction - however 'incredible' those stories may sound to those lucky enough to have had no direct experience of such dreadful events. Sometimes the cause of a trauma may be obvious - such as the death of a parent or sibling - but more often it is chronic mental cruelty, serious neglect or worse brutalities. Certainly, as we shall see in Volume 2, what has become indisputable since Jenner's day is that - as Freud suggested more than a hundred years ago - *every mental disorder is the psychological response to a deep-seated, unacknowledged and unrelieved emotional trauma.*

In this chapter we explored the diagnostic category which serves as the linchpin to the whole psychiatric project. We indicated many shortcomings in the schizophrenia research, and began to explore wider issues of cause and cure. Pressing questions remain. For instance: How could so many 'experts' get things so wrong for so long? All this might be fine in theory, but what about real-life cases? And how is mental disorder explained and remedied if not by medical science?

The next two chapters address the first question. Then, in Volume 2: *The Social-Psychological Approach*, we examine a few cases and propose a radically different conception of mental disorder which, in turn, suggests an alternative, entirely practical kind of therapy.

111 Blakemore, SJ (2018) Neuroscience: Q & A. *The Observer*, March 28

112 *Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016* (2016) Office for National Statistics. Women were almost four times as likely as men to be survivors of sexual abuse during childhood (11% compared with 3%) and much more likely than men (3% against 1%) to have been sexually assaulted by penetration (including attempts) during childhood; three-quarters of the victims said they did not report what had happened at the time, most commonly due to 'embarrassment, humiliation or thinking that they would not be believed'.

113 Read, J et al, op. cit. (n. 104).

114 Shevlin, M et al, op. cit. (n. 105).

Chapter 13: THE PSYCHOPATHOLOGY OF PSYCHIATRY

It's much easier to lie to people and trick them than to tell them the truth. They'd much rather be bamboozled than be told the truth, because the way to trick them is to flatter them and tell them what they want to hear, to reinforce their existing illusions. They don't *want* to know the truth. Truth is a bring-down or it's just too complicated, too much mental work to grasp.

Robert Crumb¹

Someone is said to suffer from a functional mental disorder when there seems to be no organic cause for his obdurate and worrying irrationality. But if there is no organic cause, why say the condition is nevertheless an illness - a mental illness - that certainly requires medical treatment? In this chapter we explore this conundrum, and believe we can resolve it. This is crucial to our argument for the urgent need to substitute a coherent social and psychotherapeutic response for the so-called medical model.

Up to this point, we have examined psychiatry and found its ideas confused and many of its claims at odds with the evidence. This is because the basic assumptions of its medical model are unfounded. And not only are they misguided, vague and unquestioned, there is a taboo on examining them. We now review those false assumptions - as we feel we can discern them - and suggest why nonetheless this unsubstantiated hypothesis came to define the conception and management of mental disorder.

In psychiatry, the medical model both generates and depends on the myth of mental illness. We explore the myth and the model as they arise out of broader mythological notions of Science. These beliefs determine a consensus about which kinds of propositions concerning emotional, mental, personal and social life are appropriate for understanding and managing individual irrationality, and which are not. Orthodox mental health care and treatment is revealed as pathological and ritualised: although it masquerades as scientific medicine, it is best understood as a naive and poorly theorised reflex to everybody's deep-seated fears of madness and what it may disclose.

This takes us to a brief review of the history of the emergence from general medicine of the sub-discipline of psychiatry. We then demonstrate that psychiatrists misconceive science, and inevitably fail to make their discipline truly scientific. This is because, in logic and in practice, the science of objects cannot act as a template for a science of subjects, i.e., persons. Consequently, psychiatry is generally the application of a style of authority and intervention in peoples' lives that is announced as technical (scientific-medical) and therefore morally and politically neutral, but which is actually based in wishful thinking, and can only ever result in haphazard, partisan and reckless rule-of-thumb guesswork.

Apart from the ideological confusions, there are certainly obvious political and economic interests working to persuade everyone that the medical model is appropriate. It seems to us, however, that unacknowledged, deep-seated emotional and personal-political motives are the most decisive - that the dominant idea about the nature of incapacitating irrationality, and hence ideas about care and therapy, responds to the fears and wishes of the sane majority. There is generally a profound dread of the chaos of emotional distress and mental disorder, and then, specifically, amongst intimates to the person in crisis, there is often also antipathy to social and psychological analysis since it might suggest or discover culpability: the psychiatric medical model perfectly answers to the universal desire for a quick technical fix with no awkward questions asked. Until it is understood as primarily responding to the

¹ Crumb, R & Poplaski, P (2005) *The R Crumb Handbook*. London: MQ Publications, 297.

anxieties of the sane, there is no chance that the prevailing management of irrationality will be replaced by a response more fitting to the real needs of those in crisis.

Psychiatric dogma

We react to events according to how we perceive or define them. Today, the whole of the socially organised response to functional mental disorder is infected by the belief that it is ‘obviously’ the medical problem of a kind of illness. At the least, this notion issues in muddled, contradictory and unhelpful practice; at worst, it endorses routine malpractice and deliberate abuse. Since there is no evidence to support the medical model of mental illness, and much to contradict it, this near-universal belief is more than inconsequential dogma: it amounts to a veritable pathology - the psychopathology of the mental health professionals.

We do not suggest that doctors and mental health workers begin their careers peculiarly lacking in compassion, and do not intend to help people as best they can. Our quarrel is not with the conscious intentions of the personnel but with the ruling misconception of the psychiatric object, i.e., what it is that afflicts anyone incapacitated by an intolerable degree of emotional distress and mental turmoil. So far in this book we have demonstrated that there is neither sound evidence nor plausible argument to sustain the psychiatric medical model.

In which case, the bleak quotation at the top of this chapter seems fitting, although we might take heart from the long view. Progress in combating any kind of significant misapprehension generally issues from the pioneering efforts of a few dedicated fact-finders, proselytisers and activists. With regard to care and treatment for people suffering from a mental disorder, things might not conform today to what some of us might wish, but there are hopeful signs of a gradual change of mind. Two centuries ago the odds might have seemed just as long, yet radical changes were successfully inaugurated by campaigners such as Pinel and Tuke. By calling attention to the cruelty of their plight, and by making alternative provision, they and other reformers managed to institute a more humane kind of management and treatment for the insane, one that established standards beneath which care and treatment could no longer legitimately fall. In the meantime, however, due to a combination of factors mentioned in Chapter 1,² the accepted paradigm of madness shifted from ‘moral lapse’ or ‘alienation’ to ‘mental illness’, and this encouraged the development of the organisation of medical psychiatry which we now address.

Until quite recently the alternative, psychodynamic theory of functional mental disorder was proposed only by psychoanalysts (whose rules of evidence seemed far from adequate) and a handful of other psychologists and psychiatrists. By the mid-1960s, the latter were generally known as ‘anti-psychiatrists’. At that time, the psychodynamic perspective was endorsed by only a few disparate items of narrative or research, or by case studies which could only ever amount to anecdotal evidence. As we will see in Volume 2, though, over the last twenty years or so the emotional trauma/psychodynamic theory has found increased confirmation from a series of studies which conform to sound statistical protocols by taking large sample populations. Official thinking is yet to admit a causal link between psychological trauma during childhood and mental disorder later in life, but at least the correlation is now recognised.³ And recently it became national policy in the UK to ask every psychiatric patient if they suffered from particularly adverse experiences during childhood.

This new interest in emotional trauma during childhood has yet to influence care and treatment. Despite the stirrings of dissent, which can at last refer to a body of well-founded research, the problem remains that the mental health services are organised first of all according to the idea that anyone undergoing a personal crisis ‘has a mental illness’ and must normally be given medical

² See the section: A brief history of the management of madness, in Chapter 1, above.

³ This is recognised by Itzin, C (2006) *Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse*. London: Department of Health. Argument and evidence for the psychodynamic theory of functional mental disorder is presented in Chapter 23 (Volume 2), especially in the section: The incidence of child abuse and its association with adult mental disorder: research findings.

treatment. No doubt, since it is so comforting, this fantasy will be difficult to shift because it appears to suit everyone concerned: doctors, nurses and other officials, who are able to busy themselves with ready-made routines that are apparently strictly technical, and nothing to do with the sprawling, difficult, personal-political hurly-burly of intimate human relations; the drug companies, which are happy to supply ever-increasing quantities of profitable product; family-members and other intimates, who are relieved of onerous responsibilities such as having to administer to the person in crisis, having to listen to him carefully so as to try to help him, and admitting and reigning in their own passions, prejudices and detrimental behaviours; and perhaps the patient himself who, at least for a while, is expected to do little more than try not to be so overtly deviant and not refuse management and treatment.

In any event, a mental health patient is not ill. He may show signs of mental disorder, but he does not 'have a mental illness'. It is therefore once more time to rescue the humanity of those who struggle with a distressing and disorientating personal crisis - this time to free them from the clutches of ersatz scientific medicine. In this project, it is necessary to comprehend and counter every myth and every powerful resistance.

Perhaps the fundamental reason for mental health provision arriving at its present pass is that, over the last two centuries, just when the organised response to madness was becoming less brutal and more considered, the prevailing tendency to look to religion for answers to life's most vexing problems largely gave way to an equally blind faith in the work of secular officials claiming authority from Reason and Science. By 1819, belief in the unqualified benefits of Science was so widespread that the representative and influential socialist Saint-Simon was convinced that

...the fear that one day there will be established a despotism based on science is ridiculous and absurd fantasy. Such a thing could only arise in minds wholly alien to the positivist idea.⁴

In today's high-tech world, in which medicine looms large and there is ever-lengthening life expectancy, most of us would probably agree wholeheartedly with Saint-Simon's optimism. With regard to the travails of the tormented soul, these days most of us resort to medicine, and then, if events turn critical, to psychiatry. The trouble is, as we have seen in earlier chapters, it is not the case that the mental health experts regularly operate on the basis of sound scientific principles and clear research findings. On the contrary, practice tends to be based in precedents which are rarely questioned - that is, in rituals which may *appear* medical but which usually involve applications (drugs, electroshock, brain surgery) which are supported neither by coherent theory nor evidence, are not demonstrably helpful, and very often are positively harmful. Saint-Simon's hopes ran too high. We may not have 'a despotism based in science', but we do have one which nearly everyone *imagines* is scientific, and which is indeed based in 'the positivist idea' - an idea, as we shall see later in this chapter, that was never adequately thought through. It turns out that the fear that Saint-Simon ridiculed was not an absurd fantasy: it has come to pass, and it is called Psychiatry.

As we have seen, the first aim of mental health care is to manage the patient by managing his symptoms. On the face of it, this seems like common sense - but it leaves all the patient's other problems unaddressed. Informally, and out of good will and native intelligence, sympathetic members of staff may try to help patients with those personal problems which occasion their anxieties, and hence their confusions and distress. Nevertheless, the formal practices derived from the medical model systematically *disregard* the patient's emotional, psychological and social problems, and too often they are simply left to fester. Sympathy, empathy and appropriate assistance are hampered by a hopelessly inadequate theory and a lack of compassionate imagination.

There will be no advance beyond this muddled, pseudo-medical, ad hoc and 'sticking-plaster' kind of approach unless an effort is made to understand how and why psychiatry arrived at the theoretical impasse of its so-called medical model. The trouble with the mental health professionals is

4 Taylor, K (Ed) (1975) *Henri Saint-Simon 1760-1825: Selected writings on science, industry and social organisation*. London: Croom Helm. Saint-Simon was probably the best-known advocate of socialism in the early years of the 19th century.

that *there is simply no evidence* for much of what they think they know. In this chapter and the next, we explore the assumptions, irrationality and motives that lie behind the medical model in which nearly every official puts his faith - and not as a footnote to the history of the psychiatric profession and nursing, but comprehensively, in order to reveal it as a veritable mental disorder in itself.

First of all, we describe the assumptions underlying the alleged science of the medical model. We point out the naivety of the idea: it embodies a number of fundamental conceptual and scientific errors. Next we explore the emotional, psychological, ideological, institutional and historic reasons for the compelling allure of this 'theoretical model' - all those motives which conspire to obscure the true nature of functional mental disorder and which lead the entire psychiatric profession perennially to knock its head against the brick-wall of its ever becoming really scientific, really medical, and really helpful to anyone mired in a personal crisis.

The psychiatric medical model is rarely exposed to rigorous criticism. A number of experts have found fault with vital aspects of the theory or practice, and yet they nearly always *continue to employ* concepts integral to the medical model. As if they signify real diseases, and do therefore explain things, many critics still refer to 'the mental illnesses', and take at face-value all the diagnostic categories which are forever being invented by psychiatric entrepreneurs - schizophrenia, bi-polar disorder, personality disorder, *borderline* personality disorder, attention deficit disorder, attention deficit *hyperactivity* disorder, etc., etc. As we have seen, those categories are at best only descriptive, non-explanatory tags to different sorts of undesirable *behaviour*: they do not name *discrete conditions*, let alone real illnesses. No matter how much psychiatrists and other officials might wish it, with respect to the bulk of the case-load - the functional mental disorders - the perpetual invention of new categories is simply not diagnostic of illnesses or anything intrinsic to persons. Beyond this, a mental health diagnosis is pernicious: it is a stigmatising label which is liable to cause all kinds of psychological, social and iatrogenic problems for the person concerned. A critique of the medical model is therefore already half lost if it is conducted *in the terms of the model* - if it fails to question those allegedly medical-scientific categories, as if they are not wishful constructs but do correspond to tangible realities.

Another frequent shortcoming is a failure of nerve: the critic finds fault with psychiatric theory or research, discovers that there is no evidence for an organic basis to a particular diagnosis, or to the functional mental disorders in general, but still enters a caveat to the effect that '...of course, we must nevertheless assume that there is a genetic component' specific to functional mental disorder. As we saw in the previous chapter, that kind of assumption must be criticised rather than let pass.⁵

Apologists for the medical model are notorious for refusing to respond to criticism. Neither can the psychiatrists ever be forced to reply since they hold a legal monopoly endorsed by the general consensus: they are able to imagine and do whatever they like. In the rare instances when a criticism is acknowledged, it is dismissed without counter-argument as 'obviously' absurd and irresponsible. At the same time, propaganda for the psychiatric medical model typically takes the form of forthright declarations about genetic or constitutional causes, or the efficacy of medical treatments, without providing clear evidence (since there is none) and *as if there never was any doubt about it*.

As a result, arguments about the poor science, the false assumptions or the proven value of treatments have never much influenced psychiatric practice.⁶ The profession has rarely been forced to modify its ideas or practices in the light of obvious theoretical and practical shortcomings, and it has not seriously debated the basic assumptions of the enterprise for a hundred years. The public is so

⁵ Psychiatrists often speculate wildly (but confidently) about the percentage of cause of a mental disorder which is 'probably' due to genetics. In his many published works, beginning in the 1950s and through to his death in 2012, Thomas Szasz seems to have been the only psychiatrist to have fully recognised and consistently insisted that mental illness is a fiction, and that this ought to alter radically the whole nature of the social response. For example, see Szasz, TS, *op. cit.* (n. 18, Ch 1, and ns. 1 and 12, Ch 3). Also see text to footnotes 8 and 9 in Chapter 15, below.

⁶ Psychiatrists only seem to have felt threatened by criticism during the few years between the insurrectionary scares of 1968 and the dominance of conservative politics after 1979.

convinced by the myth of mental illness, and of the need for a medical response, that officials can afford to ignore every criticism. A few dissenters sometimes assume that the psychiatric professionals who employ the medical model will be pleased to engage in a debate in the open forum of reason and science, and they are shocked when they find that their orthodox colleagues simply *will not* hear about it, and do not and will not engage reasonably with another point of view.

But if psychiatry is simply one among the number of medical-scientific specialisms, on a par with any other, why are its representatives so extraordinarily resistant to criticism and debate? It seems to us that they are so defensive because the psychiatric medical model is bogus medicine: the orthodox position is impossible to defend by science or reason *because it has no genuine scientific standing*. Psychiatry is a closed system of ritual, myth, dogma and modern magic which only bluffs its way as a kind of scientific medicine.⁷ There is no evidence to support the psychiatric medical model, yet it is impossible for doctors and other officials to question their faith in it since it is not only the rationale for the entire mental health project (which is to say, for all their training and their careers) but they are not *emotionally inclined* to believe that functional mental disorder could be anything other than a kind of illness.

This self-deception is a scandalous disruption of genuine science and dereliction of duty to those in crisis. Any system of belief and behaviour which is at odds with reality and is a dangerous or disruptive nuisance is normally considered a mental disorder. By these criteria, psychiatry itself ought to be recognised as a kind of psychosis. Moreover, we should be particularly worried since it is a psychosis mobilised for social action, and it has a profound effect on millions of people:⁸ whereas the mental health services are supposed to meliorate individual misery and mental confusion, too often they compound and prolong it. Like any other mental disorder, there is no chance for any improvement in the mental balance of psychiatry - for the officials to develop insight into their collective delusion - until it is disputed. This challenge must not only demonstrate the poverty of the so-said science and medicine but also expose the unacknowledged emotional investments and fantasies which underpin, sustain and defend official thinking, policy and practice.

We are therefore entirely serious when we contend that orthodox psychiatry suffers from an intractable mental disorder, and that it is a kind of psychosis rather than a less troubling neurosis, for the neurotic can admit he has a problem and often seeks help to resolve it. Curing this particular psychosis, however, must be the political matter of forcing the profession to admit the irrational nature of its beliefs and practices, and to interrogate its own motives - or better still, *to give up its absolute power*. This is only likely to come about by a political challenge to psychiatry on the part of interested groups who are thoroughly fed up with a medical model that does so little to improve the lives of the patients. Yet any political challenge would amount to no more than a palace coup were it to lack awareness of the deep-seated material and emotional interests which sustain the general belief in a medical solution for every apparently intractable psychological, personal or inter-personal problem.

Orthodox psychiatry treats symptoms and not causes: its beliefs and practices chronically fail to address the patient's underlying problems. They also routinely confuse, confound, demoralise and subdue not only the patients but also all those sympathetic staff, relatives and friends who might wish to help. As we have seen, the idea which governs mental health practice is to mimic general medicine: the so-called medical model. The foregoing chapters demonstrate that this 'theoretical model' has been tested and shown to lack any empirical or predictive value. At root, this is because (by definition) someone who shows signs of a functional mental disorder does *not* have a disease, and psychiatric medicine is *not* based in sound medical science. Ignoring these awkward facts, in psychiatry the medical model is not typically employed as a tentative idea, or a hypothesis which

7 See our argument in the two sections in Chapter 3, above: The confusion of the psychiatric medical model, and The medical model of mental illness is unproven, unhelpful and harmful.

8 For a discussion of the particular resilience of a delusion when it is entertained by a group, and of its impact on individual thought and action, see Freud, S (1921/85) Group psychology and the analysis of the Ego (Ed Phillips, A) *Penguin Freud Library 12*. Harmondsworth: Penguin, 91-178.

possibly corresponds to reality, but dogmatically - *as if it were certainly true*. Because most doctors seem either not to know or refuse to recognise that it has ever undergone telling criticism, and since they refuse to entertain any alternative ideas about the genesis of mental disorder, their so-called medical model has long since become second nature as unquestionably the first and last conceptual and practical resort of global mental health treatment.

Subjected to scrutiny, however, conventional psychiatry has the appearance of a form of despotism based in bad science. It is also *experienced* as such by most patients. The evidence which supports our argument does appear sporadically in research journals and other professional literature, and so a critique such as that offered in Chapter 12 and its Appendix ought to be well known to doctors. The evidence alone - or rather the lack of supporting evidence - should be sufficient to sow in their minds serious doubts about the conventional notions and techniques. Surely this ought to persuade doctors to consider an alternative view of mental disorder and its care and treatment? This is seldom the case. Psychiatric practice and research is driven by the medical model, and the psychodynamic perspective is firmly relegated to the back seat - or rather, tucked away out of sight in the boot.⁹ Since this is certainly not due to the empirical or therapeutic superiority of the medical model - as we have demonstrated in Chapters 5, 6, 7, 8 and 12 - it must be because the medical model serves certain vital but unacknowledged needs or motives. These are not the needs of the patients, who have little or no say in the matter: *they are the material and emotional needs of almost everybody else*.

If pressed, a psychiatric official might protest his moral and political neutrality, arguing that his work is organised for the purely technical task of mending a certain kind of damaged or broken thing - the mind. However, 'mind' is not something that can be identified as any specific part of the organism: it is an abstraction, attributed to someone consequent to his behaviour. Therefore, since mind - including a very worrying state of mind, a mental disorder - is not anything organic which medicine could possibly work on, psychiatric officials cannot help but enter the thick of personal and interpersonal conflicts *as protagonists*, and be *influenced* by interested parties. As both lawful arbiters of those kinds of conflict and at the same time a party to them, psychiatric officials take on the image of technical neutrality. Usually this suits most people's immediate wishes. Psychiatry is fully supported in its 'technical' image since, except perhaps for the person forced to become a patient, everyone is normally convinced by that 'common sense' which is an unquestioning 'empiricism' or 'pragmatism' that stubbornly resists abstractions and complexity: everyone imagines that only a tangible thing could possibly be real - such as a brain, which has somehow become sick - and that it can only be worked on adequately by means of some palpable technique - such as a drug, a medical instrument or a machine.

We have already suggested that although there are, of course, associated somatic processes, the essence of any functional mental disorder is the attempt to construe and respond to unbearable anxiety. As such, the disorder can only reasonably be clarified not as a peculiarly elusive disease but as unacknowledged post-traumatic stress disorder, the attitude or state of mind itself, a response to accumulated and overwhelming anxiety and panic. A mental disorder is generally triggered by a burden of current personal stresses in addition to persistent oppressive anxieties engendered by secret or unacknowledged conflicts or horrors experienced by the individual (usually during childhood).¹⁰ In fact, psychological accommodation to anxiety is *very common*: so long as many people share an anxiety, the imaginative response often takes an entirely acceptable form as an element of a culture or ideology. Many points of religious dogma are irrational, and they tend to be fiercely defended. There

9 In the 1960s and 1970s, the psychiatric establishment only ever referred to Drs Szasz, Laing and Cooper in order to misrepresent and vilify them, and elucidation of the pioneering work of these 'anti-psychiatrists' has never figured in the textbooks. Like Soviet dissidents, they quickly became 'unpersons': written-out of official versions of psychiatric history, rising generations of mental health workers would not hear of them - or certainly would not be honestly exposed to their ideas.

10 This is argued in Volume 2.

are also a fair number of secular beliefs that are both widely held and quite irrational - *such as belief in the actuality of mental illness and the efficacy of psychiatric medicine.*

It is impossible to understand why the official response to incapacitating emotional distress and mental turmoil takes its present form without exploring how the management of irrationality developed in recent times. During the whole of the 20th century, the dominant interests would only ever countenance changes in the management of madness as either the invention of a new medical technique or organisational reform. This is because they wished every mental disorder to be a medical condition and not the product of personal and inter-personal processes. Later in this chapter we discuss the emergence of psychiatry out of general medicine during the 19th century, and we will see that medical ideology was not always so prevalent in the response to individual irrationality.

Since psychiatry fails to offer a coherent theory of mind and behaviour, we must subject the discipline to a critique based in the concepts of psychoanalysis, political-economy and sociology.¹¹ When we question the basic assumptions of the psychiatric medical model, this inevitably implies questions about the material and emotional interests which underpin the whole mental health project, and which determine the form of its dogma. And just as the motives to an individual's neurosis are discovered by analysis of his biography and the contradictions which he lives and voices, so too, at the level of culture and the social organisation, the hidden motives to the mental disorder of psychiatry are revealed by examining the history of its development. Furthermore, we can be fairly certain we are on the right track. As with the psychoanalysis of an individual, so with the analysis of an institution: in order to defend its 'character' from attack, the closer the analysis approaches the truth of the matter, the greater the resistance to the analysis.¹²

There are, then, two prerequisites to the realisation of a social response genuinely appropriate to the needs of those undergoing psychological crisis: first, we must debunk the assumptions and the mythic structure which together constitute the dogma of the psychiatric medical model; next we must understand the material and neurotic needs of all the parties to the psychiatric encounter, the wishes and fears which find their rationalisation in all those false ideas and anti-therapeutic practices.

To this end, we explore the fundamental logical and conceptual errors committed by orthodox psychiatry; we then ask how and why it is - when, in fact, it is not at all certain - that the professionals are able to convince themselves that they act soundly and successfully in accordance with the precepts of science and medicine. When the evidence makes it dubious, how and why do most mental health officials and most of the public so firmly believe in the medical model? In order to understand this puzzle, we have to locate the rise of psychiatry in the context of the wider culture which itself displays a blind faith in science and medicine, and which also has little idea about how either actually work.

In the next chapter we pursue certain further consequences of the psychopathology of psychiatry. In particular, we identify the crucial part played by the psychiatric profession in elaborating the ruling misapprehension of 'personality' and its deformations, and we illustrate this by reference to the history of the invention of the imaginary illness known as schizophrenia. We also identify psychiatry as a particular institutional embodiment of a general social and personal malaise, which is to say: alienation.

The myth of the medical science of psychiatry

Psychiatry was established as a medical discipline during the 19th century, when it seemed that scientific and technical progress would soon begin to answer every problem, social and personal as well as material. The emerging profession experimented with new techniques in an attempt to combat or contain behaviour for which, in truth, it could provide no explanation. However, the professional ideology was born in the pretence that this was not the case: psychiatric authorities played down their ignorance and implied that since they were busy accumulating a body of objective knowledge of

11 We are concerned primarily with psychiatric ideas and practices, not with details of the organisation.

12 This was discovered early in the history of psychoanalysis. See the section: Expressing and interrogating the self, in Chapter 26 (Volume 2).

madness and its proper treatment, they always worked from the solid ground of scientific medicine.¹³ All the same, after nearly two centuries, in which most people have supposed that psychiatry must be growing ever more scientifically precise, there is still no evidence that the latest techniques (usually the latest drugs) are any more effective remedies for mental disorder than the best methods of the pre-medical era.¹⁴ This must surely call into question the medical model.

Of course, treatments have since been outlawed if they involve overt violence or constraint in its crudest forms - though this was more for reasons of morality and politics than due to advances in medical science. There are still psychiatrists happy to employ barbaric methods, and some who are pleased to give the impression that they would sanction any means if it seemed effective. Psychiatry has only quite recently reduced the use of lobotomy/leucotomy, and although the use of electroshock has also declined it is far from being outlawed, and many psychiatrists defend its use. Medication is almost always employed as first and last resort, even though every doctor should be well aware of the detrimental and often irreversible damaging neural and other organic 'side-effects' of drugging, as well as widespread addiction and too frequent deaths from adverse reactions. Until the early years of the 19th century, treatment for madness was almost universally restraint, punishment and physical debilitation. Today, medicine provides internal restraint, debilitation, often pain and physical harm, and sometimes (but regularly) killing by over-sedation. Never mind - most people seem to agree that modern psychiatry is impeccably humane, and must surely be scientific and medical.

For all that, psychiatric theory and practice was comprehensively examined and found seriously wanting by a number of critics during the 1960s. 'Anti-psychiatry' called for a social-psychological perspective and response. The psychiatrists refused to debate their own methods, at the time or since, but in the 1990s the reorganisation known 'Care in the Community', with its 'team approach' and community mental health centres, seemed to acknowledge some of the ideas of anti-psychiatry.

In the event, Care in the Community turned out to be little more than a logical development of care as universal drugging: rather than keep the big old hospitals going, it seemed more acceptable (and perhaps cheaper) to privatise care as far as possible by dispersing most of the patients back home or into supervised flats, houses or hostels (the latter becoming the new long-stay wards), and to monitor and medicate 'service users' by using peripatetic community psychiatric nurses. Making care and treatment more humane was not really the issue: before Care in the Community was put into effect there was a media panic about dangerous mental patients being freed to roam the streets. The political impetus was mainly to cut costs by reducing and dividing-up the unionised labour-force, releasing the capital tied-up in the big old institutions (usually located in suburban acres ripe for property development), and providing new profit-making opportunities by the provision of accommodation and outsourced care. Many patients may have benefited by being released from unnecessary institutionalisation, but it is debatable that every aspect of life in the old mental hospitals was necessarily so awful, and some benefits were lost: respite, personal and financial security, steady routines, sociability, and a pleasant semi-rustic environment. Care in the Community was certainly not intended to replace the existing technical means by more appropriate and less harmful methods of treatment. The old ones remain: mainly drugs, and sometimes ECT. The difference is that nowadays there are more out-patients and fewer in-patients.

As a perspective on mental life, orthodox psychiatry is fast becoming an anachronism. The rest of the world seems to have some grasp of the concept of ecology, in which the characteristic behaviour

13 Although general medicine itself developed (and can still develop) in a fairly untheorised, haphazard, trial-and-error manner. In 1734 Samuel Johnson remarked that 'It is incident to physicians, I am afraid, to mistake subsequence to consequence'. If this may still be true for wishful thinking in general medicine, it certainly remains true for conventional psychiatric accounts of the nature and causes of functional mental disorders, and their appropriate treatment.

14 The movement amongst medical researchers for evidence based practice (EBP) hopes to thin-out the multitude of medical treatments to a manageable number with proven efficacy. Yet this has only recently begun in general medicine, and psychiatry lags behind. So far, psychiatry has failed to provide proof of the superior value of any of its treatments. For example, see Chapter 6, above, in the section: The efficacy and the dangers of the psychiatric drugs.

of any organism is understood as being *in exchange with its environment*. Psychiatrists only cursorily consider *the person* - his mind and his relations with the world. As if a person's beliefs and behaviour are not influenced by his personal history and social context, they are still determined to work on individual brains, each existing in isolation. The doctors' fixed idea is to alter the metabolism (mood, synapses, etc.) by some or other medical technique. Research is obsessed with discovering *the* internal organic cause, and *only* the organic cause of a disease or abnormality, which it supposes *must* generate the symptoms of this or that mental disorder. Even though for more than a hundred-and-fifty years this mysterious biological agent has eluded every piece of psychiatric research.

We have remarked that mental states or processes may only be adduced by public expression or private introspection. In spite of this, day in and day out, psychiatrists commit an elementary logical blunder, a category mistake: while bodies fall ill, and medical science is often able to trace causes and apply effective remedies, *mind is an abstraction which denotes not the organism, nor any part of it, but behaviour and intention*. We are only able to talk *metaphorically* of 'a sick mind' or 'mental illness'.¹⁵

Besides, there is a practical limitation on any attempt to find 'the cause' of a functional mental disorder inside anyone's skull. The human brain contains up to 200 billion differently constituted nerve cells (neurons), many with up to 100,000 connections to other neurons; this makes a network of one million trillion interconnections, effectively with an infinite number of possible routings, and each interchange is measured at speeds in the millisecond. As a result, there are a far greater number of possible brain states for any individual than there are molecules in the entire universe.¹⁶

The same problem may be illustrated by the difficulties in predicting even very simple decision-making. Unlike the openness of the real world, a game's closed system of fixed rules suits computing, and yet it took years to develop a computer - Deep Blue - to take on the world's chess champion, even though the responses possible in the chess environment are limited to 64 positions for 32 pieces, with just a few simple rules for the moves of the different kinds of pieces. This is because any game which reaches the fortieth move is presented with 10^{120} possibilities - and this is greater than the number of atoms in the universe.¹⁷ Deep Blue was not like human intelligence, though. It had to be trained by chess masters and operated by a technical team; and whereas humans have limited memories and need pattern-perception and creative strategies to win, the machine searched through millions of moves in seconds, thereby winning by sheer computing power.

Perhaps technical progress in replicating the operations of the human brain will lead to better knowledge of the brain's structure and functioning? In 2016 there was much excitement among artificial intelligence (AI) enthusiasts when the AlphaGo computer program developed by the DeepMind team beat a master Go player 4-1 in a best-of-five competition. The first chess move offers 28 possibilities, but in Go a stone is placed in one of 361 positions; a game of chess may last 80 moves but Go games can run to 150; and whereas the number of possible games of chess is reckoned at 10^{120} , for Go it is 10^{761} . The AlphaGo system was designed to improve its own skill by analysing thousands of games already played by talented humans, teasing out patterns of play, and then playing against itself millions of times so as to become incrementally better by learning from mistakes. AlphaGo consists of 'deep neural networks' of hardware and software which mimic the web of neurones in the human brain. But the program did not teach itself from scratch: the designers built in a mixture of clever strategies to make the searches manageable. Nor was it just one machine.

15 This is discussed in Chapter 3, above, in the sections: The confusion of the psychiatric medical model, and The psychiatric medical model is unproven, unhelpful and harmful.

16 Zimmerman, BE & Zimmerman, DJ (1993) *Why Nothing Can Travel Faster Than Light*. London: QPD, 133-134.

17 See Zimmerman, BE & Zimmerman, DJ, op. cit. (n. 16), 128-134. Although chess master Kasparov narrowly lost a series of games, human intervention was suspected and he said this upset his play. IBM then refused scrutiny of its computer, dismantled it, and refused a rematch. Afterwards, Kasparov held his own in matches with other computers, and between games the computers were still adjusted by teams of chess experts.

Spanning 170 graphics processing units (GPU cards) and 1,200 standard processors (CPUs), AlphaGo required internet connection with a network of machines in data centres across the world.¹⁸

Of course, AI is always undergoing improvements. By 2017, Google's poker-playing AI program, known as Libratus, was able to beat four of the world's top players in a twenty-day tournament. It did this solely by reinforcement learning - playing against itself in trial-and-error self-education - so as to learn No-limit Texas Hold'em poker. This is a game of incomplete information where the AI has to infer a human player's intentions and then act so as to incorporate both the direct odds of winning and bluffing behaviour to try to fool the other player. Libratus used three AIs to refine its tactics, and although beating top players was impressive, it played only two opponents at a time, thereby avoiding the more complex interplays seen at any normal poker table.¹⁹

Then, in October 2017, Google announced that a new program, AlphaGoZero, had trounced the older versions. After just three days of training, AlphaGoZero beat the previous champion-beating version of AlphaGo by 100 games to nil. And after forty days of playing itself, it beat the previous best computer version 89-11 - that is, the program which in May had beaten Go's world number one player, Ke Jie. This made AlphaGoZero 'arguably the strongest Go player in history'. Whereas its predecessors had trained from thousands of human games, AlphaGoZero took a different approach by learning the game only by playing against itself. The CEO of DeepMind said that 'removing the constraints of human knowledge' was the most liberating factor since this brings them closer to decoding one of the biggest hurdles facing AI, which is reliance on huge amounts of data training. Whether this will work beyond the confines of board games remains to be seen, but it does seem as if similar techniques could be applied to many structured problems in the real world, such as protein-folding, reducing energy consumption and searching for revolutionary new materials.²⁰

Machine intelligence is both impressive and indispensable for the modern economy. However, strictly speaking, AlphaGo is no more than astoundingly rapid number-crunching, with reference to a vast and accumulating memory. It is not intelligence in the sense that humans are intelligent, and it cannot get to full AI, or Artificial General Intelligence (AGI). The key feature of AGI is that it avoids being limited by a designer: like humans, it will make sense of the world for itself by developing its own internal significations from everything it encounters and with which it may interact. Today's AI programs do not understand what is going on, and cannot begin to deal with issues outside of the tightly-restricted domains for which they are specifically designed. While an AI can remember every operation within the remit for which it is programmed, it has no autonomous cognitive powers.

[The DeepMind] definition of 'intelligence' is so impoverished that it doesn't extend beyond the abstract calculations that an algorithm can achieve, and completely fails to understand that human intelligence is embodied and distributed throughout our physical selves - and indeed between them, in the mirror neurons that fire in sympathy when we watch a dancer or help an injured friend. In short... it's bad science. Artificial intelligence of the kind Google promotes can play Go and even - at a pinch - recognise Bach or Picasso. It can never produce Bach or Picasso, still less understand the complexity of social forms and culture that made their lives possible.²¹

Obviously, AI will continue to develop, and some general medical facilities already use it to help with diagnosis and choice of medication.²² But it is clear that other brains (persons) using any number of machines could not begin to compute the precise operations of one person's brain. More

18 Artificial intelligence: Google's AlphaGo beats Go master Lee Se-dol (2016) news.bbc.co.uk/ 12 March; Go grandmaster Lee Sodol grabs consolation win against Google's AI (2016) *Wired* 13 March.

19 Firth-Butterfield, K (2017) AI can win at poker: but as computers get smarter, who keeps tabs on their ethics? *The Observer* 5 Feb.

20 Shah, S (2017) Google's AlphaGo AI no longer requires human input to master Go. www.engadget.com/ 19 Oct.

21 Baillie, J-C (2017) Why AlphaGo is not AI. medium.com/@Synced/why-alphago-is-not-ai 12 May; Hayman, S (2017) Google DeepMind is making artificial intelligence a slave to the algorithm. *The Guardian* 2 Nov.

22 Hernandez, D (2014) Artificial Intelligence is now telling doctors how to treat you. *Wired Business* June.

than this, who is to say that any apparent organic cause is not itself an effect of the organism's response to a prior mental stimulus? It is therefore preposterous to suggest that one day the fundamental particles and relations of the ceaseless processes of the human brain will be identified, isolated and measured, and that it will then be possible to determine the specific cause of a mental correlate, such that, if it is thought to constitute a mental illness, medical experts will be able to work on it and effect a remedy. The urge in neurology to establish isomorphism or identity of mental events and brain processes is absurd. Likewise, the desire for every case of worrying irrationality to be a brain disease is not anything to do with science: it is a symptom of the anxieties and wishes of the psychiatrists.

Psychiatric dogma commits a logical blunder by taking a figure of speech as reference to a material thing or process. We recognise psychosis when someone's life is governed by his mistaking metaphor for actuality. For example, the psychotic does not *feel as if* he were John the Baptist; rather, *he imagines that he is* the Baptist, reincarnated. By definition, functional mental disorder is only metaphorically illness - it *seems like* illness - but conventional psychiatry is thoroughly confounded by its own metaphor. When it takes the metaphor 'mental illness' for a theoretically identifiable organic process, and only ever proclaims or seeks a discrete physical cause (a virus, a genetic glitch, a biochemical imbalance) and proposes technical (chemical or electrical) remedies, it makes exactly the same kind of conceptual error as that committed by every psychotic patient. This deluded dogma simultaneously puts aside every interesting psychological, personal and social factor pertaining to the crisis in hand. In as much as this 'medical' delusion is fanatically defended by the professionals, and the consequences are so far-reaching and harmful, it is both legitimate and instructive to speak of orthodox psychiatry as *an institutionalised form of a psychosis*.

It seems to us that this lack of insight on the part of the psychiatric professionals must surely be motivated by a powerful wish. To be precise, the unfounded but unquestioned dogma which underpins psychiatry is the result of a wish for a technical solution to the pressing and upsetting problem of mental disorder and any associated local (usually family) social conflicts. Labouring under the delusion that runaway misery and mental turmoil is a medical problem, psychiatry loses all interest in its proper topic - *the psychological, personal and social dynamics of emotional and mental malaise* - and forever chases twin chimeras: organic cause and medical remedy. Thereby, the entire edifice of psychiatric diagnosis, prognosis and treatment is inspired to accumulate as a monumental, ever-expanding and rococo *rhetorical device*, constructed and under perpetual extension and repair so as to convince everyone that an emotional or psychological crisis is *not* the person's disastrous response to overbearing stress and emotional trauma but instead is essentially *a mysterious disease that somehow incubated within him*, and which, therefore, is a medical matter.

Mental illness diagnoses are unwarranted by medical science. Although there is no evidence for disease, psychiatrists are nevertheless *mandated* to make a diagnosis, and thereby encouraged to attribute a peculiarly elusive kind of illness to any individual who displays apparently unaccountable emotional distress or mental disorder. At the same time, every mental health diagnosis performs the pernicious function of officially separating the population into two mutually exclusive groups: anyone receiving such a diagnosis finds himself stigmatised, degraded and quite likely harmed psychologically or physically by medical treatment; anyone *not* diagnosed by a doctor as 'having a mental illness' is assumed, by that token, to be 'normal', fully rational and not possibly a party to anybody's personal crisis.

The patient, meanwhile, is forced to submit to medical assaults: every type of medication has deleterious organic effects, and ECT destroys brain cells.²³ More than this, as we have seen, due to the pseudo-medical idea concerning the cause and appropriate management of individual irrationality, anything and everything the patient signifies about his anxieties may be routinely ignored or overruled.²⁴ When psychiatric officials routinely declare that whatever the patient feels significant is, in

23 See Chapters 6 and 7, above.

24 See especially Chapter 4, above.

fact, irrelevant to his recovery from ‘the illness’, and when they work on (harm) his brain or body, this can only compound the problems which delivered him to psychiatry in the first place.

In sum, the ill-conceived and unevidenced psychiatric medical model is based on a complex of prejudiced assumptions and unacknowledged wishes. This ‘syndrome’ can only be comprehended as *the psychopathology of psychiatry itself*.

Material interests served by the medical myth

To suppose that a distressed and confused person who suffers from no discernible physical malady nevertheless ‘has a problem with his brain’ is to run before the facts. It may only be clear that the person suffers, appears confused, has problems communicating, and has problems with his life. It is a truism that the brain is the origin and locus of the personality. This does not mean that a person’s problems are all located in his brain. The belief that they are is *the myth of mental illness*.

By ‘myth’, we mean an irrational belief based in a wish rather than evidence or reason. A myth serves to explain what might otherwise seem inexplicable, or to substitute for a more reasonable explanation which, due to their anxieties, people refuse to admit. Myths are embodied in beliefs, attitudes, manners of speaking, habits and rituals. At the level of culture and social action, a myth is the dramatic expression of important psychological phenomena, and has significant real effects. However, we also intend the term to indicate *motivated error*: a myth is an unproven or false belief which serves to justify a social arrangement. In order to accommodate their own interests, exploitative social powers proclaim the undoubted truth of the myths they sponsor. It is a myth that the psychiatric medical model best explains the facts; its corollary, ‘mental illness’, is of course also a myth.²⁵

The anxieties fuelled by a child’s imagination are often so vivid that it is impossible to persuade him that he is being silly, that what he fears cannot be the case and is only what he imagines. The fearful thing that he imagines - and might, for example, grab him by the leg if he gets out of bed in the dark to check that another monster is not hiding in the wardrobe - feels just as possible to him, when he imagines it, as all those things which, by empirical daylight experience, he *knows* exist. A myth can exert that degree of influence: someone who is completely ‘in the dark’ about some pressing issue - such as a personal crisis - may be swayed by all manner of wild imaginings. Adults tend to forget that the imagination regularly overrides reason, and yet people are *very often* in thrall to powerful myths - and the more so when they imagine that all their beliefs must be reasonable because now they are grown-up. Naturally, any myth concerning the reach of modern medicine gets its potency from our experience of the real and pervasive influence of science-based technologies in everyday life.

Why was the management of madness handed to the medical profession? Today, most of us consider any mental disorder a form of illness: almost everyone believes in the myth of mental illness, and it ‘goes without saying’ that no-one should presume to manage or remedy troubling individual irrationality without medical training.²⁶ It seems a matter of course that psychiatry should have emerged out of general medicine, and nearly all the early speculations and research efforts by which the new profession attempted to gain legitimacy were couched in terms of biology.

Medicalisation of the conception and management of madness originally proceeded by distinguishing fairly broad diagnostic categories. These were a way of referring to what seemed to be

25 See Barthes, R (1957/72) *Mythologies*. London: Paladin. This collection of terse and witty critiques demonstrates that modern life is as suffused with myth as any ‘primitive’ society; Thomas Szasz was the first to identify and elucidate the myth of mental illness. See Szasz, T, op. cit. (ns. 1 and 12, Ch 3); also see text to footnotes 8 and 9, Chapter 15, below.

26 As we saw in Chapter 1, during the first half of the 19th century the medical management of madness was not widely favoured. This was because physicians had so manifestly failed to remedy madness that other experts of the soul - often doctors of divinity and social reformers - were able to step forward with their own theories and treatments. And for fifty years or so, a number were remarkably successful. However, the great increase in the numbers of asylum inmates finally eroded the effectiveness and hence the authority of ‘moral management’.

discrete kinds of problematic behaviour which, since they were trained in medicine, most psychiatrists imagined *must have* a biological cause which will one day be discovered. Then, about a hundred years ago, the most influential psychiatrists convinced themselves that they had indeed discovered a disease which they finally decided to call 'schizophrenia'. Rather than claiming any moral, psychological or sociological expertise, this was a defining moment in establishing the authority of psychiatry as allegedly an authentic medical science. As we shall see, however, this was not the scientific discovery of an actual disease but only *the devising of a taxonomic category*.²⁷

After this victory of the medical model within the psychiatric profession, every other type of incapacitating emotional or psychological crisis might be diagnosed as undoubtedly a mental illness. Subsequently, *anything* which the patient said or did which was not approved by psychiatric authority was likely to be interpreted as one of the irrational symptoms of his alleged illness. Also, everybody would now imagine that *only* those interventions which aped the techniques of general medicine could possibly constitute plausible remedies for incapacitating emotional distress or mental disorder. And as soon as the whole mental health project was conceived in terms of medicine, the diagnostic categories and apparently medical-scientific treatments began to undergo inevitable and continuous elaboration or 'refinement'. But this was never a genuine medical-scientific development - it was only the elaboration of a myth or ideology.

Within its domain, every profession discriminates knowledge from error. It is difficult to dislodge ideas once they are embedded in the routines of an institution and rationalised and inculcated in textbooks and training. Officials are forced to compete in careers where spheres of power are jealously demarcated and protected by those at the top of the hierarchy, and so there is always a bias towards tradition. Even in general medicine, which can boast of unequivocal progress and success, better techniques often have to wait for a whole generation of the most senior practitioners to retire before they can displace older and less effective methods; some techniques *never* find favour if there is no obvious profit to a medical or pharmaceuticals company which could promote them by means of advertising and public relations.²⁸

There are many forces to buttress the myth of mental illness and medical treatment, and to prevent criticism and progress. There is always likely to be tension between the best interests of the patients and inertia based in the self-interests of the officials. Psychiatry provides a secure and lucrative career with the usual reasons not to rock the boat - unwillingness to upset powerful superiors, perks such as consultancies and private practice, and so on. The sub-discipline is also relatively low in the medical pecking order, but is well-known within the profession for providing a more relaxed working life. It is not openly acknowledged, but there seem to be two reasons for this. First, the psychiatric patient is virtually powerless, and by definition he imagines things: if he complains, this is easily ignored or 'explained away' as a symptom of his mental illness. Secondly, in contrast with every other medical specialism, there is so far barely the hint of a demand for routine accountability. For the psychiatrists this is a happy oversight because, as we have seen, they understand neither the nature of mental disorder nor recovery: since they cannot account for mental disorder and do not know how their medicine works - or even *whether* it works - methods for distinguishing successful from unsuccessful treatments are uncertain. Because there are no organic markers of recovery, success may only be calculated by estimating the numbers of patients who do not re-present for care or treatment. There is no systematic NHS audit or readily available recent research, but past research and anecdote suggests that the proportion is not high. Consequently, whereas there are clear signs and standard procedures to identify incompetent surgeons or anaesthetists, a psychiatrist is free to treat his patients in any vaguely credible manner he wishes, with very little risk of being questioned or brought to account for inefficiency, dereliction of duty or even conscious abuse.

No doubt, another reason for the grip of the medical model on the psychiatric imagination is the influence of cash and empire. The American profession now exerts the greatest influence on world

27 We explore this 'discovery' in Chapter 14, below, in the section: The invention of the mythological disease of schizophrenia.

28 The movement for evidence-based practices seeks to undermine these tendencies; but see footnote 14, above.

psychiatry, and in the USA the whole of medicine tends to be driven by the profit-motivated actuarial dictates of the insurance companies. So as to cost the various options, insurers demand well-defined categories for all the types of so-said mental illness; notionally, for each diagnostic category there is a most immediately 'effective' and cheapest treatment. This drives American psychiatry to discriminate ever more categories of mental illness, and almost entirely to disapprove of psychotherapy since in the short term, and as compared to medical treatments (drugs or ECT), it is slow, more expensive and difficult to quantify. In the early-1990s The American Psychiatric Association recognised that those members who practised according to the dictates of the insurance companies - rapidly processing patients, and only prescribing drugs - earned, on average, three-times as much as those dedicated to practicing psychotherapy. It therefore recommended that its members should never offer a talking therapy.²⁹

European psychiatry is jealous of its own separate history and has had socialised medicine for decades, so costing has not always been immediately important. For example, British psychiatrists have not been so very concerned about assigning each patient to a precise diagnostic category. Yet the question of the medical-scientific status of psychiatry raises its head as soon as two doctors are required to agree on a diagnosis, and hence its appropriate treatment. The same problem of precisely defining the various categories of functional mental illness also arises in research. In order to facilitate the replicable experiments that characterise authentic empirical science, psychiatric research has to make its concepts quantitatively operational; if only it could convincingly do so, that might prove to sceptics the scientific nature of the discipline. However, this always proves too tall an order - getting any two doctors to agree about which diagnostic category should apply to any one patient is often a difficulty. Nevertheless, this does not prevent the belief that there *are* discrete mental illnesses, and that a physical cause *will be* discovered. At the same time, due to its blind faith in the medical model, the Royal College of Psychiatrists always used to oppose psychotherapy.³⁰

Inevitably, a huge and ever-expanding market for psychiatric drugs results from the dogma that every mental disorder is an illness. Why would the drug companies question the myth of mental illness? They have always offered material incentives for GPs and psychiatrists to act as if mental illness really exists and the medications really work. Nowadays, they provide the greatest financial support for the medical model.

Even so, this development is entirely a result of the psychiatric profession's belief in the medical model of mental illness. Many kinds of studies were carried out in the early days of 'scientific psychiatry' - including psychological and epidemiological research - mainly by dedicated individual doctors. During the course of the 20th century, teams working in the universities (mostly state-funded), became more and more influential, and the focus shifted definitively towards bio-chemistry and genetics. After mid-century, however, research and development by pharmaceutical companies played an increasing part, and for the past fifty years or so the drug companies have provided most of the funding for psychiatric research. During the last quarter of the 20th century, by buying into faculties of biology and chemistry in order to recruit talent, acquire ideas and accrue prestige, the drug companies also forged ever closer links with the universities, and exerted ever more influence on research. In this manner, during the last century, psychiatric research has moved from relatively free debate and individual whim, hunch and observation, towards alignment with the concerns and dictates of the state as advised by the professional association, and finally towards conforming with the interests and demands of big business. Evidently, whatever is true or scientifically valid is of no interest to a profit-making concern unless it could result in marketable product: the pharmaceutical giants are not going to employ researchers, or broadcast their findings, unless their studies conform to the approved assumptions and the results are those which the companies wish to hear and are able to exploit. On the other hand, the industry has a strong interest in suppressing or manipulating

29 Noted by Karon, BP, in *The Introduction to Modrow, J*, op. cit. (n. 35, Ch 2), xii.

30 See Temple, N, op. cit. (n. 14, Ch 1). Mike Shooter, President of the RCPsych from 2002 to 2005, is the exception who proves the rule; he is now President of the British Association for Counselling and Psychotherapy (BACP).

inconvenient truths - such as the facts that mental disorder is not usually caused by an actual illness, and that no manufactured drug has significantly greater therapeutic effect than placebo, psychotherapy or benign forms of human association.

It is not surprising that about fifty years ago, with the apparently great success of the new psychiatric medicines, the pharmaceutical industry became a major player in the game of defining the types of mental illness. In the research laboratories, new chemical combinations are continuously created and tested on a vast animal population, and sometimes on people. If a concoction does not seem to have any benefits for a real disease, it might still seem to have useful cognitive or behavioural effects. And there is always the hope of inventing the psychiatric equivalent of a super-profitable 'magic bullet' like aspirin or penicillin. Psychiatric research is almost completely blinkered to possibilities other than those of simple, lineal, physical causes and effects for which simple, direct chemical remedies might be devised and marketed. In turn, Valium, Prozac and Ritalin each figured as the latest psychiatric wonder drug, only for the glamour to evaporate when at last it became clear that they performed no miracles and posed the same kind of risk as any other psychotropic. In the meantime, the companies calculated that the best way to find a market is to announce that each new drug has a particular psychiatric effect - it became commercially important to promote each as a cure or aid to a specific mental illness. An example is the Anafranil intravenous drip: introduced in the 1980s, it was supposed to cure obsessive-compulsive disorder (OCD).³¹

It is clear, then, that the drug companies and doctors share an interest in advocating the medical model since it extends the reach of psychiatry over ever greater areas of emotional, psychological and social malaise: the greater the variety of mental illnesses, the more necessary are the doctors and the ever-increasing number of drugs. This shared interest is boosted by periodically announcing newly discovered forms of mental illness which 'of course' must be treated medically. By way of an absurd tautology (and one which the profession never addresses), the number of possible diagnostic categories is only limited by the number of commonsense formulations which the general public *already employs* for describing the great variety of undesirable emotional, behavioural and mental conditions. The psychiatric experts seem unable to grasp that making a scientific discovery is not at all the same thing as appropriating a common-sense conception, contending that it refers to a discrete mental condition, and attempting to legitimate that assertion by giving the pseudo-disease some kind of fancy, preferably Greco-Latinate name: e.g., Schizophrenia, Bi-polar Disorder, Attention Deficit Hyperactivity Disorder, etc. This verbal trickery is a masquerade of science and medicine.

All the same, most of us are persuaded by the imposture. The major tranquilisers and the euphorics were first marketed in the 1950s. Fairly soon it became unremarkable when each newly devised drug was found to ameliorate a specific so-said mental illness. And then, by means of its influence over professional psychiatric committees, and *in order to boost the sales of pre-existing drugs*, the pharmaceuticals industry began to take a strong hand in the invention of new syndromes. The anxiolytic Miltown (meprobamate), for example, was first manufactured at the end of the 1950s, and it was later decided that it is specifically appropriate for the diagnostic category Panic Disorder, a malady that psychiatry then proceeded to 'discover' - i.e., to invent. Similarly, only when the anti-depressants were already on sale was it 'discovered' that millions of people suffered from a new category of mental illness: Endogenous Depression. More recently Prozac was said to be just the thing for treating the 'newly discovered' mental illness: Social Phobic Disorder.³²

As we have seen, however, there is no evidence that any psychiatric drug provides significantly more relief to any mental disorder than social interventions, or even placebo. This does not prevent the drug companies from waging an unscrupulous propaganda war for the all-out medicalisation of mental health provision. Xanax, an American medication similar to Diazepam, is one example among many of the deceits which the drugs companies have been willing to employ. Xanax became the world's most profitable anxiolytic soon after its public relations and advertising launch, in 1990. However, it later transpired that the makers had suppressed the results of their own in-house research

31 See the text to footnote 21 in Chapter 10, above.

32 See Caplan, PJ, *op. cit.* (n. 101, Ch 1), and summarised in the text to note 23, Ch 5.

which showed that the drug did appear to have some initial utility, but after four months there were no comparative benefits. More worrying, most test subjects who used it for more than two months felt much worse than they had before they started the treatment; and the makers had also failed to publish their own research findings about the addictiveness of the product and the severity of withdrawal symptoms.³³

The corruption of psychiatry by commercial interests did not go unrecognised by everyone in the profession, although outspoken critics are generally treated as pariahs. Loren Mosher was the first director of the Centre for Schizophrenia Studies at the American National Institute for Mental Health. In 1998, after thirty-five years as a member of the American Psychiatric Association, he resigned and openly accused most psychiatrists of purposely keeping their distance from patients while promoting the overuse of toxic chemicals with known and serious long-term effects. Mosher knew that there is no evidence for the dogma that schizophrenia is a brain disease. He felt that the decisive force of this idea was due to ‘fashion, politics and money’.³⁴ He declared:

Unfortunately, the APA reflects and reinforces, in word and deed, our drug-dependent society... Psychiatry has been almost completely bought out by the drug companies... No longer do we seek to understand whole persons in their social contexts. Rather, we are there to realign our patients’ neurotransmitters. The problem is that it is very difficult to have a relationship with a neurotransmitter, whatever its configuration.³⁵

Psychophobia and the wish to identify individual irrationality as illness³⁶

The medical model legitimates the activities of groups of professionals ranged around the crisis of a functional mental disorder. No doubt the myth of the value of the medical approach is sustained by the desire of each official to be viewed as a properly-trained and indispensable expert, a technician whose employment is warranted by his playing a vital role in remedying or holding at bay mental illness. Added to which, the drugs companies spend as much on advertising and public relations as on research, and their propaganda is now the loudest voice in the field. It is clear enough what material interests are served by the twin myths of mental illness and the efficacy of psychiatric medicine.

Still, none of this quite answers the question. It is unlikely that any doctor or psychiatric official would recognise the image of himself as a cynical manipulator of vulnerable people for his own base purposes. Nor do we suggest that there is general approval for the idea that emotionally distressed and confused people should be systematically maltreated by cohorts of a certain type of medical official. Indeed, two centuries ago, management of the insane began to undergo radical reform in answer to public outrage at the manifestly abusive exploitation of madhouse inmates; and today most of those working in ‘the caring professions’ would probably consider themselves alive to the possibilities of abuse. The fact is that drug industry and professional propaganda would not be effective if doctors and the general public were not *already convinced* that incapacitating mental disorder really is an illness. Many people might be surprised to hear that psychiatric therapy still does not focus on talking with the patient, but few who are aware of the current treatments question the idea that, by and large, taking into account the difficulties of precise diagnosis, and despite inevitable human failings, psychiatry does the best it can by pursuing the most promising medical avenues.

In which case there must be a compelling but more elusive reason for the fundamental conceptual errors in psychiatric thinking. Underpinning the notion of mental illness and the efficacy of medical treatment, there must be a certain belief which emerges out of a shared neurotic need; this belief must feed irrational ideas that are integral to the whole culture, of which psychiatry is only a component and simply plays its part. For it seems that what the psychiatrists assume about medicine and mental

33 Xanax and a number of similar examples are cited by Breggin, PR, op. cit. (n. 107, Ch 1), 251-255.

34 We explore the factual basis to Mosher’s assertion in the section: The invention of schizophrenia, in Chapter 14, below.

35 Quoted in Obituary: Loren Mosher (2004) *The Guardian* 28 July.

36 The term ‘psychophobia’ seems to have been the inspiration of Terry McLaughlin, one-time editor of *Asylum magazine*.

disorder is organised and expressed by reference to certain *universal* myths of human nature, personality, pathology and cure; these, in turn, are based in a particular myth of Science; and most of us are mightily relieved to entertain this collection of false beliefs since it serves to allay shared but unacknowledged anxieties.

In other words, the obvious material interests of the professionals and pharmaceutical companies are only served so successfully because, first of all, they answer to everyone's profound wish; and this wish could only arise out of perplexity and certain anxieties. There must be powerful emotional and cognitive motives encouraging us all to believe in the medical model of mental illness and remedy, despite its theoretical incoherence and the lack of evidence for its truth.

A psychiatric patient is very different from every other kind of patient. Any emotional or psychological crisis which is so disruptive as to invite the diagnosis of a mental illness not only causes distress to the individual but is also likely to trigger a high degree of a particular kind of anxiety in everyone around him. This anxiety is not for the outcome of an identifiable organic condition, for which there may be a clear and dependable medical remedy (or certainly none at all), but for the nebulous and unpredictable problem of the state of the person's mind; moreover, the individual in question is not required to submit to medical authority because his physical health is at risk but because his *behaviour* is deemed a serious nuisance or danger; and not only is his behaviour puzzling, even to the experts, but unlike anyone who suffers from a physical illness and welcomes the attention of trained physicians, very often the psychiatric patient only submits to treatment and care reluctantly or under coercion. As a result, those closest to the patient, and caught up in the crisis, are themselves usually troubled and perplexed: they also may feel as if they are 'at the end of their tether' or in danger of 'losing their wits'.

This kind of crisis is often frightening, and not necessarily because violence is committed or threatened but because 'for no apparent reason' the person seems to have lost the ability to function normally. Community and identity only exist in communication; perhaps madness seems such a dreadful condition due to the impossibility of communicating with the afflicted person. More than this, there is likely to be fear of contagion. An individual who enters a critical emotional and mental state may already cause stress and anxiety to others by making exhausting physical and emotional demands, but his aberrant behaviour may also arouse anxieties about their own fragile certainties, about what is right and what is wrong, what is true and what is false or only imagined. A disruptive mental disorder calls into question the psychic stability of anyone at all involved in the crisis: it threatens emotional and mental contagion.

In the normal run of things - in the absence of overt crisis - events may arise at any time to make any of us suddenly aware of the fragility of our own mental balance. Who has not experienced an extreme and negative emotion, a sudden loss of meaning, a frightening feeling of depression or uncontrolled euphoria? It is therefore understandable that great anxiety may be aroused in witnesses to acute or persistent irrationality - that is, anxieties concerning the meaning of the witnesses' own lives, their own purposes, motives and coherence, their own identities and significance, their own sanity. This is especially likely to the extent that the irrationality in question takes a relentlessly active rather than a passive form (mania rather than depression) or otherwise disrupts witnesses' settled routines and identities. Anxiety amongst the witnesses to a mental disorder is likely to evoke a defensive-aggressive response which first of all registers as abhorrence. This is normal - a reflex of normal character.³⁷ - and we might recognise it as *psychophobia*.

Among the witnesses to anyone in the throes of a personal crisis so serious as to seem to require psychiatric intervention, only those who feel certain they know its cause and are able to manage its course do not themselves experience disturbing anxiety and feelings of helplessness in relation to it. The majority - those who are only relatively troubled and psychologically insecure, those who only suffer from neurosis - welcome the myth of mental illness as protection against the dread of chaos. If intense irrationality were not so threatening to social stability and everyone's normal certainties,

³⁷ The nature and production of what we refer to as 'normal character' is discussed in Chapter 23 (Volume 2): The Genesis of Character.

psychiatry would be called on less often. Medicine promises to contain and remedy this particularly disturbing kind of malaise. At the moment, however, as we have demonstrated in the course of this Volume, anxiety in the face of serious mental disorder is generally allayed only by resort to a demonstrably *false* sense of certainty about individual irrationality and its efficient management - that is to say, by a modern rationalisation: the myth of mental illness.

Given the consensus that functional mental disorder is an illness that causes the person to be dysfunctional and unpredictable, and that it may well have a genetic cause or be contagious, it is no wonder that people are wary. But there may be an uglier side to psychophobia and the wish for a medical explanation and solution to this kind of personal crisis. The medical model serves as a convenient alibi for anybody implicated in the events which actually lie at the root of the individual's present emotional and psychological difficulties. For anyone in crisis must be part of a circle of intimates (or emerges from one), some of whom are likely to be culpable, in varying degrees, and in one way or another are generally in denial. However, everyone but the patient is wonderfully exonerated by the medical diagnosis: the crisis is defined as simply an unfortunate illness, and not anything to do with anything anyone might ever have done to cause emotional or psychological trauma, or to trigger the crisis by causing the individual undue stress; neither is there much that anyone except a medical expert could possibly do to remedy the situation. The psychiatric medical model offers relief all round. First of all, to those who know what they have done and are anxious that their part in causing the person distress and confusion might become public knowledge, and that they might be held to account were it not for the mental illness diagnosis. Naturally, the perpetrators of cruelty, neglect, exploitation or abuse might fear exposure, but so also might any witnesses or confidants who failed to act to prevent or protest the stress or trauma, or who deny its reality, or deny the extent of the hurt and distress that was caused. Official sponsorship of the medical model sanctions everyone's evasion or indifference: response to the crisis is taken out of their hands by the experts, and they are absolved of responsibility.

These days, everyone is in thrall to the power and prodigality of Science and Technology which attain mythic status in the popular imagination because they bestow such control over things. Medical science has long since proved its high value by alleviating pain and mending bodies. It is therefore not surprising that people assume that the kinds of bio-chemical or surgical techniques which work on the body must surely work 'on the mind'. Certainly, there is a sense in which drugging and electroshock (poisoning and burning) *do* perform a kind of work that is satisfying enough to many of those troubled by someone's psychological crisis - to doctors, families, neighbours, and sometimes the individual himself. The mental health treatments may not be as unambiguously helpful as the more clear-cut successes of general medicine, but nevertheless most of us are persuaded that any kind of mental disorder is best treated by a doctor.

And yet the idea that medicine is the appropriate response to every form of emotional distress or mental disorder is quite modern. Not so long ago, religious officials monopolised the management of the soul or spirit. When theology ratified mythology, mental disorder was conceived as possession by demons or The Devil - or at least as moral lapse. The naivety of such belief has not been replaced by a widespread sophisticated understanding of psychopathological processes - it is not as if a social-psychodynamic hypothesis springs readily to most people's minds, especially since anyone close to the person in crisis is likely to have his own neurotic position to defend. Nowadays, blind faith in Religion is simply replaced by blind faith in Scientific Medicine. Instead of possession by demons, the person is said to be possessed by illness: when he seems to have become very irrational, the reflex is to interpret this as a sign of something bad which incubated inside the unfortunate subject's brain, or which somehow descended on him, in the same way that any of the body's organs might degenerate or be invaded by a pathogen. In the mindset that takes for granted scientific medicine, it seems entirely plausible to attribute a mental *illness* to anyone who troubles those around him with his intolerably dysfunctional ideas and behaviour.

It therefore seems to us that blind faith in the medical model is best understood as the result of the distressing uncertainty and anxiety which is aroused in anyone affected by the crisis, or in anyway involved; this makes people welcome the intervention of an authority which will relieve them of very

much responsibility. There is a universal wish for a medical expert to define and then manage the individual's upsetting behaviour, and a mental illness diagnosis conveniently invalidates every uncomfortable or upsetting thing he says or does, while simultaneously exculpating everyone else. This way of 'making sense' of individual irrationality is preferable to the efforts and pains required to comprehend emotional and psychological processes which develop in the context of particular social relations; opening up that 'can of worms' also risks revealing some or other onerous personal responsibilities. Wishing that medicine were the appropriate response to every troubling personal crisis, everyone believes that it is.

At the same time, not having to face the rigours of evidence or logic, a myth may be conveniently self-contradictory. In the mental health response, there is a confusion of so-said medical-science and moralising. According to the myth of mental illness, although the illness descends upon or incubates within the unfortunate person by pure misfortune, somehow he must also take responsibility: although 'the illness' consists precisely in his unwilling irrationality, he is expected not only to accept medical treatment like any reasonable person but - unlike being cured of a physical illness - at some point in the treatment he must begin again to exert his will and, in effect, *cure himself* by 'doing something about' his aberrant thoughts and behaviour.

It is by these unconscious verbal and conceptual contortions that belief in the myth of mental illness permits everyone around the crisis to repress any knowledge or intuitions they may have about any possible part anybody may have played in the genesis of the mental disorder, and to rationalise any of their own culpability by saying that the individual who is forced to submit to psychiatric diagnosis and treatment is either ill or must be responsible for his own condition - or both at once. It is also generally agreeable that, by virtue of the official ratification of his status, the person diagnosed with the mental illness may be systematically invalidated: every uncomfortable or inconvenient thing that he says or does may be ignored or denied on the grounds that it is irrational and only another symptom of his illness. The medical model provides everyone with an alibi - even, to some extent and for a moment, the patient.³⁸

Professional anxieties

We have seen that psychiatric medicine is far from proving its efficacy. As much as success might be indicated by patients who seem to recover, failure is indicated by the greater number who relapse and must taken back into care through the 'revolving door', by the harmful side-effects of drugging and ECT, and by the fact that it is easy to administer drugs but difficult to wean patients off them. Psychiatrists may claim to *manage* mental disorders, but this is not always demonstrably by means of medicine so much as by persuasion and crypto-policing, i.e., by detention or the threat of it. Psychotropic drugs and shock treatment may often seem to affect patients' behaviour, but unlike general medicine, no causal link between treatment and benefit has been demonstrated; physicians are able to sedate patients or induce euphoria, but they cannot claim to cure mental illness. In short, medical psychiatry might seem to work, to a degree, but the doctors have little idea of exactly which treatment will work, or if it seems to, how it *changes the person's mind*.

Given the medically exceptional nature of the so-called mental illnesses, what anxieties might influence the psychiatric imagination? What might psychiatrists fear and desire? Since they cannot reasonably explain their medical model, this is not something that the professionals have ever properly discussed, and is therefore a matter of conjecture. But it seems to us that, first of all, they might very much wish to be as effective as other kinds of doctors. The dubious efficacy of psychiatric medicine and the poverty of mental health theory might cause them the anxiety that they are unable to help their patients very much - that, compared with many other kinds of medicine, theirs always courts failure. Added to this, since any serious mental disorder poses a risk to the patient (and perhaps to others), and since doctors do not have a clear understanding of the aberrant psychological

³⁸ There may also be a much darker side to psychiatric diagnosis and invasive treatment: we discuss the general deference to social power, and eagerness to see any deviance punished, in the section: Sadomasochism and the authoritarian personality, in Chapter 23 (Volume 2).

conditions they are required to administer, they may be anxious about the unpredictability of their patients. More than this, we might suspect that doctors refuse to admit that they fear the appalling truths that their patients often embody or express: a mental health patient may not always announce the full extent of his personal problems with absolute clarity, but it is unlikely that there are no indications of some of the grim details of his fraught life, or that at least some are not learned easily enough from witnesses or official records. Finally, it is doubtful that many doctors are oblivious to the fact that for one hundred years there has existed a competing 'model' of the causes of mental disorder and its appropriate therapy - psychotherapy - and it works precisely with all those details of patients' lives that are considered irrelevant by the psychiatric medical model.

In particular, there are two major, unusual and anxiety-provoking consequences to the medically unique, apparently policing and judicial dimensions to psychiatric authority, i.e., the concern not with sick bodies but with disturbed beliefs and behaviour. First of all, processes of diagnosis and treatment are supposed to be purely technical and objective, that is, morally or politically neutral. In reality, however, both processes are forever undermined by a welling-up of that moral or personal-political discourse in which the whole of psychiatry is unconsciously grounded. A psychiatric official can never be certain that the given diagnoses and treatments are correct, and he finds he is always having to *admonish, persuade or argue with* his patients - having to work on their attitudes or beliefs - rather than simply work on their bodies, with their ready acquiescence, as is normally the case in general medicine. Secondly, a psychiatrist can never have a high degree of confidence in the efficacy of any of his allegedly scientific techniques: there is no saying if or when the patient will recover, and if he does seem to recover there is always a high risk of relapse.

The insecurity of any professional is addressed by his banding together with his peers in an association to promote their mutual interests. Each profession is keen to mark itself off as a monopoly which exercises a discrete and indispensable knowledge and technical skill within a particular domain. But the language in which professionals conduct their business, education and public relations is never only technical; it is always to a degree rhetorical - that is, deliberately impressive or authoritative-sounding. This, of course, is to persuade everyone that accredited members of the profession do indeed possess an indispensable, complicated, esoteric and scientific-technical expertise to which the uninitiated are not privy, and which renders them *essentially* incompetent. Rhetoric and jargon are likely to intrude wherever there is an inexperienced clientele and a living or a profit to be made: every professional is tempted to over-persuade the public with jargon, which, when used as rhetoric rather than simply as useful shorthand communication between peers, is the debased and mystifying use of a technical-sounding discourse for the purposes of confusion or deception. Moreover, the more insecure the members of a profession, and the less they really do possess a discrete, unambiguously fitting and sophisticated technical expertise, the more they will be tempted to hide this from everyone (including themselves) by inventing and employing high-flown rhetoric, jargon, dogma and propaganda. Rhetoric may be employed consciously or unconsciously, but in the history of the professions, very often hyperbolically and with full and barefaced awareness. As we shall see, rhetoric which appeared medical and scientific was crucial to psychiatry passing off the contrivance of the diagnostic category 'schizophrenia' as the discovery of a real illness.³⁹

As a way of trying to allay the anxieties brought on by the many uncertainties of the enterprise, psychiatry appears particularly prone to an exponential expansion of rhetoric. Psychiatrists have to persuade not only each other and the public (which must be convinced that it needs their special skills) but also the wider medical-scientific community. We have seen that psychiatry is unique amongst medical specialities in that the test of the value of its theory and techniques is not any clear benefit to the patients, as measured by unambiguously positive organic effects. Rather than working on objects (illnesses, lesions, etc.) psychiatry works on subjects (persons or personalities) in order to improve states of mind and demeanours. As a consequence, success and failure may only be vaguely assessed, and always only by implication. Unlike other kinds of physicians, psychiatrists cannot very often and with much certainty answer the question: 'Does the patient get better?' They may only be

39 See Chapter 14, below, in the section: The invention of schizophrenia.

able to answer the question: 'Does he quickly re-present?' And all too often the answer is: 'Yes, he does.' Hence, while it is far from clearly the case, everybody must be persuaded that psychiatric officials do indeed possess a specific, unique and valuable competence in the matter of mental disorders. The problem is, psychiatrists have been trying for two hundred years, and they have yet to produce a single concept or technique that is demonstrably more successful than the terms and techniques which they borrow from the lay-public. In matters of high emotion, confusion and distress, ordinary folk are able to show that they are able act as compassionately, competently, wisely and helpfully as any doctor.⁴⁰

In this chapter and the next we argue that, as a matter of propaganda and self-persuasion, psychiatry employs a *pseudo*-medical and *pseudo*-scientific rhetoric. It proliferates jargon which is not scientific and medical but only *appears* and is *announced* as such; it employs techniques and rituals which may *appear* scientific and medical but which are largely a kind of *white man's magic*;⁴¹ and it announces certain quantitative attributes of both alleged illnesses and alleged remedies that might superficially appear more substantial than moods, attitudes and ideation, and which are amenable to a kind of accounting - such as forms and quantities of neuron electro-chemistry and hormone excretions, milligrams of drugs, and ECT voltage. Yet, aside from the guides for maximum levels of medication - which are anyway often ignored (and always with impunity) - precise quantities of psychiatric medicine serve mainly a persuasive purpose rather any reliable therapeutic use.⁴²

Even though it is misleading, unhelpful and a hazardous misconception of functional mental disorder and its appropriate treatment, we are all supposed to find the medical model reassuring - and most of us do. As suggested in the previous section, the unspoken value of this misconception of emotional or psychological crises is that, except perhaps for the person who is made into a patient, it rationalises and excuses everyone's behaviour. The medical model assures members of the family (or other interested parties) that, since they play no material part in the crisis, they bear no responsibility: mental illness is a disease which some unlucky people simply happen to contract or inherit. It is the psychiatric experts who will take on all the responsibility, and the medical model provides the rationale for detention and forcible treatment, if needs be. This management of the crisis is justified as 'healthcare', and it may be lawfully done to the person 'for his own good'.⁴³

We have also mentioned that psychiatrists do not encourage free debate in the spirit of genuine science; they only tolerate arguments about mental health issues if they are conducted in terms of the medical model. Since doctors are well regarded, well-paid and enjoy high levels of job-security, it seems to us that their insecurity must to a great extent therefore be due to *subliminal appreciation* of the fundamental weakness of the psychiatric medical model. Unwarranted hostility is the sign of paranoia. In this case, we believe it indicates the deep and pervasive emotional and cognitive insecurity of that great majority of psychiatrists who subscribe to the medical model; antagonism towards dissent or reasonable criticism (whether from inside or outside the profession)⁴⁴ indicates a pervasive insecurity about the viability of the mental health enterprise, and thereby the value of the doctors' medical-scientific credentials. As long as psychiatrists are committed to a so-said medical science that forever falls short of any satisfactory achievement, they will be liable to emotional and cognitive insecurity, and they will react with frustration and hostility whenever anyone dares question any aspect of the orthodox mental health project.

40 Or, indeed, as callously and with as much confusion and incompetence.

41 Medical psychiatry is the invention of privileged white men (European and North American).

42 As we saw in Chapter 6, above, especially in the section: New evidence from pharmacogenetics, doctors are not interested in providing doses precisely suited to each mental health patient's unique metabolic system; and in Chapter 7 we saw that the administration of doses of electroshock is pretty much 'rule-of-thumb'.

43 This is not to imply that many officials do not genuinely try to help their psychiatric patients.

44 See for example: Breggin, PR, op. cit. (n. 107, Ch 1), with documentation scattered throughout, but especially 77-80 and 82-85.

There are, then, a number of powerful historical, professional, emotional and cognitive motives which come together to impel psychiatrists to wish to appear indubitably medical, and to act in a manner which they claim is objective and scientific. During the 19th century, the medical profession steadily appropriated the management of the mad from every other interested party. We argue that this is because established power always prefers to view every personal problem (including emotional or psychological crisis) as individual pathology rather than the result of any social imperfections. Consequent to this medical coup, every psychiatrist is first of all trained for years as a physician; he receives little psychiatric training during that time, and since he is given no adequate guidance and would not feel comfortable dealing with a psychiatric patient as *no more and no less than a very disturbed person*, he is willing to believe that the patient simply 'has a mental illness'. And at last, in the 1950s, with some plausibility the doctors felt that if they could not claim to cure mental illness by means of medication, at least they were able to contain it. In the intervening years, however, this management has proved precarious and often harmful. More than this, and contrary to expectations, no real cures were devised in the meantime. For these reasons, and since it wishes to cure people rather than only to contain them - after all, it is ostensibly a branch of medicine, not the police force - psychiatry continues with its medical posturing, as if one more research effort might finally discover an organic cause or a medical cure.

The insecurity of the psychiatrists, which we believe we can discern, gives rise to defensiveness that, in turn, manifests as a paranoid projection, a psychotic urge⁴⁵ to view every disturbing emotional or mental condition as a medical problem. Doubtless, the compulsion to believe in the elaborate taxonomy of the so-said mental illnesses is based in the allure of establishing a genuinely viable medical-scientific sub-discipline, on a par with all the other specialisms. But psychiatry has had more than a hundred years to discover an organic cause which it can link with any of the types of mental disorder, or even to prove itself a kind of medical science that can definitely help people recover their emotional and mental balance. With both projects it has failed. On the other hand, a mental health diagnosis is a cast-iron excuse for any functionary to carry out his duties and at the same time not really care about the patient to the extent of genuinely wishing to get to the root of his problems. Psychiatry has proved most successful as a kind of police-work which, without much relieving their misery, can to an extent contain some patients' deviance.

In the face of this lack of medical success, as measured by rates of recovery, we can guess that a variety of unhelpful emotional responses are summoned up. It must surely be an occupational hazard that any doctor who is daily reminded by his more or less recalcitrant mental health patients that his theories and his medicine are not very successful - and who cannot or will not imagine a different 'model' of mental disorder - will feel insecure in his profession, and might therefore be likely to adopt a defensive-aggressive attitude towards any person or event that contradicts his belief. Besides, there is an atavistic instinct of aggression towards the weak, which manifests as the urge to blame someone for his illness or misfortune. Amongst those who do not comprehend that the root to a functional mental disorder is emotional trauma - which is to say, nearly everyone - this urge is especially strong with regard to someone said to have a *serious* mental illness. It seems that these days there is generally a confused understanding that mental illness is indeed a kind of illness - since all the experts say it is - but also that it is not quite like other 'normal illnesses' (such as a broken leg, heart disease or cancer), in that a central dysfunction is *motivation*; in which case, mental illness still registers as a kind of moral failure. This accounts for the stigma, and the punitive or authoritarian reflex towards the psychiatric patient on the part of many 'normal' people - and not necessarily excluding doctors.⁴⁶

Of course, as trained experts and educated men of the world, psychiatrists might consider themselves alert to the intrusion of such a regrettable 'pre-scientific' attitude. All the same, as we

45 Of course, the doctors prefer to see themselves as focussed or single-minded.

46 Normal punitive or authoritarian character is explored in Chapter 23 (Volume 2). See especially the sections: Sadomasochism and the authoritarian personality, and Normal character and unquestioned institutions.

suggest in Chapter 3, above,⁴⁷ it seems that the psychiatrists' paranoia cannot help but surface as the fanaticism with which so-said medical theories and methods are pursued in the absence of any evidence for their value, and to the exclusion of a viable alternative (i.e., psychodynamic theory and therapy). As we mentioned, this paranoia appears at the personal level whenever anyone but another psychiatrist dares question a diagnosis, a prognosis or a treatment. Furthermore, if obsessions and compulsions become a mental disorder when they reach a certain degree of dysfunction and incapacity, we could argue that the psychiatrists' paranoia also issues in a vigorous obsessive-compulsive disorder; this is manifest in the compulsion to assign a particular diagnosis to every mental health patient (but not convincingly for his benefit), and by the obsession with taxonomy itself, which is evident from the endless proliferation of types within the psychiatric diagnostic system, as the attempt to articulate a precise category of disorder (illness) for every conceivable case of mental or behavioural deviance. In word-magic, to name is to control. No deviant behaviour or ideation must escape the control of the psychiatrists.

Unfortunately for them, psychiatrists and general practitioners have to ply their trade in a field where 'common sense' often proves just as viable as medicine. This trade is called into question whenever people 'look after their own' without medical help, or when patients seem to recover after refusing or forgetting to take their prescribed medications, or decide unilaterally to 'come off' them. Furthermore, not only is the history of 'scientific psychiatry' littered with failed medical ideas and techniques, but nowadays other caring and curing professionals - such as nurses, therapists and counsellors - compete openly and sometimes successfully with the doctors. All this must surely conspire to make psychiatrists feel insecure.

Meanwhile, anyone undergoing an especially worrying emotional or psychological crisis may be legally appropriated by an official power which is under no compulsion to account for itself, to answer objections to its theories and methods, or adjust them according to whatever reasonably seems to be the case. Because they are free to choose to define the problem and the remedy of functional mental disorder in any way they wish, psychiatrists doggedly and dogmatically assign every upset and confused individual to one of the supposedly medical diagnostic categories, and attempt to work on his brain with an allegedly objective-scientific technique. In law, psychiatrists are barely required to account for themselves to any other authority, let alone to critics. Unlike their peers in general medicine (or other real scientists), they are never forced to make their own beliefs conform to reality - for example, to recognise the pernicious circumstances of a life which might, in fact, generate the mental disorder. Instead, they possess almost unrestricted powers to keep on forever trying to make reality - the beliefs and behaviour of their patients - conform to the demands of psychiatric dogma.

How Psychiatry emerged out of Medicine

People have always turned to spiritual advisors or healers when faced with the enigma of mental disorder. Down the ages, various medicinal remedies have been tried, albeit with little clear benefit - herbs and psychoactive substances such as opium and alcohol are known to have been used for thousands of years, and drilling a hole into the head (trepanning) seems to have been practiced as far back as Neolithic times.

By the end of the Middle Ages, a few hospitals had been established to contain and occasionally care for the mad. During the 17th century - later known as the Age of Reason - unreason came to be seen as an offensive blight on the otherwise increasingly rational organisation of a society which was becoming more mobile, urban and crowded, and in which the mad were therefore a more visible nuisance. More hospitals and public asylums were established during the 18th century, but also many more private madhouses. Few inmates benefited from incarceration, and regulation of commitment, care and treatment was desultory or non-existent. By the beginning of the 19th century, medical treatment was still mostly barbaric and always guesswork. Reform of care and treatment at that time, known as 'moral management', was mainly led by philanthropic laymen; especially with regard to

⁴⁷ See text to footnote 45 in Chapter 3, above.

madness, doctors were generally viewed as little better than quacks. By the middle of the 19th century, though, the management of madness was beginning to fall into the hands of physicians who had established a new specialism: psychiatry. To an extent, this was due to the public's interest in the sudden improvement in the medical understanding of disease and hygiene. Coupled with the perennial tendency to perceive any serious psychological problem as a medical matter, new demonstrations of the scientific nature of general medicine recommended doctors to the management of 'patients' in 'mental hospitals'.

It was also somewhat by default that the doctors took control: at that historical juncture there existed no other well-organised, plausibly qualified and obviously available professional group. To recap the history sketched in Chapter 1, the grounds for this change were laid mainly by non-medical reformers who campaigned for the state to regulate the madhouses and hospitals, and who made up an influential number of asylum organisers and managers during the first half of the 19th century. Public interest had been roused by the use of chains, shackles, starvation, purging, bleeding and beating (especially when those methods were used on the madness of King George III).⁴⁸ The famous Dr Pinel was active in the French Revolution but, rather than in the name of medicine, it was on behalf of freedom and humanity that he opposed routine physical restraint of the insane. In 1796, as part of an English wave of reform, and in response to revelations of the terrible and often murderous conditions of the madhouses, Tuke established humane care at The Retreat, outside York; Tuke was a Quaker.⁴⁹ This reforming impulse was not medical but humanitarian, and it found popular support. In 1808 an Act of Parliament enabled the counties to erect and maintain pauper asylums, which in practice often also took 'paying guests'. Some of the new asylums proved beacons of enlightenment. 'Moral restraint' replaced overt coercion and medical tinkering. In the absence of techniques other than various mechanical means of violence or methods for debilitating the person, successes in the Age of Reform led to almost complete abolition of restraint, except as a last resort. Physical restraint, bleeding, purging, vomiting, and devices such as hot or freezing water-torture and the spinning chair, sometimes remained residually as treatments employed by physicians, but they were more likely used in the unreformed madhouses purely as punishments or threats. At this time, self-styled 'mad-doctors' or 'alienists' were only able to make manifestly unscientific guesses about treatment, could not cure or ameliorate madness, and did not have a good reputation. As a matter of policy, no physician was employed at The Retreat during its first forty years.

It was not until 1845, with the Lunatics Act and the County Asylums Act, that doctors were involved statutorily in the care of the insane. They were included with magistrates as authority for compulsory detention, and set up as Medical Superintendents of the new public asylums. This inclusion of doctors was intended more to deal with widespread problems of inmates' physical health than with their mental conditions. At that time, scientific medicine could offer nothing at all in the way of treatment for the insane: the two Acts simply authorised doctors to act as physicians and also to organise a life of sociability for patients in as pleasant and soothing surroundings as possible.

During the early 19th century, then, progressive authorities abolished restraint, torture and casual abuse of the mad. At that time, insanity (or lunacy) was viewed by most responsible members of the public as a moral issue, a certain kind of regrettable alienation from the community, more to be pitied than punished or treated as an illness. Attempts were therefore made to reintroduce the inmates of the asylums to civilised society by means of example and 'moral management'. Enlightened managers conceived and organised the asylums as benign and secure places of retreat from the world, in which every able-bodied inmate was to be employed in simple routine tasks around the buildings, gardens and farms. (This also made the asylums fairly self-sufficient.) Attention was given to diet, hygiene and physical health, and efforts were made to organise a pleasant, entertaining and improving social life. These changes contributed to the remission of symptoms in many inmates. Especially before mid-century, when the asylums were not yet crowded and many managers were fired with reforming

48 Medical historians dispute whether he suffered from functional mania or the organic condition, porphyria.

49 The Retreat was given its name so as to denote a secluded place of quiet spiritual contemplation, and to distinguish it from the disreputable 'asylums', 'madhouses' and 'mental hospitals' of the time.

zeal, some institutions could justifiably claim to cure 40% or more of the intake, entirely due to the benign effects of 'the moral regime'. It is likely that at least one-third of the inmates would have been suffering from an incurable organic condition (usually, as was discovered later, either syphilitic GPI or dementia), so these are impressive results which easily match those of modern psychiatry. Even so, later in the century and into the early years of the 20th century, due to the dire conditions of work, housing and unemployment in the rapidly growing industrial towns and cities, the numbers of the insane also grew, and most asylums expanded and became therapeutically unmanageable: they became overcrowded, 'silted up' by an apparently incurable population of 'the insane poor'.

In the interim, as early as 1848 the house journal for the emerging profession of psychiatric doctors had announced, as an article of faith,

...Insanity is purely a disease of the brain. The physician is now the guardian of the lunatic and must forever remain so.⁵⁰

This was audaciously imperialistic since, in 1832, Baille had reported evidence for brain pathology in only one-third of his post mortem sample,⁵¹ and no-one had any ideas about the possible cause of madness. Until the end of the 19th century, general medicine understood the causes of very few physical diseases, and could offer even fewer cures. Earlier in the century there had been a fine line between general medicine and ineffectual or harmful quackery, both in the public imagination and in reality: Simpson's chloroform anaesthesia did not appear until 1847, Pasteur's germ theory and inoculation in 1850, and Lister's antiseptic surgery in 1860. Besides, improvements in the health of the general population which began to manifest later in the 19th century were not so much due to medical advances as to political and administrative reforms: better health is explained almost entirely by the widespread introduction, from the mid-century onwards, of sewage disposal and the provision of clean water for the hitherto dangerously polluted urban sprawls.

By about 1850 it was generally understood that illness was the result of damage to the body's cells. Confirmation of the germ theory of disease caught the public imagination, and the medical model quickly became the fashionable theory for every kind of personal malaise. Its assumptions remain unchanged to this day: rather than anything to do with the whole person in his environment, the body is viewed only as a bio-machine with vulnerable parts; every disease is caused by a specific material agent such as a virus, a bacterium, a parasite, a lesion or abnormal DNA; since the problem is supposed to be in his body, a patient must become the passive recipient of an expert medical intervention; health is only restored by mending the malfunctioning body-part and thereby bringing the whole 'body-machine' back into equilibrium; obviously, this is to be achieved by employing the latest techniques of medical science. The belief that madness must always be the sign of an illness - some sort of tissue damage or malfunction - took on vigorous life in response to the successful germ theory, *but only by wishful inference*.

In this manner, by the end of the 19th century physicians had become the undisputed managers of the mad. As impressed as everybody else by the sudden and spectacular scientific successes of general medicine, psychiatrists began to dabble with some of the new industrial chemicals. Sedating barbiturates, bromide and chloral hydrate were introduced so as to control psychiatric symptoms. None cured madness, and each soon proved either dangerously toxic or addictive. At this time, the main thrust of the infant psychiatric profession was a massive research effort in which more than a million brains were dissected post-mortem, searching for a clue to the problem of the incurability of the insane. This led to a considerable increase in knowledge of the structure and function of the brain and the nervous system but not one iota to the knowledge of functional mental disorder or its causes. By association with the growing reputation of general medicine, and in the absence of claims from any rival profession, psychiatrists managed to increase their statutory powers whenever Parliament considered the recurrent problem of how to manage the great numbers of the insane.

Psychiatry emerged as a junior and poor relation to general medicine. It contested the management of the mad with keepers and curers who, if they offered anything beyond containment

50 Editorial (1848) *Journal of Mental Science*; quoted by Pilgrim, D (1995) Letter. *The Psychologist* Jan.

51 See the section: A brief history of psychiatry, in Chapter 1, above.

and punishment, espoused ‘moral authority’. But the psychiatric profession has always cast about willy-nilly for techniques, and neither in terms of logic or science has it ever proposed a coherent or evidenced theory, either concerning the cause of madness or the remedies employed; mental health practice is still not evidence-based. It was not until 1909, when a cure for syphilis was discovered - and hence a cure for General Paralysis of the Insane (GPI) - that psychiatry could at last celebrate an authentic scientific success.⁵² Even though the cure was not their discovery, the psychiatrists were heartened and felt legitimated, really for the first time. Thereafter, psychiatric researchers laboured in vain for another chemical cure, and a range of dubious and dangerous treatments were devised. Insulin coma therapy, for example, first employed in the 1920s, was never a convincing remedy for the so-said illness of schizophrenia; and yet it was only abandoned when the major tranquillisers came onto the market thirty years later.

Perhaps the most notorious example of this casting about for a method of treatment is electroconvulsive therapy (ECT). This was tested in 1938 by two Italian psychiatrists who happened to hear that pigs in the slaughterhouse often fidget instead of dying when subjected to electric shocks to the head. Because another psychiatrist had suggested that epilepsy and schizophrenia were mutually exclusive, they conjectured that inducing an epileptic fit might ‘drive out’ the schizophrenia. Despite his protests, the first convenient psychotic person who then fell into the doctors’ hands was subjected to increasing amounts of unanaesthetised electroshock across his temples, until he fidgeted. He became agreeably submissive.

This experiment was considered so successful that ECT was soon standard practice in every advanced nation. Subsequently, after countless electroshocks had been administered, audits began to show that it did not appear to cure schizophrenia, after all. Perhaps it worked, however, to some extent, with the severely depressed; to this day, it is used mainly for that category of patients. As for how the technique ‘works’, all that is proven is that autopsies show that brain cells are burned out. Aside from that, nobody can say how it works, or even strictly speaking *if* it works, as a benefit for depression or any other psychological condition, except perhaps by impairing memory. On the other hand, as we already suggested, there may well be processes at work to ‘improve’ depression - such as intimidation which makes a patient think twice about ever complaining, or faith healing, or perverse meanings involving the patient’s ideas about her own guilt and desire for punishment.⁵³

Since doctors, nurses, drugs and precise instruments are employed together in focused operations on a supposedly recalcitrant/unhealthy part of the body (the brain), this kind of activity all *appears* indubitably medical. If appearances are particularly important for psychiatry - which we think they are - the enthusiasm of some psychiatrists for techniques such as ECT and psychosurgery⁵⁴ may be explained by the fact that both have the spectacular appearance of scientific medicine: they require a visibly deliberate social and technical organisation. At the same time, whatever other functions they may perform, medication, ECT (and occasionally leucotomy) serve to justify the dominant role of doctors in mental health work. Unfortunately, the doctors give only casual regard to questions of efficacy, and none at all to the possibility of their own abuse of power by maltreatment; i.e., they never seem to interrogate their own decisions and motives. Subtleties such as the possible part played by the *emotional and mental* processes of doctors, nurses and patients in all this unevidenced ‘remedy’ seem beyond their imagination. As a sign of psychiatry’s indifference to the social context of any mental disorder or form of therapy, both psychosurgery and electroshock were developed under fascist dictatorships and by experiments on involuntary patients.

Despite the alleged success of shock treatment, psychiatry was floundering with regard to the functional mental illnesses until the advent of the major tranquillisers. These became widespread in the early 1950s; the anti-depressants soon followed. It then seemed that psychiatry was surely on the right medical track. By 1959, with a new Mental Health Act, optimism about the possibility of

52 See footnote 94, and the text to it, in Chapter 1, above.

53 Most of the recipients are female. The physiological effects and the symbolism of electroshock are discussed in Chapter 7, above.

54 Psychosurgery is still endorsed by a few doctors. (It is also discussed in Chapter 7, above.)

remedying every kind of mental disorder was such that lay control of the management of serious cases (the Board of Control) was abolished: every decision on compulsory detention and treatment was devolved entirely to the psychiatric profession. With this reform, increased credence was given to the myths that every serious mental disorder must be an illness and that medicine was at last getting to grips with it. In reality, however, the mental hospitals were beginning to empty *before* the new tranquillisers and anti-depressants came onto the market. This is best explained by two factors: on the one hand, successive social reforms since the turn of the century had much improved living conditions by providing at least minimal welfare so as to cushion the extreme forms of social stress that had fuelled much of the despair and madness of the 19th century; on the other hand, in 1910 probably at least one-quarter of the inmates suffered from GPI, and the terminal 'back wards' began to empty by natural mortality as soon as a cure for syphilis was implemented.⁵⁵

In the meantime, the terms of the technical discourse altered as the medical profession began to take control of the management of mental disorder. Before the middle of the 19th century, words like 'madness', 'lunacy' and 'idiocy' had been interchangeable. First, a distinction was made between 'mental handicap',⁵⁶ for which there seemed a clear constitutional cause, and 'insanity'. The latter was divided into only a few sub-types, such as 'melancholy', 'mania', and 'hysteria' ('women's madness'). Since there was only a limited set of treatment options, this sufficed during the early years of psychiatry. As the profession accrued ever-increased legal powers, however, its members more confidently proclaimed themselves a credible medical specialism, like any other, and set about discriminating an ever-increasing number of Linnean-type sub-categories of mental disorder, each with its own scientific-sounding, Greco-Latin name. Today there is a complex taxonomy of the functional mental illnesses, and a great many different permutations for treatment.

The crucial propaganda victory of 'the medical model' - over 'moral management', psychology and social-psychology - was the profession's acceptance and elaboration of the so-said mental disease that came to be called 'schizophrenia'. The psychiatrists announced that they had discovered a severe and degenerative mental illness which usually onsets in late adolescence. During the earlier part of the 20th century, this barely questioned 'discovery' led the way for people to talk much less about 'lunacy' or 'insanity' - terms which were stigmatising and dreadful but connoted no particular cause - and more about 'mental illness'. That formulation 'obviously' connotes an organic cause; thereby, it offers hope for a medical remedy, and at the same time it provides the rationale for a social response which convinces everyone that it takes no interest in moral, political or even psychological dynamics.

The unacknowledged circular logic of the consensus could now run: since doctors are mandated to manage serious individual irrationality, the crisis must be a kind of illness; and if the crisis is diagnosed as an illness, it must be a real disease and doctors must treat it with medicine. Psychiatric training was meanwhile always an afterthought to general medical training. In the UK, to this day, doctors normally spend only eight weeks on the psychiatric component of their first five years in medical training; they then take a further probationary year of experience and training in a general hospital; only then, when they are thoroughly indoctrinated with the medical conception of personal malaise and methods of treatment, do they enlist for a probationary year specialising in psychiatry.

By the early part of the 20th century it was generally established that any emotional or mental disorder is a medical event; and since it is supposed to be the symptom of an illness, it might inflict anyone at any time. More than a hundred years later, however, psychiatrists still cannot legitimately claim to understand aetiology or cure their patients. Sometimes they may feel that they are able to contain aberrant behaviour, but this is often only by means of coercion: a psychiatrist's daily dealings with madness are precarious, and he only ever stumbles a step or two ahead of failure. This makes psychiatric practice tentative, insecure and quite unlike that conventional medicine in which each doctor was trained for so long. On the face of it, this practical and cognitive insecurity might make

⁵⁵ See text to footnote 94 in Chapter 1, above.

⁵⁶ In descending levels of intelligence, this was differentiated further, and by 1914 legally codified as: feeble-mindedness, imbecility and idiocy; there was also the category: 'moral defective'. See Jones, K, op. cit. (n. 86, Ch 1), 204.

psychiatrists as fearful of the chaos of the presenting individuals as anyone else. For all that, they are able to call on a powerful weapon with which to control the apparently random outbreaks of madness, and this must somewhat compensate for any uncertainty: that is, they possess legal powers to restrain and work on their patients.

By employing medication as the first and main treatment, psychiatrists might reassure themselves that they act scientifically and medically.⁵⁷ Surely psychiatric research will one day deliver clear evidence of the benefits of drugs to aberrant enzymes or neural pathways? Year after year, research papers announce how close they are to discovering precisely measured quantities of biological causes and effects. But they miss the point. Undeniably, drugs and shock treatment affect brain chemistry, hormones, neurotransmitter pathways, etc., and of course they affect a person's functioning. An aspirin might relieve a headache, and doubtless a biochemist could tell us how it acts on the chemistry of the brain. In itself, however, that tells us nothing about the cause. In the absence of any demonstrable physical cause - and often even where there is an evident cause (e.g., the person was working when he needed to sleep) - a headache is usually a reaction to a way of living. In other words, it is well-known to be a matter of emotional, mental or social processes which are not best modified by resort to medication but by understanding motives, beliefs and behaviour, and changing them.

The attempt to manage every kind of mental disorder by means of medicine is reckless wishful thinking. A physiological/medical account of the individual may or may not be interesting, but his problematic behaviour requires *psychological* or *social-psychological* analysis. Psychiatry is peculiar in that it spends most of the time side-stepping its proper topic, which is to say: psychopathology, disorders of the mind, the soul, or spirit. This is because the medical experts are thoroughly perplexed by mind, soul and spirit; these are abstract phenomena which may only be *inferred* from behaviour - they are not anything which may be captured, measured, cut up and put under a microscope. In which case, so far as the doctors are concerned, 'mind', 'soul' or 'spirit' are worthless pre-scientific concepts which denote only imaginary entities. As a matter of principle, and along with every significant emotional or mental event that any patient ever experienced, the medical model banishes mind, soul and spirit from the scope of psychiatry.

Science is now in the grip of a technocracy closely tied to big business and the state. Of course, medicine is now rightly counted as a genuine science, and its prestige is due the delivery of so many tangible and spectacular benefits. In this context, and since the lack of evidence for their medical claims is not widely known, psychiatrists - after all, fully trained doctors - are able to provide a rationale for the universal wish to avoid fraught encounters with the hazardous chaos of emotional distress and mental disorder. We have seen that Medicine is the alibi for psychiatric officials never to listen carefully to the patient, or to respond adequately to his actual somatic, emotional and cognitive needs.⁵⁸ We have also seen that there is no evidence for the belief that every mental disorder is caused by abnormal biochemistry or genetics, or a virus.⁵⁹ Nor is there clear evidence that psychiatric medicine provides much benefit, but much that it is harmful.⁶⁰ Nonetheless, in retreat from their own anxieties, forever in hope and in order to claim legitimacy for what they do, psychiatrists cling desperately to inappropriate but allegedly medical-scientific methods.

The management of worrying mental disorder is a medical monopoly: that is what society wishes. Dedicated to alleviating suffering, having made sacrifices and worked hard during years of training, psychiatrists are often defensive and resentful of what they see as the carping ingratitude of too many of their patients. They also resent the encouragement of these patients by others the psychiatrists perceive as irresponsible denigrators of the best that medicine can offer, i.e., anyone who disagrees with the so-called medical model. And since they have legal possession of a kind of total power, and no-one can demand that they answer their critics or reflect on their methods, there is simply no

57 But see Chapter 6, above, for a discussion of the lack of evidence for the efficacy of psychiatric medication.

58 See especially Chapter 4, above.

59 See Chapter 12 above, and its Appendix.

60 See Chapters 5 to 7, above.

incentive for the doctors to do so. In this manner the psychiatric profession piggy-backs the prestige of general medicine - even though the presenting problem is seldom an organic disorder but instead is usually deviant ideation and behaviour resulting from stress and psychological trauma.

Arguably, the psychiatric patient is worse served today than his counterpart in the days of 'moral management'. At least in the more humane institutions of the pre-medical age he would not, 'for his own good', have been poisoned by chemicals or had his brain blasted with electricity.

The wish to be scientific

The plausibility of psychiatry relies on its association with general medicine which, of course, is held in high esteem due to its successful employment of the scientific method. Hoping that science will one day explain and find a treatment for every kind of mental disorder, psychiatric research focuses almost entirely on discovering biological evidence that would make the profession into a medical specialism on a par with any other. But in Chapters 6, 7 and 8 above, we saw that the various mental health treatments are not more effective than talking therapies, placebo or even no treatment at all. And in Chapter 12 we saw that psychiatrists cannot even begin to account for the genesis of the archetypal mental illness, schizophrenia, that there is no evidence of an organic cause for any kind of functional mental disorder, and that much of the research is hopelessly ill-conceived and therefore inevitably ill-fated.

Faced with the apparent enigma of the functional mental disorders, for more than a hundred years researchers have tried in vain to discover a medical cure or any proof at all for a whole variety of disease hypotheses. This was always a wild goose chase. If, by definition, functional mental disorder is not brain pathology but deviant ideation and behaviour, this surely rules out trying to account for it in terms of medical science: any explanation has to be in terms of *psychological* theory. In spite of this, their propaganda is so persuasive and everyone's preconceptions so entrenched that it has long been taken for granted that the authority of the psychiatrists does indeed derive from the medical-scientific nature of their concepts and methods.

What is meant by 'science'? And can scientific method ever be successfully applied to *processes of the imagination*, whether rational or irrational, normal or abnormal, sane or insane, benign and functional or anguished and dysfunctional?

In its most general sense, 'science' denotes a systematically organized body of knowledge about a certain topic. More specifically, it is the systematic study of the structures and processes of the natural world by means of observation, hypothesis and experiment. The term first appeared in the 14th century, but the experimental method only achieved sufficient rigour during the 17th and 18th centuries, and the sciences reached their modern forms when they became institutionalised in the laboratories of the 19th century. A genuine science must be able to generate causal explanations of perceived regularities: it develops hypotheses which may be tested by empirical verification or falsification, as deduced from experiments which may be replicated. A proposition therefore has no scientific status unless it is possible to translate it into a testable hypothesis or predictions, whereby evidence is brought to bear on it by means of experiments in which each relevant element is exactly repeatable since it is quantified and subjected to measured control or variation.

One aspect of the scientific method is especially dear to doctors since they might find it difficult to work on the human body were they not distanced by ritual from the person and his pain: the requirement that whoever interrogates reality should be detached from immediate contact with it. Detachment is achieved first of all by the hypothesis; this is generated by a theory expressed in a specialised language that applies uniformly to all instances of the topic, invariably by translating the object of study into measurable quantities, and preferably by using technical instruments. Through these mediations, the topic is perceived as something separate from (and other than) the scientist: for the sake of clear and disinterested focus, the scientist is dislocated from nature. This objectification and alienation of the universe of events within the scientist's purview is a deliberate and necessary ploy. Historically, childish (or childlike) relations between the enquirer and the topic - the magical

connections between persons and things - were a great hindrance to the emergence of dispassionate scientific knowledge.

Overt dispassion or detachment may not always be such an astute response to functional mental disorder. The aloof, so-said objectivity asserted by the doctors is irksome to many mental health patients who experience it as a callous lack of empathy and compassion. Moreover, this perception is not ignorant or silly, but well-founded. Psychiatric practice is not generally based in authentic medical science, and much of the doctor's putative objectivity is redundant, oppressive and counter-productive to the patient's well-being. 'Detachment' and 'scientific objectivity' easily become alibis for the doctor's biased subjectivity - first of all, for his blind belief in the psychiatric medical model. In addition, this unconscious and denied subjectivity - this alleged objectivity - only gets in the way of anyone ever discovering the real nature and cause of any particular mental disorder, and therefore of the troubled person ever being able to find meaningful assistance.

Meanwhile, nothing avoids its appropriation for ideological purposes. (We mean 'ideology' to denote not *any* belief or idea, or system of ideas, but one which is demonstrably false and which dissimulates significant material or social interests.)⁶¹ In the wake of the revolution in knowledge wrought by the natural sciences, especially by Newtonian physics and developments in mathematics, the wider cultural diffusion which came to be known as The Enlightenment or The Age of Reason proposed itself as undoubtedly progressive and in opposition to all the superstition, unreasonable social habits and unfounded metaphysics of the previous centuries. When defining essences such 'the person' and 'mind', the rising class of entrepreneurs and administrators tended to endorse ideas which aped the new physics. This ideology celebrated the atomised, self-possessed, self-sufficient and rational individual, unfettered by the old traditional irrationalities. After all, this seemed to mirror the experience of the members of that class. In this perspective, the scientifically proven truth of everything under the sun - including everything social and personal - would be revealed by means of the correct perceptions, thought processes and practical methods of the fully rational individual. Ordinary speech is a social habit based in tradition, and so it was definitely suspect, i.e., error: the pure logic and mathematics of science would surely replace the archaic imprecision of language.

Obviously, the ambition to reduce the whole of reality to an assortment of *predictable objects* has since been much encouraged by the accelerated accumulation of spectacular advances in knowledge and control, as delivered by the natural sciences. Nature only began to reveal her secrets under proper scientific scrutiny; mankind is part of nature; therefore, it was (and is) supposed, the only sound knowledge of human nature is to be achieved by means of the scientific method.

At the beginning of the 19th century, Saint-Simon was a popular philosopher, herald and protagonist for a scientific, industrial and technocratic utopia which would finally rescue humanity from the appalling ignorance, drudgery and barbarism of the Middle Ages.⁶² This would be achieved by the scientific discovery of 'positive social facts' which everybody would have to acknowledge and to which they would reasonably submit, just as they already must submit to the undoubted empirical facts of physical reality revealed by the natural sciences. A new social science would bring an end to every personal and social conflict: harmony would result from everyone recognising and reasonably conforming to factual necessity. In this positivist ideology, every form of deviance is irrational - it can only be explained as either a conscious, wilful and absurd refusal to submit to the dictates of reality or a pitiable kind of sickness. Two hundred years later, the psychiatrists - who almost certainly know nothing of Saint-Simon - are stuck with this conundrum. Since they would like to be seen as medical and humane, psychiatrists *wish* that every kind of inconvenient mental deviance were a sickness, and yet they simply fail to locate, calibrate and work on any organic causes; and, at the same time, since a material cause can never be found, and since his behaviour might often appear wilful, a psychiatrist can never rid himself of the suspicion that the patient *decides* to be deviant and is *responsible* for his condition.

61 See Marx, K & Engels, F, op. cit. (n. 46, Ch 3), and the discussion at the top of the section: Psychiatry as a component of the ruling ideology, in Chapter 15, below.

62 See the quotation towards the top of this Chapter (n. 4).

The subject matter of any natural science exists independently of what anyone thinks, but thinking is a vital part of the subject matter for any social science: *reflection is intrinsic to social and personal phenomena*. Failing to recognise this fundamental difference between nature and human nature, the psychiatric profession has committed itself to a positivist ideology - a kind of wishful thinking based in an inappropriate conception of human being as essentially reducible to the causal relations of objects:⁶³ in the case of mental disorder, reducible to *illness*. This kind of thinking fails to recognise that when it comes to a person, 'the object' is always a subject who *actively conceives of* his relations to others and to reality in general, as well as *subsists in or is implicated in* those relations. The central role of the imagination in human life, in construing events and their significance, means that 'the facts' about any social or personal event are *always socially constructed and very often contentious*. Actually, against the backdrop of a generally anticipated flow of routine human relations, 'an event' is often only remarked *as an event* precisely because 'what is happening' is unexpected and perhaps problematic, a matter of some dispute which may only be settled politically or judicially. The logician Lewis Carroll understood this very well:

'When I use a word,' Humpty Dumpty said, in rather a scornful tone, 'it means just what I choose it to mean - neither more nor less.'

'The question is,' said Alice, 'whether you *can* make words mean so many different things.'

'The question is,' said Humpty Dumpty, 'which [of us] is to be master - that's all.'⁶⁴

A century later, this insight was elaborated by a French critic:

Language is legislation, speech is its code. We do not see the power which is in speech because we forget that all speech is a classification, and that all classifications are oppressive.⁶⁵

In short, no personal, social or mental 'fact' is ever anything other than a more or less plausible or persuasive proposition about an aspect of human actuality. For example, just because officials happen to define the parts and relations of reality in a certain way, that is no guarantee for the *intrinsic* reality, significance or superiority of the resulting facts over and against argued and plausible propositions which may be derived from a different perspective. (Consider variations between official and 'probable' rates of suicide or rape, due to the contentious nature of those events.) Naturally, official facts about social, emotional or mental life are couched in terms of the perceptions and discourses favoured by those who hold the reins of social power; they are the outcome of conventions determined by the play of specific material interests, they serve certain interests (and perhaps not others), and would not survive as 'the facts' unless they did so. But if unquestioned 'experience', 'custom', 'common sense' or the official categories are to be the sole measures of what is significant or real, where does that leave reason, criticism and reform?

...Facts do not speak for themselves; they speak only when theory teaches them to do so, and then only in the voice and with the resonance that theory may lend them. Without a theory, facts are mute or gibberish... 'Matter-of-fact thinking' unites revolutionaries and reactionaries; such a style is heavy with admiration successfully established, which become, like power successfully used, unchallengeable. To weave elaborate suspicions of fact is nowadays subversive. It is an affront to popular science. There is a hidden relation between the worship of fact and the worship of power.⁶⁶

63 Towards the middle of the 19th century, Auguste Comte founded the academic discipline of Sociology. He was a follower of Saint-Simon, and believed that only information derived from logical and mathematical treatments and reports of sensory experience could deliver authoritative knowledge (i.e., the truth). Like Saint-Simon, he hoped that predictive social sciences would soon develop from the discovery of 'positive facts' about human affairs.

64 Carroll, L (1871) *Alice Through the Looking Glass*. London: MacMillan, 72.

65 Barthes, R (1982/93) *Selected Writings* (Ed Sontag, S) New York: Vintage.

66 Rieff, P, op. cit. (n. 3, Ch 8), 141.

'Empiricism' and 'pragmatism' reach an apotheosis in psychiatric positivism, in which blind belief in 'the facts' - propositions about persons and their mental or emotional states, couched in terms of the diagnostic categories - combines with a desire for quantitative-scientific precision in the hope of discovering and treating disease processes, just like general medical science comprehends and is able to remedy or manage real illnesses. This is the rationalisation or ideology of a reactionary monologue which, with its ersatz science and its asserted objectivity, persuades itself that it stands above politics and morality. Because it inevitably serves established power, the positivist urge has dominated social and psychological thought wherever Science replaced Religion. As a result, two hundred years after Saint-Simon, a scientific and social scientific technocracy - the servant of its paymasters - tries to dictate throughout the whole of our lives what is real and what is not. In the name of scientific medicine, anyone who is exceedingly troubled and turns to his doctor for help, or who otherwise finds himself subjected to psychiatry, is routinely categorised by means of a pseudo-medical diagnosis, invalidated as a person, and then drugged. In this respect, Saint-Simon's scientific-technological optimism has turned into a sick joke played on the vulnerable.

Our time subscribes first of all to a modern religion of Science and Technology, and so this scandalous irony goes unrecognised. Saint-Simon was Church Father to this faith, and we are all positivists now. It is hardly an exaggeration to call positivism a religion, since for most of us our relation to science is entirely one of dependence, faith and worship, not rational and critical understanding. We are overawed by Science. Because it does already explain so much, we imagine that it will eventually account for every puzzling aspect of reality, including our private thoughts, fears and wishes. But scientific theories and techniques are developed by way of esoteric discourses and methods - mostly involving abstruse mathematics - far from the public gaze. Aside from a small population of practicing scientists, each working in a particular discipline, the great majority of us are only able to experience science as some or other product which arrives in the public domain as a finished technique, or perhaps as a highly simplified story about a theory or a discovery. Even if the details of a particular scientific topic are patiently explained to us, we are not likely to understand because we are not ourselves specialist practitioners in that field: unlike a practicing scientist, most of us could not begin to translate into meaningful scientific or technical activity any 'understanding' we might think we have. At the same time, our civilisation would collapse without science, and each day what is naturally lived is increasingly artificial or man-made.

In imitation of physics and chemistry, and promising technical control, naïve empiricism in social and psychological theory holds that propositions are only true if proved by experimental manipulation and mathematical measurement of the relevant objects and their relations. When this belief is applied to the life of the imagination - to the person and his life with others - research takes the form of scientism or positivism, that is, a method and discourse which strives to be scientific but which can never succeed because it is simply unable to conform to the rules of genuine science. The best it can achieve is - *the appearance of science*. Psychiatry is dominated by the wish to predict human behaviour. This desire issues in a positivist idea, in which the topic (the patient/the mental illness) is conceived as *a fact* which just happens to be the inverse of 'the fact' of the normally functioning citizen. The deviant individual is abstracted from his lived context, and the psychiatric topic is conceived as *a curiously elusive disease* (a mental illness) which causes the person to display woeful deficiencies in self-possession, self-sufficiency and rationality. It helps to sustain this ideology by recruiting most doctors from the ranks of the privileged - who have no experience of the kinds of misery from which most of the patients emerge - and by training them *only* in medicine. Psychiatry is ruled by an ideology which combines naïve positivism and moralism.

Why is it not by now evident that psychiatry is neither scientific, nor medical, nor very helpful to disturbed individuals? Blind faith does not demand logical consistency or perfect satisfaction of its promises; a belief is not necessarily weakened by the failure of its predictions. With religious faith, this is the well-attested psychological effect of the toleration of cognitive dissonance by those who cling blindly to a particular belief despite its clear refutation. When a community is strongly committed to an irrational belief, counter-instances do not necessarily undermine it as a point of dogma: the need to believe trumps consistency, and any empirical refutation is simply 'explained

away' by some or other newly devised supplementary belief.⁶⁷ This kind of denial works for any kind of fundamentalist belief - and certainly not excepting communities supposed to be scientific, such as the psychiatric profession. In psychiatry, the failure of an idea or technique only calls forth the demand for more research or more and 'better' technology; like a drug, any technique which fails (perhaps after an initial appearance of success) may simply increase dependence on it. Many of our scientific and technological expectations are over-reaching. As a result, rather than question an attractive theory and have to consider a less appealing alternative, there is ever greater investment in the same methods for researching solutions to problems bad science has already failed to resolve.

In the case of psychiatry, the response to cognitive dissonance is a rationalisation which works to preserve the medical model of mental illness and treatment in spite of its manifest failure. This is not remarkable, however: prejudice is likely to hold sway whenever we are influenced by what we dearly wish. Heisenberg, something of an authority in the real science of physics, understood that

...in natural science the object of investigation is not nature as such, but nature exposed to man's mode of enquiry.⁶⁸

There is no perception without prior conception, no proof without a prior hypothesis. More than this, we are predisposed to discover in the infinite complexity of nature something intimately connected to our first unconscious assumptions and manner of framing issues, such that what we think we discover is *very often* what we expect or wish to find.

Psychiatrists wish and expect to find organic causes and medical remedies for mental disorder. However, causes are simply not to be found where psychiatry seeks them, and so the research fails. Continued attempts by psychiatry to comprehend functional mental disorder by the lights of the so-called medical model are so at odds with the real nature of the problem that every complicated, 'more precise' or 'further focussed' study of every latest organic 'possibility' or 'probability' leads the researchers deeper into the morass of an infinity of possibilities, and ever further from the truth. Each failure to arrive at even the hint of an answer only generates plans for further, 'more sophisticated' research. This is psychiatry's response to its own cognitive dissonance.

By applying the 'illness' metaphor to undesirable emotional and mental states, the commonsense notion that such events are located 'in' the head befuddles everyone, lay-public and psychiatrists alike. Whether involuntarily detained, threatened with detention or simply persuaded by an official that he is very unwell, anyone assigned a mental illness diagnosis is thereby rendered powerless and voiceless.⁶⁹ Everyone imagines that he is ill, so the intention is to process the patient purely technically, as an object (a sick brain) to be dealt with just as real illnesses are treated in general medicine. This systematic disinterest in the patient *as a person* has been indulged throughout the history of psychiatry and, as we suggest, primarily to the benefit of the social peace rather than the individual concerned.

In the meantime, the essential first requirement of any systematic method which could deliver the truth, rather than a parody of science, is a certain precision of concepts. A scientist reflects on his own attitudes, concepts and techniques. Do his concepts and methods generate testable hypotheses, i.e., propositions which can be tested by reference to empirical evidence? When he tests a hypothesis, might his concepts skew his perceptions and his findings? Does he really discover what he thinks he does, or could some other factor create the effect? What do critics have to say about his results or his approach? Is there another plausible hypothesis, or one that is more plausible?

Psychiatric diagnosis, prognosis, treatment and research pay scant attention to these checks and balances. Lacking a coherent theoretical basis, and simply decked out in the fancy-dress of scientific-sounding jargon, the diagnostic categories are little more than an elaboration of what is borrowed

67 See Festinger, F (1957) *A Theory of Cognitive Dissonance*. Evanston: Row, Peterson. This cognitive acrobatic was originally remarked amongst religious cultists who believed that the end of the world would arrive on a particular date, and who continued to be fully committed to the cult when that day came and went as usual.

68 Heisenberg, H (1958) *The Physicist's Conception of Nature*. London: Hutchinson.

69 Whereas, with significant numbers of voters or powerful groups it is more difficult to carry off the political trick of managing mental, emotional or social malaise by purely technical means.

from vernacular or 'folk' psychology. Everyday terms are made to sound scientific by renaming them in Greek or Latin, and by making ostensibly precise discriminations such as endogenous, exogenous, manic- or bi-polar depression, etc. The rhetorical tricks include ever finer discriminations, the construction of hierarchies of organisation, and inventing new categories, such as 'schizophrenia': this was a formulation to replace *dementia praecox*, which itself was a discrimination within the general category 'dementia'. In authentic science, a theoretical concept has to be measurable and operational for rigorous, precise and predictive testing. Mental health diagnostic categories do not begin to approach this requirement - doctors cannot even be relied on to agree amongst themselves about the diagnosis of the type of mental disorder suffered by any one individual.

Given this state of affairs, it is no wonder that the keepers of the psychiatric dogma do not invite criticism in a spirit of free enquiry. The profession blunders on unreflectively, trying to bring some precision to concepts which, in everyday speech, were only ever rule-of-thumb, and could never have any other reasonable use. In the absence of an organic condition, no-one is ever *essentially* depressed or psychotic, paranoid, anorexic, or whatever. A person may get into a worrying emotional and cognitive state, and he may recover, often least of all when psychiatry expects it; yet he is *always* essentially something other than any label which may be attached to him simply because it seems appropriate at the time. In a two-century fit of misplaced concreteness, and in the face of substantial evidence to the contrary, psychiatry imagines that its categorical tags indicate discrete medical events: the various mental illnesses. Doctors refuse to consider an alternative possibility: that disabling anxiety, being very upset, panic and confusion are common and usually transient states of human being, but as an individual's personal and social existence ebbs and flows or gets stuck at an apparently irresolvable impasse, it sometimes seems to congeal into a worrying 'condition'.

Psychiatry is able to succeed with its charade of medical science and its dogma because it provides an emergency service for managing those who become so distressed or irrational as to constitute a nuisance or a danger. In the face of an apparently unmanageable personal crisis, tolerance and reason tend to fly out the window, and we all wish psychiatry would provide a quick technical fix, just like the A&E department at a general hospital. In response, psychiatrists forever try to appropriate the predictive methods of science and apply them to personal crises. This is an impossible project which makes the discipline barren in both theory and practice. Psychiatry is only *mythically* scientific and medical: it is not an activity which moves forwards and upwards from ignorance towards truth. Unwittingly, then, each generation of mental health officials only ever enters an interminable circumgyration of wishes, conceptual dead-ends and evasions - a masquerade of medicine, glorified by an ever-expanding rhetoric of scientific-sounding jargon and pseudo-medical methods and 'facts'. Psychiatric ideas and techniques are an ever-increasing confusion of the issue at hand - a modern kind of alchemy. Medieval alchemists tried to turn base metals into gold. By dosing brains with chemicals and electricity, and in their research by poking around with genes and biochemicals, psychiatrists hope to turn base personalities into more pleasing ones.

We repeat that there will be no progress towards reforming the management of emotional distress and mental disorder until it is recognised that it is not enough to criticise the medical model as serving certain political and economic interests. Nor is it simply a matter of psychiatric ideology serving certain cognitive and practical purposes which are *only* confused or ill-conceived. Much more than this, a fundamental emotional response is articulated - on the part of mental health officials, social workers, family members and lay-public alike - when the psychiatric medical model is taken for granted: in mental health, the medical model is the response to a shared and powerful wish.

Psychoanalysis recognises that a child's speech and conceptualisation emerges in play; it is a mode of erotic or sensual expression which is soon forced to submit to the demands of reality. Like any other neurotic symptom, language is a compromise in the conflict between the desire for pleasure and the demands of reality. Magical thinking is therefore not simply random error which only lacks true or 'scientific' understanding of the real connections between things, and which posits causal relations on the basis of a superficial association of ideas. More than that, *magical discourse is neurotic word-play*. Freud recognised that the psychological basis to magical ideas and rituals is a belief in the omnipotence of thoughts and wishes, and that this is a feature of the early narcissistic

phase of everyone's development. The greater the anxiety, the greater the tendency for the adult neurotic to regress to that infantile emotional and cognitive condition in which he plays with language to increase his pleasure or reduce his pain, but in a thoroughly compromised and deformed manner.⁷⁰

It is likely that amongst the social circle of anyone seriously afflicted by emotional distress and mental disorder, and amongst the doctors and psychiatric workers, and other members of the community, the real causes of the person's distress and confusion are often suspected or secretly appreciated but too painful or burdensome to openly admit; therefore they remain unspoken and repressed from awareness. People believe in the myths of mental illness and the medical science of psychiatry because they so much wish they were true, and so much dread the alternative.

Confusing subjects with objects

There is a long history to the hope that Science would rescue humanity from ignorance, misery and injustice. Because of the spectacular successes of quantitative science and subsequent technological advances, concepts and 'facts' which *appear* scientific often achieve a false authority in the so-called human sciences. But whereas there have been debates within economics, sociology and psychology as to whether or not each discipline is scientific, and what theories and methods might be appropriate, similar discussions have effectively been shut out of psychiatry by those holding medical power.

In everyday life, most of us share fairly serviceable ideas about morality, motives and the causes of madness and despair. However, since Science seemed to be rapidly reducing every other form of knowledge to the status of out-dated error, by the end of the 19th century psychiatry had developed largely as a determined attempt to imitate scientific medicine. And why would people not turn to medical authority when faced with the problem of someone in the throes of a personal crisis? As we have suggested, we are easily persuaded to defer to a doctor, mainly out of a combination of fear, convenience and convincing, apparently medical-scientific rhetoric. Like any other type of authority, psychiatry will remain unquestioned as long as most of us are persuaded that it does more or less solve the problem at hand. After all, it is not so much the distressed and confused person as *everybody else* who must be persuaded that help is at hand - and everybody else's first concern is likely to be safety and the social peace. The public will hardly be interested in the fact that most mental health treatment is not based in sound evidence but only in a tradition of empirical 'rule-of-thumb', of 'what seems to work'. Our concern, however, is to optimise the patient's welfare.

In the preceding chapters we have seen that the medical conception of the nature of functional mental disorder is far from proving itself superior to other ideas. Like almost everyone, psychiatric officials seem to be mesmerised by the achievements of Science: they wish to be identified with the spectacular achievements of general medicine, and this seems to prevent them from recognising the dubious nature of their concepts and methods. But blind faith hardly guarantees their expertise.

The natural sciences which psychiatry wishes to emulate are concerned only with structure, function and use. 'Hard science' is clearly able to make quantitative, predictive sense of elements and relations in the objective world. A functional mental disorder, however, consists in troublesome *subjectivity* - the person's aberrant consciousness and behaviour, i.e., his perceptions, beliefs and actions. Although it is routine for doctors to conflate subjects and objects - to confuse worrying personal conditions with illnesses - the dictionary distinction is clear enough: when something exists objectively it 'belong[s] not to the consciousness or the perceiving or thinking subject but what is presented to this; the non-ego, external to the mind, real'.⁷¹ And a functional mental disorder is recognised precisely by *the absence* of any real object or process (any disease): it is no more and no less than disordered *subjectivity* - a psychological problem, not a neurological one. The psychiatric topic is therefore not the person as object - his allegedly sick brain - but the person *as a subject*.

70 Freud, S, op. cit. (n. 87, Ch 12), 865-883.

71 Fowler, HW & Fowler, FG (1960) *The Concise Oxford English Dictionary of Current English*. Oxford: Oxford University Press.

Science is able to explain the reactive behaviour of objects, but significant human behaviour is distinct as *activity*, which is always more than motor impulse, stimulus-response. Action is predicated on the person's *definition of the situation*; it depends on meanings and intentions, the workings of the person's mind - his subjectivity.

By contrast, science is a process of systematic enquiry defined by a purge of the subjective. To that end, as we mentioned, it requires peer scrutiny and empirical tests of predictive hypotheses by means of replicable experiments in which every element is rigorously defined and may be varied or held quantitatively constant.⁷² According to these criteria, it is clear that the categories and methods of the natural sciences cannot be applied to the study of the mind and significant human behaviour. A person imagines and makes a certain sense of his world in which he does not simply *react* but *acts with purposes in mind*, and this conditions his behaviour. It is not possible to arrive at causal explanations for very much human behaviour, and certainly not possible to employ the quantitative precision of the natural scientific method to much that is *significant* to persons. Given certain assumptions which may hold true, statistical *probabilities* may be usefully proposed for certain aspects of human populations - for example, in demography or economics - but the mental events of individuals are not easily amenable to the classic experimental method. For example, there can be no guarantee that what a person does, says or thinks in the context of the supposedly standardised conditions of a laboratory would play out in the normal circumstances of his life: an experimental subject's response depends on how he construes the experiment, and it is inevitably coloured by his attitude, at the time, towards being tested. Every experimental subject remains someone who is continuously engaged in the project of interpreting events and situations: whatever he may say or do during an experiment - and especially if he is aware that he is involved in an experiment - at any other moment it may seem appropriate for him to change his mind and his behaviour. (Similar limits apply to questionnaires about states of mind, attitudes and hypothetical situations.) We are simply not able to test many very interesting hypotheses about the behaviour of persons by trying to employ a quantitative-experimental method.⁷³

Any understanding of the nature or state of things is tentative, inherently imperfect. Nobody is in possession of incontestable truth; there is always a divergence between reality and our understanding. Added to which, 'the facts' are especially complicated for any human science since the topic is characterized by reflectivity: our behaviour is conditioned by what we imagine, and thereby the events in which we participate and about which we think. Attempts to apply the natural scientific method to the study of persons give rise to all sorts of confusing and intractable problems. If the researcher approaches his topic while supposing himself an objective-quantitative scientist - 'just like a natural scientist' - this only delivers results which add nothing to any genuine knowledge: all he produces is pseudo-knowledge in quantitative-causal clothing, which is to say, a delusion. The best we can do is try to *comprehend* another person's behaviour. Comprehension or understanding requires empathy and interpretation: in order to grasp what meaning he seems to give to his behaviour - what his intentions might be - anyone who tries to explain someone else's behaviour, thoughts or motives has to try to imagine how it would be were he in his place. If an investigator does not attempt this imaginative act he will *very likely* misinterpret the other's behaviour, and assign it to an inappropriate category. This limitation ought to encourage psychologists and psychiatrists to

72 This was settled by Popper, KR (1934/59) *The Logic of Scientific Discovery*. London: Routledge & Kegan Paul. We discuss this point further in Chapter 16 (Volume 2), in the section: Systematic knowledge of persons.

73 See Popper, KR, op. cit. (n. 72). In his most popular books, Popper mounted an attack on some influential modern political and cultural thinkers (especially Marx and Freud) for asserting their conclusions were scientific. However, as we argue in Chapters 16 and 17 (Volume 2), it seems to us that whether concerning personal development or history (and including the ideas of Marx and Freud), this does not mean that every comment or generalisation about human behaviour is unfounded, meaningless, and courts totalitarianism - so long as no claim is made for its natural scientific status. See Popper, KR (1936/57) *The Poverty of Historicism*. London: Routledge, and Popper, KR (1945/47) *The Open Society and Its Enemies: The spell of Plato*. London: Routledge.

develop *qualitative psychological* theory which recognises contexts and the meanings and intentions which people give to their activities.⁷⁴

Whether or not psychiatry is a kind of scientific medicine is crucial to the way in which care and therapy is organised. So as to settle this issue, we should further elucidate the differences between the science of objects and any possible systematic knowledge of subjects. Before that, though, we should recognise a pervasive wishful thinking - apparently shared by psychiatrists - which idealises the scope and certainty of natural science.

Objective knowledge attempts to free itself from prejudice by making concepts, methods and findings transparent and open to testing by peers who are able to replicate experiments exactly. Whereas it is essential to build checks against bias into any theory and method, the myth of the perfect objectivity of science as the basis for all knowledge founders on the fact that science must be knowledge of the objective world *as represented to themselves by subjects*. What is more, to uphold the purity of 'the objective method' by arguing that science is a uniquely careful inter-subjective process in which peers cross-check each other's work, is to assume that a community cannot labour under a collective blindness or delusion. Things are not so simple, and the history of the development of knowledge of the objective world is full of examples to the contrary. When Copernicus proposed that the Earth circled the Sun, this had already been mooted by Aristarchus, an Ancient Greek. For another eighteen hundred years, and simply to satisfy the subjective demands of philosophies and religions which wished the Earth to be the still centre of the universe, astronomers forced their observations to fit an ever more convoluted celestial model. Copernican theory cut through this compromised model to account for the facts more coherently. Unfortunately, many people also found this frightening because it removed humanity from the centre of God's creation, and placed it on a rock orbiting millions of miles from an average-sized star in a vast and mainly empty universe.

The natural sciences emerged gradually out of forms of knowledge which experienced difficulties disentangling subjective wishes from objective reality - that is, religion, philosophy, astrology and alchemy. It may be necessary for an observer to try to detach himself emotionally from his topic in order to forestall bias, and the scientific method is obviously a useful way to discriminate objects. Detachment also has a certain utility when trying to comprehend subjectivity: when I try to understand someone by putting myself in his place, in my imagination I must separate myself from my own urges and interests. But the attempt to *reduce* subjects to the status of objects - 'for the sake of scientific objectivity' - is entirely counter-productive. A person always has in mind his own understandings and intentions, and no sense can be made of his behaviour if we ignore this subjectivity. Of course, every emotional or mental event or 'condition' is bound to correlate with somatic processes measurable and explained in terms of bio-chemistry and physics. Be that as it may, by consisting in significations, personal and inter-personal processes are a completely different, emergent order of actuality, and we can make no sense of their nature by trying to reduce them to processes of physics or chemistry.

If we look to explain human behaviour, the only interesting elements - such as the behaviour and beliefs recognised as a mental disorder - are kinds of action; and as such they only arise and exist in the communication of significant symbols in specific social contexts. Yet any approach which tries to construct a quantitative science of human behaviour has no interest in significant symbols, and therefore no possible purchase on them. Just because it may be difficult to avoid a motivated, passionate or rhetorical frame of reference when trying to analyse or explain a meaningful human event - such as a mental disorder - this does not mean that it is impossible to achieve a provisional objectivity when we indicate how an action is accomplished, by and in relation to whom, in what context, and from what motive. Facts are already decided this way by evidence and argument in the law courts. When this is denied, psychiatry is like astronomy before Copernicus. In as much as there

74 Discussion of this matter began early in the 19th century with FDE Schleiermacher's textual hermeneutics. It was later argued in sociology by Weber, M (1949) *The Methodology of the Social Sciences* (Ed Shils, E & Finch, H) Glencoe: Free Press, and then explored in detail by Schutz, A (1932/67) *The Phenomenology of the Social World* (Trans Walsh, G & Lehnert, F) London: Routledge & Kegan Paul.

is a plausible alternative theory of mental disorder - the psychodynamic hypothesis - we must assume that the doctors continue in denial because their anxieties concerning the real nature of functional mental disorder are as profound as those experienced by our ancestors with regard to the alarming idea that our planet is not the still centre of the universe.

This unacknowledged anxiety of the psychiatrists issues as their envy of the predictive power of the natural sciences. The method of cut and analysis, prediction and exactly replicable experiments works at the level of physics and chemistry - at the level of the material substance of the universe - and it delivers the predictive control of *objects*. In answer to Science, the Romantics were the first to mount a coherent defence of qualitative experience. William Blake wished us to appreciate the multiple significance of everything that exists. Already, in 1802, he deplored the literalism of the Newtonian mindset, with its attempts to apply the natural scientific method beyond the proper bounds of its application: he called this 'single vision'.⁷⁵ More recently, Herbert Marcuse argued that not only has science made the domination of people more efficient by means of the domination of nature, but because the basic categories of social science are always operational - they conceive of any topic as a matter of objects or processes to be controlled - this inspires ideologies of domination and manipulation.⁷⁶ Psychiatry, of course, is concerned with techniques of surveillance and control. More than this, however, we might guess that few of the managers, psychologists, doctors, psychiatrists and social scientists who administer modern organisations are able to imagine that the template of natural science cannot be applied directly and precisely to the measurement, prediction and control of psychological and social processes. Psychiatry simply follows the general culture when it assumes that the theories and methods of classical physics and chemistry constitute the paradigm to which, if they are to be true and useful, all other ideas must aspire.

Objectivity is written into the natural sciences whenever a theory is expounded or an experiment is written-up; 'I' or 'we' who propose the theory or carry out the research (the formulating subject/s) disappear. Scientific findings are reported as if, whenever arranged according to the 'scientifically correct method', 'these things conjoined in this manner give this result'. Consequently, any discourse which wishes to appear authoritative - which wishes to appear as systematic knowledge rather than mere opinion - mimics the disappearance of the speaking subject, i.e., the person who proposes it. Whenever a doctor is at work, his personal thoughts and feelings are supposed to be banished from the objective (scientific) medicine that he practices. When psychiatrists communicate professionally, or write texts or do research, or talk authoritatively to lesser beings such as patients, nurses or the public, they employ rhetorical devices such as the disappeared subject and a scientific-sounding, quantitative-statistical and apparently medical vocabulary. In reality, whenever he faces someone who seems to suffer from a psychopathological condition, any doctor is no more than another locus of fallible subjectivity. Moreover, underwritten by the confused medical model, the official monologue tends to lurch erratically between pseudo-science, aesthetic preference and an imagined high moral ground. Given this delusion of scientificity, if a mental health official shows signs of his own humanity - for example, as friendliness or sympathy - this is not because therapy is conceived as *necessarily* including benign sociability but only because the individual functionary happens to be 'a pleasant sort of a chap'; or it is a ploy to oil the wheels of the psychiatric routine, to get the patient's co-operation with whatever arrangements and treatments the doctor or 'the team' wishes to put in place.

Psychiatric medicine is not based in scientific evidence, but the ruling idea in the management of individual irrationality takes the form of scientism or positivism. The precepts of the so-called medical model would have it that every psychiatric official must manage each patient not as an active subject but only as a reactive object (an illness). And it is clear that mental health officials have difficulty conceiving of any valid knowledge other than that of the control of things (illnesses). Hence, they subscribe to rituals of knowledge, practice and research which regard the person in crisis

75 "...May God us keep From Single vision & Newton's sleep." Blake to Thomas Butt, 22 November 1802. Quoted in Keynes, G (Ed) (1956) *The Letters of William Blake*. London: Rupert Hart-Davis.

76 Marcuse, H (1964) *One-Dimensional Man*. Boston: Beacon Press.

as a patient like any other - as suffering from an illness, as if he were beset by a malfunctioning object (his brain) which must be repaired or otherwise brought under control, and as if the fact that the patient is a person has little or no clinical significance. This encourages mental health officials to conceive of the signs of 'recovery' or 'successful management of the illness' as the person (the patient) rendered more docile and amenable, i.e., more like an inert or pliable object. Unfortunately, knowledge of how to help liberate distressed and confused persons from their overwhelming anxieties does not at all correspond to the knowledge of how to control objects (so-said illnesses) only for the purposes of utility or convenience.

In point of fact, then, the scientific method is not the only way to formulate useful knowledge - and especially that concerning persons. Before the rise of the revealed religions, and out of them the natural sciences, there was the idea that every thing in nature has its own sacred autonomy. People imagined that *everything* was animated: instead of the dispassionate or disinterested use of what we now consider 'mere objects', people imagined that every thing was imbued with spirit. Under the objective gaze of the natural sciences, however, everything becomes only a thing, devoid of autonomy. The natural scientific attitude encouraged the rise of a strictly utilitarian view of the world in which the person who knows how things are articulated (or 'work') has no obligations to them, and is permitted to exploit any thing he encounters. Anything can then be done to any object (or anyone) since every object is 'essentially, only a thing'. Those wishing to practice an unsentimental human science - such as psychiatry - imagine that attitudes such as respect, communion, compassion or love between the knower and the known only ever 'introduce bias', and that 'real knowledge' is only ever produced by the natural scientific method.

The psychiatrists want to practice scientific-medicine, and so even though 'good mental health' might be defined well enough as 'the presence of human spirit' - and mental illness as its absence - there is no place for such imprecise metaphysics in their perspective. Yet psychiatry only takes for granted the prevailing notions of the era. Responding to the astonishing fruitfulness of the Scientific Revolution, as epitomised by Newton's physics and the mechanised factory, common-sense ideas about the nature of personality changed radically. Natural science rigorously excluded any theory or speculation which read into the natural world purposes, ethical meaning or personal communion. In the old magical or religious conceptions of things, the universe was suffused with significance, but with the rise of Science these ideas disappeared. The old beliefs were replaced by the idea that a person is *nothing but a kind of organic machine* which science will one day fully explain. Value, meaning and intention were demoted to the status of 'epiphenomena' - secondary symptoms of 'more basic' processes. We are still overawed by Science, and generally people assume that if a theory for any aspect of reality is not reductive and quantifiable it cannot be scientific, and so it cannot be true. This notion might be particularly attractive to the managers of people. After all, it constitutes their normal daily experience - they decide and those under their authority obey; most enterprises would fall apart without the flow of pre-directed objects, and managerial anxieties are increased by the unpredictable activities of autonomous and wilful subjects. Hence, rather than taking centre-stage in the mental health project, compassion and 'respect for the patient' is not essential to the medical-therapeutic remit but almost an optional extra.

Yet machines only dance to mathematical tunes, perform pre-set functions, and serve the purposes of their operators; they have no inherent, self-appointed, wilful consciousness or autonomy - what used to be known as 'spirit'. According to contemporary positivists, since they are particularly complex bio-machines, people (patients) are of course not so easily explained as simpler physical processes or chemical reactions. For all that, social scientists and socio-biologists still like to imagine that the intricate exchanges of human life - for example, what, in their chuckle-headed naivety, the public knows as 'emotions', 'thoughts', 'feelings' and 'intentions' - will one day, in a future just around the corner, be perfectly understood as the responses of bio-chemical behavioural feedback systems consisting of quantities of causal exchanges. Apparently, this happy day will arrive when all the relevant data is finally collected and computers are developed with sufficient power to process the great amount of information. Psychiatrists seem to be enthusiastic supporters of this ideology, in which people-machines will soon be fully explained by the operations of their DNA (for example).

Yet this idea cannot possibly be subjected to any empirical test; it is not a scientific proposition, only a point of dogma in a faith which misapprehends what science really is. For if, in some ethically dubious experiment, the DNA or parts of it were altered, subtracted or added for any human being, whatever or whoever then developed would still exist in a world replete with significations which could not but influence the 'operations' of the 'person-machine'. Notions of persons-as-organic-machines - or 'ultimately only DNA', or 'only brain electro-chemistry' - are not scientific but science fiction.

And so, along with much of the rest of the culture, psychiatry succumbs to the naïve idea of applying the method of the sciences of inert matter to processes of the person. This skews the whole mental health project towards routine and casual mistreatment of the patients. In the previous section we suggested that the attempt to apply the concepts and methods of classical physics and chemistry to emotional and mental life commits a category mistake and is bound to fail. Even so, it is nevertheless manifest in the attempt to find 'positive facts' in social and personal life - that is, facts which are determinate and indisputable. Mental health officials certainly seem to imagine that diagnosis reveals such facts. Just the same, a mental health diagnosis is not a scientific discovery which accords with objective reality: nobody ever 'has' an illness called 'schizophrenia' or 'depression'; the diagnosis is an ideological device endorsed by social power. Biological reductionism and invalidation of the patient's point of view degrades the psychiatric topic - the person in crisis - by depriving him of what remains of his autonomy, dignity, mystery and charm. Viewing a person in terms of utility is pathological and oppressive; it is a response born of the dread of chaos, or life itself. Mental health officials may manage to repress this dread by means of a compensatory posture which is celebrated as unsentimental, uncompromising, muscular, capable: the practice of scientific medicine. This does not prevent each distressed and confused patient from continuing to inhabit a universe of significant symbols. He is not an object bidden purely by mechanico-organic causes, and he is hardly helped by being worked on as if his problem were only that of a malfunctioning object - his brain.

The medical model reduces the patient from a dynamic, multi-dimensional locus of feelings, motives and purposes into a flat image of a part of his anatomy: his bio-chemistry, his brain waves, his hormones, his brain-scan or his DNA. Psychiatrists imagine that medical science authorises this reduction, and they proceed to work on patients' bodies (brains) while ignoring the intentions of whatever the patients say or do. This administration of a cold, hard and allegedly 'objective' pseudo-science and technology is oppressive, and only likely to alienate the patients: it obstructs recovery and often results in iatrogenic harm. At the very moment when the individual needs solidarity and human warmth, he is faced with so-said helpers or healers who, as fellow-feeling subjects (persons), wilfully disappear behind their pseudo-objectivity. Under the sway of the medical model, mental health officials may easily appear as blank-faced, prejudiced, and unresponsive technicians who mouth a mystifying pseudo-scientific jargon and insist that the patient must submit to their abuse of him (the treatment). This is a sharp lesson in what psychiatry thinks of the patient, and it is only likely to remind him of his standing in the world at large.

In the foregoing Chapters we provided compelling reasons for rejecting the notion of the nature of functional mental disorder which is supposed to be based in medical-science. Psychiatry celebrates itself as the appropriate response to a certain kind of illness. As pseudo-surgery it is a crude assault on the brain - lobotomy and electroshock; as psychology it proposes Behaviourism, e.g., the reward/punishment economy and CBT. Each of these techniques aims to obliterate or override the symptoms of the mental disorder.⁷⁷ By and large, however, today's psychiatry mimics general medicine by administering hazardous medications. While doing little or nothing to help him with his problems, these standard attempts to change the person by intimidation and altering his metabolism amount to a form of superintendence which homogenises, degrades and dehumanises him. No matter - few mental health officials seem to have qualms about employing these methods. And perhaps we should not discount an unconscious element of sadism since as well as suffering from emotional and mental

⁷⁷ Recently, micro-surgery and micro-electrical stimulation of the brain have also been offered as 'more sophisticated' or 'improved' techniques.

turmoil, the psychiatric patient may appear unattractive, and is always vulnerable - he is incapacitated and lacks confidence, self-esteem, and often friends or relatives who might help him. In the eyes of competent social actors, he may already appear *less than fully human*.⁷⁸

Where there is no recourse to open hearings concerning justice, value or even sanity, it is always possible to impose on a vulnerable population a tyranny of use by measurement and technical control. It is easy enough to take an isolated and confused person and adjust him administratively to a specified standard of conduct: psychiatry uses the sanctions of pills and injections, shock treatment, behaviourism and compulsory detention. By means of bureaucratic management, it is possible to produce robot-like individuals who may be accounted for in terms of quantities of causes (punishments and rewards), and to some extent predicted by them; this makes behaviourism seem plausible. It may be possible to predict a psychiatric patient's behaviour *when he is treated as an object*, but any such prediction (e.g., as with behaviourist therapy) is only ever a self-fulfilling prophecy based in coercion.

What about the inner-life of the patient? Medical and behaviourist techniques are sometimes able to perform the proverbial successful operation in which, *as a less miserable and more vital and autonomous being*, the person dies. Still, despite all the efforts of the various medical therapies which are used to subdue the patient as a way of subduing his symptoms, many patients continue to show great resilience. Unlike a well-founded science, psychiatry can never be sure that its techniques will produce the desired effects, and there is no definitive way of telling whether any patient is 'better' or 'cured'. Consequently, psychiatrists fear that if they were to release a patient or take him off medication prematurely, at any moment his chaotic inner life might burst forth randomly and with terrible effects.

The inevitable failure of psychiatry's medical model

To count as scientific, knowledge has to conform to the appropriate standards of argument and demonstration. Each scientific theory 'models' a part of the universe and provides a set of rules which relate quantities in the model to possible observations; a theory is scientific if it can make predictions that may be proved or disproved by the evidence; and so a model is only good if it can accurately account for a large class of observations.⁷⁹

Experiments under laboratory conditions make it possible to hold constant or vary the relevant measurable factors. By contrast, the life sciences tend to be more complicated because the analytic process itself is likely to influence or destroy elements of the object under scrutiny; laboratory experiments concerning the behaviour of organisms tend to lose their utility the higher the level of organisation of the life-form. For this reason, experiments concerning human behaviour are often questionable, especially when insufficient attention is paid to the *understandings* of the participating subjects.

Since the life of any human being is always an ongoing imaginative project, methods for researching personal and inter-personal behaviour have to be akin to the rational approach most of us are usually able to take towards the problems that arise in the relations between people in everyday life; they may only differ from this routine capability by the researcher being less personally involved, more focussed, more systematic and concerned with drawing wider conclusions. What we are able to deduce about someone's psychological problems is achieved largely by employing normal processes of observation, conversation and interrogation, and not from attempts to apply a quantitative science which fails to take into account what the event or events in question might signify, or what might be intended by the person.

More than this, any form of rationality always has emotional, moral and political dimensions, whether knowledge is derived by the methods of natural science or those of psychology, another

78 How else explain the callousness, contempt and abuse - touted as 'good practice' - documented in Chapter 4, above?

79 See Hawking, S (1988) *A Brief History of Time*. New York: Bantam, 10-11; also text to footnotes 71 and 72, above.

social science or everyday life. While the techniques of the natural science are clearly appropriate for explaining objects, the human sciences investigate the realm of subjects, in which events are always swayed by intentions, decisions and the imagination. In this domain, both the investigator and the investigated are motivated, and the investigator must be wary of possible prejudices or bias. Any human science addresses a complex and dynamic field of significations, and it is not possible to make accurate or useful sense of a person except by making *qualitative* statements about his life. If what is relevant to the natural sciences is generally irrelevant to psychological knowledge, why would the concepts and methods appropriate to the human sciences mimic natural science? Attempts to impose the natural scientific method wholesale onto the human sciences ignore the ethical, political and psychological implications.

None of these considerations are seriously addressed within psychiatry, which is generally considered a straightforward sub-set of scientific medicine. The confused nature of this branch of medicine is nonetheless indicated by the fact that it is often clear that the psychiatrist has to deal with problems of morality - as when, for example, a symptom of schizophrenia is defined as 'breaking social norms'. Actually, mental health diagnosis is *irreducibly normative*: the major concern is precisely with the patient's *inappropriate behaviour and beliefs*. Meanwhile, to anyone who is not a mental health official, it may seem obvious from what he says and does that someone diagnosed with a serious mental disorder has reached a desperate impasse - that his dysfunctional beliefs and behaviour respond to traumatic events *within the moral order*. However, this is not a proposition endorsed by quantities of 'hard data' and, as we have seen, psychiatry is only interested in what a patient has to say as a sign of his irrationality or rationality, i.e., as a sign of the presence or absence of the so-said mental illness. What a patient says or intends is otherwise of no interest, and neither are conjectures about his psychology or any possible social causation. Entranced by the prodigal power of the quantitative sciences, psychiatrists ignore the patient's experience - and his constructions on his experience (his experience of the normative order) - as irrelevant to the problem in hand, i.e., the purported mental illness.

Nowadays the ill-defined but vaguely quantitative-objective psychiatric medical model is taken for granted by the general public. Anyone dazzled by the successes of the natural sciences is likely to regard individual misery and despair as simply an uninteresting anomaly, epiphenomena, a sideshow to the 'real truth' about the person, the real cause of his malaise, which is a mental illness that 'must be' due to a genetic anomaly, a virus or an errant hormone - some 'thing' which medical science will soon discover. Meanings and purposes barely register in the psychiatric medical model. This corresponds to the philistine attitude towards art, whereby there is no truth or value in a work of art - it is simply fiction or error, devoid of that genuine knowledge which is only delivered by the scientific method. Still, people keep responding to works of art; they do continue to act as if art, literature and philosophy are valuable kinds of moral, emotional, intellectual and spiritual activity - the emergent attributes of human life - as if they do deal in truth and wisdom.⁸⁰

Even if none of this were so, it is still clear enough that the human sciences (and psychiatry) could only ever be scientific in a metaphoric sense. The natural sciences developed as specialised accumulations of objective facts in relation to testable theories, and by careful quarantine of personal or qualitative experience. When the psychiatric medical model rules that the personal and the qualitative is scientifically inadmissible, all that is left to investigate and work on is the brain; and that, apparently, only as a machine without a context. Attempts to construct sciences of psychology and psychiatry in imitation of the natural sciences, to manage someone or his so-said illness 'objectively', as if he is only to be understood quantitatively as a bio-chemical machine, - all this leads to the disappearance of everything that normally defines a person as such: his thoughts, memories, attitudes, motives, emotions, intentions and actions.

The pre-set machine is a limited metaphor for understanding any form of life, which by definition is emergent and only develops in feedback with a changing environment. The life of a person is infinitely more complicated by the fact that, by means of representation, he continuously experiences

⁸⁰ Picasso once defined a successful work of art as 'a lie which tells the truth'.

and relates to *himself* as a crucial part of his environment. This makes experimental analysis of material causes and effects under laboratory conditions inappropriate for investigating states of mind. More than a century of neurological research has discovered that interference with certain regions of the brain does indeed have gross effects on mood and various sensory and intellectual functions. But with respect to any functional mental disorder, this is no more helpful than announcing the discovery that if someone breaks a leg he has difficulty walking. Determinist psychiatrists have no conception of the impossibility of their project.⁸¹

No doubt research has improved our knowledge of the effects of actual brain defect or damage on specific sensori-intellectual functions, and hence on the personal and social functioning of some unfortunate people. All the same, even if (for the sake of argument) the events of one brain could one day be computed, this would still fail to deliver any signs of that consciousness which really drives human behaviour. Neurophysiology may be able to correlate an emotional or a cognitive state with clusters of particularly active neurones, but that still does not discriminate cause from effect, let alone discover consciousness and intention. For while there are obviously physical or brain-neural correlates to every mental event, there is no way of reducing a state of consciousness to a state of the brain or, vice versa, predicting an intention from a brain-state. The findings of a century of brain research have no meaningful bearing on the problem of understanding those sorts of psychopathology for which there are no demonstrable organic causes.

Quantitative-causal explanations do not begin to comprehend any of the interesting features of the complex, emotionally and mentally dynamic person who begins life as a purely reactive organism but rapidly emerges as an active participant in an ongoing social organisation and culture. As we move from infancy towards adult autonomy we become more fully human, and the less our behaviour is explicable by quantities of causes or 'stimuli'. Mind is a form of communication. It is the emergent property of the exchanges between a human organism and its environment; it is a result of the *social* life of the person who, if he becomes worryingly irrational, is these days consigned to psychiatrists for inquisition, control and treatment. In point of fact, if someone *does* appear to be subjected to a quantitative cause - which is to say, he does seem to lack the wherewithal to exert his will - he is by that token recognised as suffering from a mental disorder and in need of help.

Having come so far, we may as well mention one last objection to the psychiatric medical model. As well as the practical limits mentioned earlier in this chapter, the attempt to reduce states of consciousness (mind) to states of the brain (matter) comes up against a limit in logic: it is not possible to construct a definitive science of persons. Philosophy has long recognised this as the logical problem of universals and classes, that is to say, of making a statement which is universally valid for any particular class of things. This problem does not pertain for objects, which tend to uniformity (e.g., one hydrogen atom has the same attributes as any other) but it certainly does for subjects. The problem lies in describing the class with sufficient rigour. For example, it is not possible ever to arrive at an exhaustive description of the class of (say) 'John Smith, the difficult psychiatric patient'. Not only is the class (i.e., the patient, John Smith) an indeterminate entity, but any attempt to describe the class (John Smith) will be insufficient unless it contains within it a full account of the person making the description, and of the grounds or assumptions upon which his description is based. In an impossible infinity of reflection - like looking down into facing mirrors - the description of the class (the patient, John Smith) has to undergo perpetual qualification, both by taking into account changes in the class itself (e.g., John Smith's perceptions and intentions) *and* by including a full description of the prejudices, changing moods, motives and intentions of whoever describes that particular class (that patient). This makes it impossible to work up a *logically sufficient* description of any such class of things - which is to say, any person (any patient) or everything he feels or thinks.

Not only is it impossible to fully or adequately describe someone's mental state or condition, but it would be operationally worthless. Life is an open-ended matter of becoming. Even if the person is

⁸¹ See text to footnotes 16-18 in this chapter.

subjected to duress, or his behaviour seems driven or habitual, it could not be predicted with certainty.⁸²

The reduction of persons to imaginary brain diseases

By itself, medical treatment cannot help distressed individuals find solutions to their emotional and mental turmoil. Worse, the medical model denies that this kind of malaise is psychopathology generated by deleterious social relations. When every psychiatric case is viewed as essentially the problem of a peculiarly elusive organic malfunction - a mental illness - the illness metaphor is given a literal reading whereby the mind is confused with the brain, and the brain is conceived as no more than part of a biological machine that runs according to chemical and genetic determinations. In this manner, psychiatry deludes itself that it is medical science, when all the while it controls the patients as best it can by mystification, by flexing its totalitarian muscle, and by chemically or electrically altering their moods.

Moreover, 'feeling like a machine' is a common symptom of that kind of perception which is diagnosed as paranoia. A humane approach might interpret paranoia as the person being overburdened by a weight of oppressive demands and manipulations - for example, as feeling bereft, used, unloved and subjected to surveillance and opprobrium. But psychiatry tends to compound the problems of anyone who reports his distress as a feeling of oppression: his complaint is likely to be discounted as only the inconsequential chatter of that supposedly malfunctioning bio-machine, his brain. At the same time, all that the psychiatric officials 'know' about the presenting case is that (due to some yet to be discovered cause) this person's brain happens to have developed a serious fault (of an undetermined kind). The medical-psychiatric response to the problem is then to try to remedy or 'manage the symptoms' of the allegedly malfunctioning brain by insisting on treatments that amount to nothing more than shots in the dark. All of which is to say that the medical model knows *nothing* about the causes of functional mental disorder, and tends unwittingly but systematically to *aggravate* patients' problems.

Whereas the psychiatric patient is alive, a machine is inert - it neither communicates out of an emergent life nor develops responses to the demands of a dynamic environment. This means that the notion of the brain as a kind of machine (a computer, for example) can never help remedy a mental disorder. To think of the patient's dysfunctional behaviour as due to his malfunctioning brain is to run up against the fact that a mental disorder is recognised precisely as the person's loss of autonomy,

82 Of course, none of the considerations in this section prevent the popularity of the scientific ideology, which claims that only those categories and methods which *appear scientific* (e.g., quantities of material causes) can apply to the study of persons. According to this dogma, the arrival of a determinist neuroscience is always imminent - undoubtedly, scientists will soon be able to predict every move that anyone could make, thereby making redundant all those cackle-headed pre-scientific and indeterminate notions of free will, morality, politics, psychology and history.

In the early years of the 19th century, Saint-Simon (amongst others) prophesied that human behaviour would one day become predictable by means of a positive social science. Towards the end of the 20th century, Edward Wilson and Richard Dawkins were both celebrated for announcing the determinism of genes, and discounting 'the environment' or culture. See Wilson, EO (1975) *Sociobiology: The new synthesis*. Cambridge: Harvard University Press, and Dawkins, R (1976) *The Selfish Gene*. Oxford: Oxford University Press. Apparently, due to advances in computing power, every gene would soon be fully calibrated and thereby everyone's behaviour will become predictable. And by means of testing and pre-emptive controls on whatever (or whoever?) is genetically undesirable - by drugging, implants, gene surgery, etc. - this will allow technicians to solve every problem of crime, educational failure, mental illness, etc., etc. This was a modern version of the pseudo-science of eugenics which, because of the connection with Nazism, now dares not speak its name.

By the 21st century, Wilson and Dawkins had become old hat and 'only theory'. Nowadays, researchers enthuse about their cutting-edge technoscience, and point to colourful video displays of brain-images moving in real time, made possible by means of positron-emission, magnetic-resonance and PET reporter gene/PET reporter probe. Of course, it is early days, and - as ever - the results are not yet conclusive.

Eugenics was once influential within psychiatry, and although now discredited, it continues to lurk in the wings. This is discussed in Chapter 14 below, in the section: The invention of schizophrenia.

meaning, purpose and community *in the absence of any discernible organic cause*. It is necessary to make this perfectly clear, since the psychiatric patient is only further oppressed when he is viewed *as* or *like* a machine - as his being burdened by a brain in need of repair by chemical or mechanical tinkering.

Psychological trauma and distress is often the result of the person being regarded as an insignificant object by a more powerful other. Patients are unlikely to feel reassured if they find themselves subjected to a psychiatric system in which the officials are admonished not to get involved, where they are oppressive and often dishonest, and where they attempt to remedy psychological malaise by invading the body with painful or otherwise disturbing forms of treatment. Certainly, some patients do come to feel better, to some degree, even perhaps due to the ministrations of such 'no-nonsense', bustling, apparently medical routines. Nonetheless, there is no proof that any such improvements are due to active medical impacts rather than improvements patients could have made anyway ('spontaneous remissions') or placebo effects, or that they are not the result of obliterating the symptoms while leaving the underlying problems and anxieties intact.

However, in the prevailing myth, everything - including personality - is only *really* comprehended by trained technicians, so what can the public ever truly know that is not validated by an expert? Dazzled by science, we are convinced that our needs, politics, emotions, tastes, sex-lives, dreams, manners, personal development, emotional, cognitive and volitional problems - anything and everything that might matter to us - are all so much better understood by experts than by anyone who is simply a part of the poor ignorant public. This tends to make us excessively humble and docile, which in turn suits very well the various manipulative schemes of politicians, advertising men, public relations experts... and psychiatric officials. The attempt to reduce all truth to the 'objective' knowledge of experts may well deliver a kind of predictive control over people, but only by means of mystifying rhetoric, intimidation and coercion.

As opposed to the failed medical model, the question of establishing an adequate theory of mental disorder is not a matter of finding some kinds of objectively existing and fundamental things and their relations, such as diseases or bio-chemical or genetic causes. Rather, the question is: what is our interest? What do we wish to find out, and to what end? Besides which, a moral choice is already made when it is decided to separate and elevate some particular party's narrow and short-term utility above every other value. It is only possible to force that kind of choice on the topic, which is to say (for our interest) the person in the throes of a worrying mental disorder. Choice of perspective and theory is not some sort of inevitable or natural outcome which occurs whenever scientists do science. No form of knowledge or rationality is neutral; it always involves a moral or political stance towards its topic. Strictly speaking, any science which splits reason from morality is schizoid. A prime example is that management of incapacitating emotional distress and mental disorder which does not set out with an open mind to help the person recover his subjectivity and autonomy but, on the contrary, assorts and contains him by degrading him to the status of a malfunctioning object, an entirely imaginary illness.

When defining a category in any genuine science, certain conditions must be met: peers must know that they mean the same object, it must be possible to replicate the experimental circumstances, and there must be a high degree of predictability. We have seen that the categories of psychiatric diagnosis are ill-defined and bear no relation to anything objective, and so the idea of replicating personal circumstances is an absurd impossibility. Each individual is as much part of his own environment as anyone or anything else. To a great extent, an individual's circumstances are defined by the person himself, in terms of what is significant to him and moves him to act in the ways that he does. As a result, even if it may seem to some expert that two people inhabit 'the same' or 'a similar' environment, inevitably it will be different for each person, and it will constantly change. In addition, there is a continual flux in our needs and perceptions; and these become a part of our circumstances, the whole of which determine our intentions. What are anyone's circumstances, and how would an observer recognise them? That depends - on when and where and why and with what or whom the person is placed, and upon his needs and perceptions; and this could only be discerned by discussing the matter with the person in question.

Psychology is not reducible to neurophysiology. Each of us lives imaginatively; it is impossible to construct a causal, quantitative and predictive medical science for personal or mental dysfunction. Experiments which attempt to hold constant the conditions of human life simply take us into the artificial realm of laboratories and questionnaires or, since the psyche is so clearly resistant to measurement, away from the real life of people and into the psychologically uninteresting neuro-chemistry or behavioural responses of rats and pigeons. Differences in the abilities of individuals to react to stimuli, or to remember things, or to perform tasks under various conditions do not, in themselves, tell us anything about persons or the causes of functional mental disorders. Concerning any particular person, the best we can do is predict the *probability* of his behaviour, other things being equal - which, of course, they rarely are since what someone thinks and feels, his relations to others, and how they respond to him, are all continuously changing.

The failure of the medical model clears the way for an alternative

Karl Popper points out that any proposition is scientific only to the extent that it is possible to set up the conditions to falsify it: progress is achieved just as much by falsifying hypotheses as by their confirmation. Obviously, a hypothesis is seriously doubtful if the evidence seems to invalidate it. But psychiatry does not conform to Popper's requirement: not only does its research fail to provide evidence for the truth of the medical model, but it ignores the rules of science. First of all, psychiatric concepts (e.g., the diagnostic categories) are not rigorously defined, and so it is not possible to properly verify or falsify the medical hypotheses; second, even if the first point is disregarded, with respect to both the causes of so-said mental illness and the efficacy of mental health treatments, psychiatrists seem oblivious to the regular falsification of their medical model.⁸³

In Chapter 12 we discussed the absence of proof and the logical and practical difficulties facing any attempt to test the hypothesis that functional mental disorder has an organic cause. The mental health medical model is unproven. When evidence that refutes the medical model is simply ignored - that is, evidence which might instead confirm the null hypothesis - we are fully entitled to argue that medical psychiatry is motivated and ideological rather than genuinely scientific. Meanwhile, an alternative to the medical hypothesis was always available: psychodynamic theory was proposed more than a century ago.

There has been extensive psychiatric research during the last one-hundred-and-fifty years, nearly all related to disease theories of mental disorder. First there were brain autopsies and then, continuing to this day, a variety of investigations into possible biological or constitutional causes for functional mental illness. There is still not the slightest evidence that any functional mental disorder has an organic cause. In which case, the alternative theory (the null hypothesis) remains entirely viable: that any functional mental disorder is a response to the psychologically deforming circumstances in which the individual was and is forced to exist; it is a response to psychological trauma. By now there is much evidence and argument to support the psychodynamic hypothesis - that psychopathology is based in unacknowledged emotional trauma - and we explore it in Volume 2.

Psychiatry is thoroughly confused about the patient *as a person* - a moral and political actor who lives amongst others, remembers a past, construes a present and imagines a future. Management of functional mental disorder is dominated by the medical model which only attempts to treat a malfunctioning object: the allegedly sick brain. It may certainly be helpful to recognise a person's depressed or psychotic episode (for example) - which may last a few hours, a few days, or weeks or even years - but there is no illness (in the usual sense of the word), and no-one is ever *essentially* depressed or schizophrenic. This is not to say that if someone in crisis is treated as if his being a person is irrelevant, and that he suffers from an illness (a mental illness), that a fair prediction may

⁸³ Aside from scrutinising research evidence that might seem to support a particular hypothesis, peers in a scientific community are likely to propose an alternative hypothesis that might fit the facts as well or better. And we cannot be certain of the truth of any pleasing hypothesis until attempts have been made to prove the null hypothesis (the opposite hypothesis). These processes constitute an essential counterbalance to wishful thinking and vested interest. See Popper, KR, op. cit. (n. 72).

not be made about his behaviour when he is legally restrained and his body worked on with drugs or electricity. But this would not be the prognosis of an illness. The patient is not a free agent who happens to have contracted or developed an illness; it is therefore a prediction of the behaviour of a psychiatric prisoner, and it speaks mainly of the power of the officials to exact conformity to their demands.

In the attempt to control the aberrant moods, minds and behaviour of troubled individuals, the urge to use the methods of natural science is an expression of a widespread neurotic need. The style of objective-quantitative science is a radical form of rational clarity, and in our culture it is generally understood as the only guarantee of truth. In accordance with the aggressive ego and the desire for mastery, under hierarchal and competitive social relations this style tends to dominate all forms of knowledge and practice - not excepting theories of the person and techniques and organisation for the management of distress and confusion. Today, propositions are only counted true if they are said to be endorsed by science. Hence a proposition is only accepted as an item of knowledge, rather than mere opinion, if it is couched in terms which appear quantitative, objective, invariable, impersonal and context-free; it must consist of atomised 'facts' not limited by time and place, but universal. In short, for any proposition to count as knowledge it must be predictive, thereby offering mastery. Only fantasies of certainty can allay the anxieties of the aggressive ego and the desire for narcissistic satisfaction.⁸⁴

We may have difficulty imagining that anything other than science could possibly deliver what we wish for. Bewitched by the predictive power of science, we tend to forget that we may also value forms of knowledge which do not give us the control of things - qualitative knowledge derived from other sources, such as unobtrusive participation in society or nature, or insights derived from ecstasy and transcendent aspirations, which lead to artistic or mystic expression, to joy, wisdom, salvation, or just plain freedom. The terrors of hallucination and the comforts of delusion are negative images of these persistent feelings and intuitions. In the psychiatric medical model, however, those negatives count for nothing; they are no more than the random and meaningless signs of illness - mental illness. By contrast, psychodynamic theory suggests that the highest value should be attached to the irrationality expressed in the mental disorder: it is the most significant psychiatric resource, an entry into the person's experience, the key to discovering what it is that causes his distress and confusion.

It is more than forty years since Ivan Illich argued that general medicine has largely become a gigantic misconception and a fairly disastrous malpractice that, in effect, persuades us to give up responsibility for our own health. Illich exposed the chemical-medical-vivisection ideology, the industrial-bureaucratic practice, and the unacknowledged but significant degree of iatrogenic illness; he maintained that today's medical interventions are often unnecessary, ineffective, and actually harmful. Illich and Ruesch both argue that too many medical interventions fail to make people healthier; it seems to them that the quality of a society's health and healthcare system is not estimated by simply counting the numbers of patients and the costs of the medicine provided.⁸⁵

The medical establishment has become a major threat to health... [A] professional and physician-based healthcare system which has grown beyond tolerable bounds is sickening for three reasons: it must produce clinical damages which outweigh its potential benefits; it cannot but obscure the political conditions which render society unhealthy; and it tends to expropriate the power of the individual to heal himself and to shape his or her environment.⁸⁶

As long as the official organisation insists on mimicking general medicine, this critique certainly applies just as much to the management of individual irrationality.

84 See Easthope, A (1986) *What a Man's Gotta Do: The masculine myth in popular culture*. London: Paladin, 78-85. We discuss the production of normal, 'assertive' personality in Chapter 23 (Volume 2), in the sections: Sadomasochism and the authoritarian personality, and The conditions for the development of normal character.

85 Illich, I (1975) *Medical Nemesis: The expropriation of health*. London: Calder & Boyars; Ruesch, H (1982) *Naked Empress: Or the great medical fraud*. Massagno/Lugano: Civis.

86 Illich, I, op. cit. (n. 85), 12.

We now have libraries and vast data banks that proliferate information by heaping fact on fact, and yet they seem to be employed mainly in the service of a short-sighted materialist ideology and in pursuit of the impoverishing use and abuse of everything that exists. It is time to recall and employ those other ways of knowing which, by the way, constitute the forms needed to limit and contain the sciences of objects. Even when the evidence stares it in the face, psychiatry is in denial of the actual sources of the extremes of distress and mental disorder, which is to say that sort of personal trauma and terror which is generally the result of over-repression, exploitation or abuse.

Possessed by the wish to reduce everything human to predictable quantities of atomised things, so that it may impose the absolute control over irrationality which everyone desires, we could say that psychiatry labours under a *paranoid delusion*.

...Specialists proliferate and encrust individual life. Those who succumb to the magnetic attraction exercised by the huge Kafkaesque cybernetic machine [of the social relations] are nicely divided from those who follow their own impulses and try to escape from it... The latter are the trustees of everything human...

Already by 1867, a member of the First International declared: 'We've been towed along by marquises of diplomas and princes of science for too long. Let's look after our own affairs and however inept we are we can't make more of a mess than what they've done in our name.'⁸⁷

87 Vaneigem, R (1967/75) *The Revolution of Everyday Life*. London: Practical Paradise Publications, 207.

Chapter 14: ALIENATED THEORY & PRACTICE

It is not their ideas which determine people's existence, but on the contrary, their existence determines their ideas.

K Marx and F Engels.¹

In the official mental health project, attempts are made to process every individual as if the problem were that of an isolated object (an illness) and not a socially-embedded subject - as if the problem were a diseased brain and not an emotionally distressed and confused person confronted by urgent and intractable problems. Since, by definition, functional mental disorder is not illness, we can only comprehend standard practice as ideologically-driven and motivated primarily by the urge to contain and domesticate serious but ostensibly unaccountable emotional and mental deviance, without disparaging any social power and by almost any means.

Nowadays, most of us agree with the psychiatric doctrine that any kind of persistent emotional or psychological problem is an illness that will benefit from medical treatment. Dr Thomas Szasz identified the administrative consequences of this unfounded belief as 'the rise of the Therapeutic State'. This tendency ignores emotional trauma, psychodynamics and the role of oppressive social relations in the genesis of mental disorder, and to understand it we have to interrogate the ideology by which it is rationalised. (By 'ideology' we mean a system of significant but unevicenced ideas which, in the service of a particular material interest, are proclaimed as undoubtedly true.)

Established power likes there to be no question that we live in the best of all possible worlds. Psychiatry's medical model obligingly assures everyone that when someone is overwhelmed by distress and confusion, to the point of disabling irrationality, it is not the social relations that are dysfunctional but always the individual who is stricken by illness - mental illness. It seems to us that rather than providing the most appropriate response to anyone in crisis - which, as we have seen in the preceding chapters, it does not - psychiatry is an invaluable prop to established power: not only does it administer psychological casualties in a manner that satisfies the consensus, but its 'medical' ideology vindicates the status quo.

So far we have seen that psychiatry works to contain very confused individual tribulation and, by employing an ideology which insists that it is objective medical science, to deflect the person from awareness of the origin of his malaise. This inevitably conflicts with the stated intention of the mental health services, which is to remedy individual misery and mental turmoil by the most reasonable and compassionate means. We do not suggest that ignoring intimate oppressions and dominating the patient are the conscious motives of every psychiatric official. Rather, as an element of the wider society in which medical expertise is pervasively fetishised, it would have been surprising had the official management of irrationality not developed as an alienated, pseudo-medical form of motivated misperception and social control. We argue that psychiatry's ideological role in mystifying the oppressions in private life was decided by a pivotal event in the history of the profession: the contrivance of an imaginary disease that the doctors call 'schizophrenia'.

Medicalising psychological problems

The scientific and industrial revolutions ushered in our era, in which technocratic and managerial rationality now defines every truth and value. Ever better organised, far-reaching and more securely

¹ Marx, K and Engels, F, op. cit. (n. 46, Ch 3).

rooted in daily life, in modern times the professions have come to dominate every social function and aspiration. Complementing this trend is the growth of a passive clientele which is persuaded to defer to every expert, and expects them to solve an ever greater variety of social and personal problems. Clients have consequently become increasingly mystified, dependent and economically exploited, and too often materially and psychologically harmed by the very agents supposed to help them.²

We are interested in the medicalisation of inconvenient or worryingly irrational kinds of personal crisis. Two hundred years ago Goethe already feared that the modern world might turn into one giant medical institution. Fifty years ago it seemed to Philip Rieff that 'the hospital is succeeding the church and the parliament as the archetypal institution of Western culture.'³ More recently, Irving Zola observed that

...medicine is becoming a major institution of social control incorporating the more traditional institutions of religion and law. It is...the new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts. And these judgements are no longer made in the name of virtue or legitimacy but in the name of health. Moreover this is not occurring through any increase in the political power of physicians. It is instead an insidious and often undramatic phenomenon, accomplished by 'medicalising' much of daily living, by making medicine and the labels 'healthy' and 'ill' relevant to an ever increasing part of human existence.⁴

Zola suggests that we need to recognise two important characteristics of any profession: its legal monopoly of a particular kind of work and the tendency to generalise its expertise beyond purely technical matters. This echoes the insight of Everett Hughes:

Not merely do the practitioners, by virtue of gaining admission to the charmed circle of colleagues, individually exercise the licence to do things others do not, but collectively they presume to tell society what is good and right for the individual and for society at large in some aspect of life. Indeed, they set the very terms in which people may think about this aspect of life.⁵

How the medical profession secured the exclusive right to control activity in its particular domain is well enough documented elsewhere,⁶ and we have already outlined the history of the rise to dominance of medical power in the management of individual irrationality.⁷ But a question remains: why should a profession wish to extend its influence into wider and more diffuse areas, beyond its traditional or generally agreed competence?

Until the end of the 17th century, conceptions of society and the individual were grounded in a religious worldview. This dominance of the transcendental then rather rapidly gave way to more prosaic ideas based on secular law. The shift in perspective responded to the needs of the emerging modern world: the introduction of far-reaching new technologies (gunpowder, printing, water- and coal-power, etc.), and hence developments in markets, commerce and industry; the consequent rise of the centralised nation states; the emergence of the experimental sciences and discovery of laws of nature; recognition that the universe does not turn on humanity and its tiny planet, and that the Bible is often factually wrong. In amongst an emerging consciousness of 'progress' instead of reliance on received wisdom, there developed a concern with 'the nature of man'. As religion steadily retreated (to limit itself mainly to the inner life of the spirit), during the 18th and 19th centuries the authority of the law expanded to embrace the whole of material or secular reality.

2 This is the gist of the argument made by Illich, I (1977) *Disabling professions*. In Illich, I et al. *Disabling Professions*. London: Marion Boyars, 11-39.

3 Cited by Zola, IK (1977) Healthism and disabling medicalisation. In Illich, I et al, op. cit. (n. 2), 42.

4 Zola, IK, op cit. (n. 3), 41-42.

5 Hughes is quoted by Friedson, E (1970) *The Profession of Medicine*. New York: Dodd, Mead & Co.

6 For example, by Friedson, E, op. cit. (n. 5).

7 See above, in Chapter 1, the section: A brief history of the management of madness, and in Chapter 13, the section: How Psychiatry emerged out of Medicine.

However, belief in the absolute value of law was always open to question. The public tended to suspect the legal profession of self-serving or corruption. Democracy does not necessarily allay that fear: legislative bodies always contain more lawyers than any other occupational category - and making more laws means more work for lawyers. Then there is the notion of 'bad law', often in relation to punitive taxation: 'the downtrodden' have always opposed 'bad laws' by evasion, protests, petitions, strikes, riots and other civil disobedience, including insurrection. During the 20th century a number of events particularly concerned the democracies: two fully legal and yet disastrous World Wars; countless smaller wars, prosecuted either by governments which flouted national and international law or which employed dubious legality; a number of genocides which were either legalised, not properly referred to law or simply arbitrary; and, over all, accumulating evidence that the law does not seem especially to mitigate exploitation or otherwise serve social justice - as witnessed by periodic extended bouts of high unemployment and hard times, and always by evidence that 'there is one law for the rich, another for the poor'. In turn, then, the authority of the legal interpretative system of values was also called into question.

The ultimate ground of Christian influence...was *The Truth*. This does not mean that what was preached was true or not true, but merely that it was with reference to its truth-value that the claims of Christian influence were asserted. In an equally fundamental sense, the idea of *Authority* was the basis of the influence of jurisprudence... Obviously, it cannot be said that Christianity did not claim authority; nor...that the law neglected questions of truth. However, what in the former was the authority of Truth became in the latter the truth of Authority. The crises of the ministry and of jurisprudence consist precisely in the fact that the former could not sustain its truth claims and that the latter was failing in its authority claims.⁸

Ultimately, the Reformation undercut the status of religion. A modern person is an activist: he wishes to master nature, not simply accept or adjust to it. This attitude emerges in a stronger form where there is a greater interest in practical, secular pursuits rather than aesthetic, mystical or theoretical ones. Since Law had proved fallible, by the middle of the 20th century there was no institutionalised opposition to the claims of Medicine - a profession that had always embodied the humanist notion of direct service, and by then it was becoming ever more generalist, encompassing not only biology, physics and chemistry but also economics, psychology, sociology, statistics, ethics...

The basis to this pre-eminence was Medicine's analytic and technical development. By the middle of the 19th century, success-rates had at last begun to rise above the level of a lottery based on guesswork, and the direct and increased successes of Medicine established it as the predominant science of human being. By then it was obvious that the wealth of the new urban-industrial world was based in certainties established by the recently developed sciences of physics and chemistry; with Darwin, the idea of a universe fixed in its hierarchy by God was replaced by that of a universe - including human beings - fixed by scientific laws. With the sudden increase in its reliability, Medicine rose rapidly in its organisation, scope and prestige, and when religious and legal authorities went into crisis this new dispensation of truth and authority was ready to replace them. The steady decrease in child mortality and the increase in the average lifespan in modern societies may have been due more to the provision of clean water and urban planning than to medical advances but, with the rise of Science and Medicine, interest in 'the afterlife' and religion was bound to decline in the 20th century, and there was a commensurate increased interest in conditions of the body. Much of the interest was in remedying diseases which had hardly figured before - cancer, heart disease, diabetes, etc. In the Age of Anxiety there was also increased interest in the 'disease' of mental illness.⁹

8 Bittner, E (1968) The structure of psychiatric influence. *Mental Hygiene* 52 427.

9 WH Auden's long poem *The Age of Anxiety* appeared in 1947. Auden's characterisation of the impact of the social disruptions of the first half of the 20th century was immediately popular with artists, intellectuals and the media.

This 'medicalising' of society was not announced publicly as a wonderful new principle. Instead, it developed insidiously so that nowadays Medicine tends to hold sway over any aspect of life that it deems relevant to its own practice. Whereas it used to be committed to a specific etiological model of disease, it now embraces the idea of multi-causality. By way of ideas like psychosomatics, comprehensive medicine and preventative medicine, and with advances such as genetic profiling, medical concern has expanded beyond the boundaries of what used to be thought relevant to understanding and preventing illness. Before the introduction of networked computers, a patient would usually divulge personal information only to one or two officials who recorded a limited number of 'strictly medical' details on a file not routinely read by very many others. By contrast, a patient is nowadays expected to reveal information about every anxiety and his whole 'lifestyle', no detail of what he divulges and what the medical experts say about him is lost, and this information may be perused and freely analysed by 'the team' or any other official able to access it.

The medical profession keeps tight control of every technical health procedure, and its dominion always expands. As a matter of course, people resort to prescribed medications or treatments for more and more organic conditions, including those not previously considered illnesses - such as being fat or being thin, the menopause, erectile dysfunction, etc. These days, medical experts intervene radically in what used to be seen as irremediable natural processes such as pregnancy, birth, aging, and sexual or reproductive problems. Doctors are now the main arbiters of matters of life and death at both ends of the life-cycle - abortion and human fertilisation as well as the use of life-support systems and lethal painkillers. Medicine is also increasingly asked to create a good 'quality of life' or prevent a bad one: there are now thousands of recognised genetic disorders that doctors are called on to counsel, remedy or prevent.

Today, the medical profession also speaks with apparent authority about many questions of taste or aesthetics, e.g., with regard to body-shape, cosmetic surgery, sex change - and particularly, of course, with regard to undesirable ways of thinking, feeling and behaving. Medicine now claims *exclusive* and *absolute* right of access to the formerly taboo areas of the innermost workings of the body and mind. Aging, pregnancy and childbirth were not considered anything that doctors could do very much about until the middle of the 20th century, when they were rapidly included in their remit. And at that moment, alcoholism and drug addiction were also suspected or defined as illnesses rather than kinds of immorality. The 'disease model' had by then fully surfaced in the vision of a heroic struggle to save lives and improve both physical and mental health, at almost any cost.

Everyone now seems to accept that licensed access to the body can legitimately be extended so as to access any other intimate part of a person's life. As traditional sources of personal, emotional and psychological support continue to decline - for example, stable and close-knit family networks and communities - increasingly people have turned to doctors for help or advice. Without seeing it as particularly a problem of mental health, people now go to the doctor for drugs to help with any imaginable psychological or behavioural condition: for getting to sleep, for waking up, for reducing or stimulating the appetite, for increasing energy level, for lack or excess of sexual function, for enhancing intelligence or memory... They are also willing to see the doctor about their unhappiness, grief, depression or any other emotional or mental problem, and they seem fairly comfortable about being referred on to what is now known as 'the mental health service'.

Social, political, and economic action is influenced by this ongoing process of medicalisation. A significant ideological consequence is the use of the metaphor 'illness' so as to account for every psychological problem and many interpersonal and socio-economic questions, too. Naturally, when these kinds of issues are conceived as 'mental illness' - i.e., where there is no discernible organic malaise (or if there is, it does not directly cause the problem at hand) - this immediately indicates that the trouble is not located anywhere else but inside the 'abnormal' individual. Specifically, the problem is supposed to be in his mind or brain (if at all, the two phenomena are hardly differentiated); and this person is required to co-operate with a medical intervention - one which 'everybody knows' is strictly technical and nothing to do with anything outside the organism. However, by taking the medical metaphor literally, emotional, mental or behavioural deviance and

interpersonal conflict are denied their normative context, i.e., the social relations; which is to say, there is no acknowledgement of psychodynamics.

This conflation of contentious ideation and behaviour with illness is applied to almost any kind of unapproved activity, ranging from private individual misery and mental deviance to undesirable behaviour in the family, school, workplace or community, to criminal acts or protest, riot and rebellion. A literal reading of the medical metaphor serves the political function of surreptitiously defending the status quo by simply refusing to recognise the weight of any pernicious factors in the social context, and by persuading, drugging or otherwise coercing deviants so as to elicit their conformity. Medical officials employ legal authority and wield great power: it is hard to refuse any kind of mental health diagnosis or prescribed therapy, and by law impossible to refuse *psychiatric* diagnosis and treatment.

Thomas Szasz argued that by the last quarter of the 20th century the routine medicalisation of such a broad spectrum of personal and social problems had finally issued in the fully-fledged Therapeutic State. In order to change attitudes and behaviour, whole armies of officials are now entitled to intervene obsessively so as to manage and therapise those deviant or 'marginal' citizens who do not seem able to govern their own lives or abide by the approved norms. Historically, medicalisation was applied first of all, of course, to the prototypical subjects of the therapeutic regime: individuals accused of being mentally ill.

Joining the traditional rationalizations for state coercion - 'God's will', 'the consent of the governed', and 'social justice' - comes a fourth: 'coercion as treatment'. Unlike theocracy, democracy and socialism, however, pharmacracy has met little opposition.¹⁰

Psychiatry as a component of the administrative and ideological system

So far, we have characterised as 'mythic' that metaphoric thinking which is widely accepted as literally true - such as belief in the actuality of mental illness. But to say that an idea is a myth is not necessarily to imply that it is covertly in the service of a material interest; that aspect of widely-held but unevincenced beliefs is emphasised by the concept of ideology.

In the previous chapter we examined the rickety conceptual and methodological foundations that are supposed to underpin normal psychiatric practice. We also suggested political, institutional and economic interests that may account for the vigour of the myth of mental illness. However, we argued that more pressing than those interests are the anxieties which urge everyone to wish for a medical solution to any functional mental disorder - that the organised response to serious emotional distress and irrationality is largely based in a false impression driven by a shared neurosis. To conclude our investigation of the unspoken motives and irrational beliefs which endorse the psychiatric medical model, we now deploy the concepts 'ideology' and 'alienation'; thereby, we hope to make sense of the way this shared neurosis is institutionalised as the conventional wisdom and a normal, fully approved kind of social action. We illustrate our argument by referring to the deliberate *contrivance* - rather than the discovery - of a discrete psychopathological condition said by the psychiatrists to be undoubtedly an illness: i.e., 'schizophrenia'. We also suggest that confusion and insensitivity in mental health care and treatment is not extraordinary: it is only a particular embodiment of that alienated kind of knowledge and practice which tends to invade *every* transaction in our society.

Mind is first of all practical consciousness, and it develops in communication with others. Social organisation and mind must surely have emerged together: human consciousness, including the organisation of perception and conception, could not have appeared separately from social organisation. Meanwhile, each newborn child is helpless and dependent; a child only achieves a degree of autonomy by participating in the social order, and submitting to it. In order to survive, the first imperative for each of us is to facilitate ongoing co-operative activity - those around us are vital elements of the world into which we are born. Therefore, interposed between every relation of an

10 Szasz, TS (2001) The therapeutic state: The tyranny of pharmacracy. *The Independent Review* 5 4. Also see Szasz, TS (1984), op. cit. (n. 18, Ch 1).

individual to any part of his reality is bound to be a social power which is persuasive in its definition of situations: our experience of the world is inevitably mediated to a large extent by perceptions and definitions endorsed by the consensus, and we cannot begin to know or communicate our own experiences, desires and intentions without submitting to the rules of speech and employing the concepts prevailing in the community around us. Mind is from the beginning directed towards the problem of defining the parameters of the social-symbolic order, and the individual's place within it: 'What is going on?' and 'Who am I, and what must I do?' But wherever there is dependency (or interdependency), there is also conflict between powers or interests. Neither social nor individual organisations of mind and sentiment are ever exempt from overt and covert dynamics of domination and exploitation.

Marx and Engels argue the general implications of the relations of domination to thought and feeling. Regarding the quote at the top of this chapter, that 'existence determines consciousness' is not for them *inevitable* - otherwise, why would they have made that pronouncement in the first place, or bothered to have made a single journalistic or political intervention? What they propose is the certainty that existence determines consciousness whenever people are *unaware* of the great yet often hidden force of material interest that tends to sway feelings and perceptions, or when they deny the reality or strength of that force. Moreover, in the rhetorically-loaded conversations of social and personal life, which are always weighted so as to advance or defend an interest, unawareness and denial is *normal*.

In every part of human life, then, from the most intimately private to the routines of the social organisation and the general political-economy and culture of the society, there is a pervasive and ongoing production of *false consciousness* which, for covert reasons of material interest, insists on its undoubted truth: that is to say, a production of rationalised beliefs. Marx and Engels use the term 'ideology' to indicate this alienated thinking: it is any idea which fails to admit contradictions, either in what it takes for granted without good evidence or in the consistency of its arguments, and especially when that false consciousness constitutes a system of socially significant beliefs. 'Ideology' denotes not just any random thought or organisation of ideas, but one which is demonstrably false and which masks and serves powerful motives shaped by the material, technical and social conditions. In the critical-sociological sense, ideology is

...an inverted genealogy of culture that makes for illusion and mystification by treating ideas as primary where they should have been treated as derivative.¹¹

Ideological thinking operates under an illusion, and the dynamics of domination constrain patterns of feeling and thinking most effectively when people are unaware of that ideological influence being worked on them. When this is the case, it is easily assumed that one's own particular and historically specific misperceptions and delusions are unquestionably and universally normal, natural and true reflections of reality.

False beliefs are not always inconsequential. Far from it - whether action is guided by beliefs founded in reality or in delusion, there are always real consequences. The first Volume of this book is written precisely to point out the unhelpful and often harmful consequences of psychiatric ideology - the so-called medical model - for those who suffer from undue emotional distress and mental turmoil but not from a neural (brain) illness. The history of the development of science shows that ideology in relation to objects in the material world has its real effects - that is to say, what people wish blinds them to what is actually the case. Nevertheless, false thinking about the material world is more easily brought up short by hard reality, i.e., by the empirical evidence. By contrast, every 'thing' or event which is specifically an attribute of human behaviour, or an aspect of individual thinking or feeling, is always a *social construction*; and the immediate reflex of every party to any social relation is to attribute significance depending on his or her own particular and motivated interest. What is socially

11 Burke, K (1950) *A Rhetoric of Motives*. New York: Prentice Hall, 104. What is missing from Marx's conception is an appreciation or analysis of the *visceral* attachment to ideology. This was explored later, with regard to individual psychopathology, by means of Freud's concept of rationalisation; see Chapter 21 (Volume 2).

or psychologically ‘the case’ always and irreducibly depends to an extent on how the terms of the events or situations are defined, and is hence a matter of who has the power to impose on others his own preferred definition of the situation.¹² By way of self-fulfilling prophecy, *ideology is the cognitive component of that activity which really can create the social and personal world according to how it is falsely imagined.*

Our interest is in the consequences of ideology for the care and assistance of those suffering from a functional mental disorder. In the preceding chapters we have seen that despite evidence and unanswered arguments to the contrary, the prevailing ideology defines every psychiatrist and mental health worker as the competent agent of a remedy which is essentially medical. Because there is no one and no other theory who or which will contest that definition of his status and role - least of all the powerless patient with his mythically sick brain - every psychiatric official is further validated as an undoubted expert whenever he appears to perform his function as a manager or therapist of mental disorder. In the meantime, each day that the patient wakes up to find himself still in the clutches of psychiatric power, he knows that everybody around him believes he has a serious illness which renders him ignorant and lacking in competence with regard to any aspect of his own condition. In addition, before it will ever allow that he may have recovered from his mythical illness, the full lawful weight of the consensus is bent on persuading him of the truth of this belief. No psychiatric patient is considered to have ‘recovered’ or be ‘on the road to recovery’ until he indicates that he ‘has insight into his illness’, i.e., until he agrees with everything the officials say about him, and behaves exactly as they wish.

We have witnessed the consequences of this ideology for a patient’s whole life: if the consensus maintains that a particular individual is essentially ‘different’, he is treated as such.¹³ At the point of diagnosis, since his world immediately becomes quite separate from the world of those subscribing to the ruling consensus - those who, by implication, must be ‘normal’ - for all intents and purposes *he does become different*; which is to say, anyone stigmatised by psychiatric diagnosis is viewed by every normal person (undiagnosed person) as *intrinsically* mentally deviant, and is thereby exiled from the context of routine normality to a situation in which everyone views him as a particular kind of *alien being*, and expects him to act as such. As a medically-registered kind of alien being, the psychiatric patient cannot but act ‘differently’: at any time, *anything whatsoever* that he says or does - however normal it might appear in another context, or however normal he tries to make it - is likely to be construed by anyone else as yet another sign to confirm his essential difference. And since he is not subjected to a *rational* process of technical medicine but to an arbitrary social power which only *asserts* that it is rational and medical, it is never possible for the patient to predict when some psychiatric agent or ‘normal’ member of the public may decide to condemn any aspect of his behaviour or demeanour as ‘just another symptom of his mental illness’.¹⁴

We might characterise any false belief as ‘ideological’ if it serves an identifiable material interest, in opposition to other interests. Beyond this, Marx and Engels write:

[t]he ideas of the ruling class are in every epoch the ruling ideas, i.e., the class which is the ruling material force of society is at the same time the ruling intellectual force. The class which has the means of material production at its disposal has control at the same time over the means of mental production, so that thereby, generally speaking, the ideas of those who lack the means of mental production are subject to it.

The ruling ideas are nothing more than the ideal expression of the dominant material relationships, those relations grasped as ideas; hence of the relationships that make the one class the ruling one, therefore, the ideas of its dominance.

12 See the discussion in the text to footnotes 63-66 in Chapter 13, above.

13 See especially Chapter 4.

14 This was established by Rosenhan, DL, op. cit. (n. 41, Ch 5). Also see much of Chapter 4, above. Obviously, stigmatisation and the ‘heads I win, tails you lose’ situation established for the individual by means of psychiatric labelling (the medical diagnosis) has parallels in other areas of social life, e.g., prejudicial racial, ethnic, religious and gender discriminations.

The individuals composing the ruling class possess among other things consciousness, and therefore think. Insofar, therefore, as they rule as a class and determine the extent and compass of an epoch, it is self-evident that they do this in its whole range, hence among other things rule also as thinkers, as the producers of ideas, and regulate the production and distribution of the ideas of their age: thus their ideas are the ruling ideas of the epoch.¹⁵

The reader's attention is particularly called to our emphasis in this quotation. If, in the dominant material relationships - the relations of political-economy - most of humanity are considered and treated as non-executive objects with greater or lesser exchange value (like every other commodity), and as contributing or not to the production of profit (i.e., treated as exploitable objects of labour-power), there is an overbearing inclination for them to be so conceived by official culture, administration and science *throughout every aspect of life*.

Inevitably, the genesis of hierarchy and domination yields the objectification of nature as mere natural resources, of human beings as mere human resources, of community as mere urban resources, in short the reduction of the world to inorganic technics and a technocratic sensibility that sees humankind as a mere instrument of production.¹⁶

For example, when psychiatry, for its own purposes and consequent to its own delusions, conceives of its topic not as distressed and confused subjects but essentially *objects* - mental illnesses/malfunctioning brains - this is because *there is a certain but inverted truth to that conception*. In the dominant mode of social organisation, most of us are indeed required to behave not as active, creative and unpredictable subjects but as passive and predictable objects which only become significantly active as does a machine, i.e., when performing pre-set functions according to some external purpose, that is, depending on the dictates of those with political or economic power.

Furthermore, pursuant to the medical model, as if what is wrong is some part of the 'bio-mechanism' of the patient - his brain, his hormones or his genetic make-up - the psychiatrist is *legally enjoined* to take the person and, according to his training, do with him as he sees fit: the medical model insists that *it is his duty to process a malfunctioning object, i.e., the person's brain, which has become ill (mentally ill)*, not generally help a living, feeling, wilful subject. Indeed, the overriding project of psychiatry, as the official organisation for the management of inconvenient or dangerous irrationality, is precisely *to demonstrate the truth of its own hypothesis concerning the essentially objective nature of the person and his mental disorder*. In this it often succeeds, *but only by employing almost any means to reduce the wilful subject (the patient) as near as possible to the status of a passive, acquiescent and predictable object*. This is no exaggeration: too often, and so as to make them conform to psychiatric expectations, patients are subjected to pain, harm, and even death by official treatment.¹⁷

The ideology of psychiatry, embodied in the whole conglomeration of its assumptions, notions, research and practice, is a subset of the ruling ideology, and as such both takes for granted and contributes to that ideology. Psychiatric workers may imagine that they practice a kind of medical science - and will tell anyone that they do so - but psychiatry is *not at all* the result of an unmotivated, immanent and purely medical-scientific development. As we have seen, it is not authentic medical-science, and its ideas and practices serve first of all the interests of social power. Together, the unfounded medical model of mental illness and the dogma of the efficacy of psychiatric medicine constitute a seductive but reactionary ideology which works to buttress the established social relations by restraining a certain kind of troublesome deviant, and by stifling any urges he may have to achieve coherence, meaning and liberation from the forces that oppress him.

We do not suggest that psychiatry is underwritten by a conscious conspiracy to deceive - even when, as we will soon see, the so-called medical model was foisted on the whole psychiatric

15 Marx, K & Engels, F, op. cit. (n. 46, Ch 3), 64.

16 Bookchin, M (1980/2008) Anarchism past and present. In Bookchin, M (Ed) *Comment: New Perspectives in Libertarian Thought 1* 6 dwardmac.pitzer.edu., 7.

17 See Chapters 6 and 7 above, and the section: Incapacity, injury and death resulting from psychiatric medicine, in Chapter 15 below.

profession not by means of a medical-scientific process of discovery but by a political manoeuvre;¹⁸ and even when this model is still regularly elaborated *not* with regard to newly emerging scientific evidence but simply by counting the votes (the wishes) of the elite *DSM* committee members, who, in turn, are motivated by the bribes of the drugs companies. Rather, those employed to manage 'the mentally ill' are able to imagine that they experience their own subjectivity or agency every working day, whenever they make a diagnosis or decide a treatment, a care-plan, a policy, etc. And as responsible functionaries, primarily they experience those they manage as objects, i.e., mental illnesses - all those patients who they process and medicate, all those 'sick persons' who do not reasonably exercise their own executive agency (who seem unable to act, or are forbidden from doing so) and who must be rendered compliant, which is to say passive, like an object.

In the world organised as it is, hierarchically and by calculations of profit and loss, those who possess wealth or power appear to themselves - 'obviously' and 'naturally' - as members of an elite of active, significant and knowledgeable subjects. Amongst the fraternity of the managers of persons, psychiatrists are likely to be particularly persuaded of an absolute difference between themselves and those they manage. This is an effect of the extraordinary powers possessed by psychiatrists, of how mental disorder is conceived, and of the extraordinary vulnerability of any psychiatric patient. When recommending or deciding a diagnosis, treatment or care plan, the psychiatric official can imagine that he acts as a subject, while it goes without saying that the object of his management (the patient) is made irrational by his mental illness and does not or 'cannot really' act. This means that when the official deals with a patient, it is with someone who everybody agrees is so debilitated by his illness that he is *essentially* deficient with regard to his reason and will, that he is *intrinsically* much less than a fully functioning subject, and that this is due to a fault in an object, i.e., the individual's brain. Meanwhile, all of the psychiatrist's training is medical, in which he learns to deal with objects, i.e., parts of the body which have gone wrong; hence he is convinced that he performs the benign office of administering medicine to malfunctioning brains.

In most other areas of life, however, some of those who are managed are apt to remind their managers that they, too, are active subjects: they do this by effectively exercising their powers of rational agency, including, for example, questioning or disobeying orders, complaining to a higher authority or their union, 'standing up to management', organising a protest, striking, or leaving the field. A psychiatric patient, on the other hand, is a kind of prisoner. He has no power to resist the officials - even if he now acts as a model of calmness and lucid rationality - and since whatever undesirable thing he says or does may be discounted as 'only another symptom of his illness', he is obliged to appear obedient, passive and object-like if he is ever to be released from surveillance and treatment. It is for these reasons that the psychiatrist does not recognise the emotional distress, confusion, oppression and micro-social conflict which call down the official intervention, except in those pseudo-medical terms which individuate, isolate, invalidate, scapegoat and treat as a defective object the person at the centre of the crisis.

If this is how a doctor views the problem with which he is faced, there is only one remedial path for him to follow: he can only imagine dealing with a personal or inter-personal crisis by treating it as the problem of an object (the elective individual's brain/chemicals/genes) which demands a technical response (chemical interference/electrical obliteration/operant conditioning). Employed to exercise his medical-technical skills, and wielding power from a comfortable position within the social order, a psychiatrist might find it difficult to tolerate, comprehend *or even recognise as such* any interrogation of the social relations whatsoever, whether coherent or incoherent (i.e., mad). Thoroughly indoctrinated with the medical model, doctors are able *only to recognise as illness* any such dissent as that which may be represented by private misery and despair, or the incoherence of 'strange ideas' and confused deviance. The social organisation affords the powerless no legitimate voice - and certainly not anyone diagnosed with a mental illness. It is therefore easy enough for elements or agents of the ruling class - such as doctors - to repress from awareness any questions which might otherwise be raised by an apparently irrational response to private oppressions. Give or

¹⁸ See the section below: The invention of schizophrenia.

take the odd reform which might be pleasant but not urgent, our social arrangements appear to a complacent administrative class not as the result of a history driven by political, economic and emotional (neurotic) interests, but simply *the nature of things*. Therefore, once it is decided that he is irrational and has a mental illness, it will appear to any doctor that the cause of the deviant's misbehaviour *must be* some kind of organic malfunction. So far as the privileged are concerned, we pretty much live in the best of all possible worlds; in which case, it is impossible to make *any other* sense of a diagnosed mental disorder: if the psychiatric patient disagrees with the official definition of his condition or situation, he must be irrational, must be talking nonsense, and *must be sick*. And of course, sickness is the province of medicine.¹⁹

So as to account for irksome or dangerous irrationality, psychiatry constructs a rationalisation which takes for granted a notion already present in the wider ideology: that of *the timeless, self-caused ego which possesses itself and is explained by empirical-medical science*. This *psychologism of the nuclear ego*, as the first cause of society and history, is the pseudo-centre of the whole of our allegedly pragmatic culture - which is to say, of the dominant ideology.²⁰ To the extent that society is organised hierarchically, to that extent it applauds the infantile narcissism of the powerful, and the ruling ideology is bound to express itself as a form of egotism. This ideology assumes that the psyche exists prior to its social determinations: that, at birth, each of us *already possesses* certain properties (or, as the pseudo-sciences of psychology and psychiatry would have it, 'traits' or 'propensities') which predispose us to behave the way we do. It is taken for granted that these attributes, if not now, will one day be scientifically measured and explained, i.e., that they are (or soon will be) amenable to quantitative, causal and experimental analysis, and hence prediction. In this perspective, *all* of human activity is in principle reducible to the reactivity of objects - the whole gamut of human behaviour, from private sensuality, the emotions and the imagination, to social organisations and the macro political-economy.

According to this dogma, and in answer to a widespread neurotic wish, everything which is *really* real already is (or soon will be) measured and predicted. Everything, that is, remarkably and inexplicably, except the wonderfully unmotivated, rational-scientific-medical activity of the psychologists and psychiatrists themselves. In opposition to those he manages, runs tests on and works on, and *because of* his technical-managerial function and the patients' passivity or 'random and irrational' behaviour, a psychiatrist is encouraged to experience and think of himself as a disinterested, lofty centre of medical-scientific thinking, motive and decision. Added to which, it seems indubitable that his status is thoroughly deserved since it was achieved by dint of his heroic efforts during the long and arduous process of professional training. While attributing the bad properties which emotional and mental deviants are supposed to possess (or be possessed by) to their being so unlucky as to have been genetically predisposed to develop a pathological personality, the ideological function of this expert of the psyche is also to systematically ignore any hint of social criticism.

Along with psychologists and educational ideologues, psychiatrists are the official guardians of the generalised illusion of the atomised and measurable, pre-existent/genetically encoded and yet self-responsible ego. Like the educationalists and the psychologists, psychiatrists believe in their own rationalisations, and propagate them as a pure knowledge, i.e., 'scientific facts'. Psychiatry plays a crucial role in defence of the status quo when it persuades the public of the truth of its own delusions and, by means of its managerial ploys - which it calls 'care and treatment' - it tries to persuade or *compel* every heretic patient to believe in these false beliefs.

Of course, this conception of what psychiatrists do, and why they do it, is far from the view shared by them or even very many of those who suffer at their hands, i.e., their patients. A

19 The widespread wish to reduce uncomfortable politics to illness is confirmed by the regularity with which, whenever vandalism or a riot is in the news, it is deplored as 'mindless', and a pundit can always be found to express the view that the perpetrators must be mentally ill (or suffer from an Oedipus complex, etc.).

20 With particular reference to the doctrines ruling in the Social Sciences and the Humanities, this is argued by Anderson, P (1968) Components of the national culture. *New Left Review* 1 50.

professional ideology which has long since usurped the language and reputation of genuine scientific medicine convinces almost everyone that ‘the mentally ill’ are simply that: ill. But it is not the critics of the psychiatric medical model who romanticise the irrationality and loss of independence of those who experience disabling emotional distress and mental disorder. Rather, any perspective which does not address the role played in the genesis of mental disorder by psychologically traumatising social relationships itself embodies a sentimental, romantic conception of society and the individual.

As we saw in Chapter 12, there is simply no evidence for the properties of a type of personality existing ‘in’ anyone prior to their social performance. Nor could there be any such evidence since we spend our entire lives as social beings. In the absence of a demonstrable organic disorder, belief in these properties, propensities or traits is never based in anything more substantial than pompous, authoritative-sounding pronouncements. Alleged ‘properties of the personality’ only exist as pseudo-scientific constructs attributed to certain persons on the basis of observations about their behaviour, and with no regard to context. And yet it remains the case that, in whatever situation we might find ourselves, none of us can help displaying certain positive or negative signs of intelligence, emotion, attitude, mental balance, etc., etc.; that is to say, in any manner which is not tied to a context, none of us ‘has’ a particular level of intelligence, any kind of emotional trait (e.g. introversion, excitability, etc.) or any kind of mental illness. Never mind, the experts are here to reduce the infinite variety of human behaviour to a few dry measures of the processes of objects.²¹ Because they have no standing as the terms of a genuine medical science, the labels used by psychiatrists are little more than tags convenient to their own ideological interests - they are an alibi employed to bestow legitimacy on the assortment and containment of certain undesirable kinds of behaviour.²² Under a pseudo-scientific legitimation, such taken-for-granted ‘empirical’ or ‘pragmatic’ categories are always a radical reduction of the subject’s full humanity for the purposes of social control.

The resort to moralising and coercion

Encounters with unfamiliar people are habitually mediated in terms of the stereotypes which we construct or adopt so as to make much more than a provisional sense of things; simultaneously, we secure a sense of our own different and estimable identity. From a psychoanalytic perspective, the reflex to make sense of events by resort to stereotypes arises from ‘the basic human need to cope with the anxieties engendered by our inability to control the world.’

As the child comes to distinguish more and more between the world and self, anxiety arises as a perceived loss of control over the world...

With the split of both the self and the world into ‘good’ and ‘bad’ objects, the bad self is distanced and identified with the mental representation of the ‘bad’ object. This act of projection saves the self from any confrontation with the contradictions in the necessary integration of ‘good’ and ‘bad’ aspects of the self. The deep structure of our own sense of self and the world is built upon the illusionary image of the world divided into two camps, ‘us’ and ‘them’. ‘They’ are either ‘good’ or ‘bad’ [i.e., threatening or non-threatening to our sense of self]...

Stereotypes are a crude set of mental representations of the world... palimpsests on which the initial bipolar representations are still visible. They perpetuate a needed sense of difference between the ‘self’ and the ‘object’, which becomes the ‘Other’. Because there is no real line between self and the Other, an imaginary line must be drawn... [This] line between good and bad responds to stresses within the psyche...²³

In our critique we dwelt on the fact that in the shared mythology there is first of all a stereotype of the mad person, and then a rationalisation of this stigmatisation by the elaboration of a taxonomy of

21 Although more subtle experts sometimes suggest that performance (and hence a measurement of IQ, of extraversion, or of mental health, etc.) may improve with practice.

22 This is fully argued in Chapters 12 and 13, above.

23 Gilman, SL (1985) *Difference and Pathology: Stereotypes of sexuality, race and madness*. Ithaca: Cornell University Press, 17-18.

the mental illnesses: from dementia praecox/schizophrenia (devised early in the 20th century) all the way through to ADHD and immature personality disorder (devised towards the end of the 20th century), this is a thoroughly modern, exhaustive and allegedly medical-scientific list of the sub-types of madness.

Any recognition of an essential difference is at the same time the projection of a value judgement into the identification: not only different, but good or bad. Hence, the definition (diagnosis) and management of individual irrationality is inevitably a moral exercise, however much mental health officials may be convinced that they practice a purely objective medical science. And unfortunately for the peace of mind of the officials, who each day find themselves face-to-face with *people* - which is not at all the same thing as what the doctors call *mental illness* - at any moment these diagnosed individuals might act or speak with coherence, lucidity and reason. A patient might disagree and give good reasons, or behave in a disapproved manner but according to his own lights, and so on. That is to say, although they perceive each patient in terms of an objective process - as a case of an illness - the officials risk being reminded that he is in fact a subject, an agent who is able to reason and act, and that perhaps this indicates that it is inappropriate to regard him as a malfunctioning object (a brain gone wrong) rather than a person who happens to have become overwhelmed by certain apparently intractable problems.

In other words, it is not that the patient is essentially different but that he is, in many important respects, *essentially the same as everybody else, including the mental health officials*. Yet anyone who holds an official position needs to feel that his authority is justified because it is based in greater competence. Psychiatric officials are therefore likely to find emotionally and cognitively intolerable that identity, equality or kinship with the patients which forever keeps rearing its head. To resolve this conundrum, a clear difference between psychiatric workers and patients may be re-established by maintaining that the patients are indeed subjects - actors and moral agents - *but only insofar as they are culpable for their troublesome deviance*: not just mad, but also bad.

As an authorised expert of the mental illnesses, an agent of the democracy²⁴ who supposedly acts purely as a skilled technician, the doctor or mental health worker cannot allow that his activity is anything to do with the distasteful in-fighting of political life - which is to say, the politics of private life (usually the family) and the discipline of a deviant kind of misery, confusion and resistance. Accordingly, whenever the medical model is called into question by signs of the rational subjectivity of the patient - as happens regularly - the psychiatric official cannot suspect any personal-political process as a fundamental cause of the malaise. For example, he cannot imagine that a mental disorder might have any connection with the patient's attempt to live with the memory or intuition of a psychological trauma such as emotional or mental cruelty, actual abuse or exploitation, or any other kind of oppression, such as denial, abandonment or the loss of a parent or sibling during childhood. At most, those kinds of events are only permitted the status of 'precipitating factors', which is to say, not decisive causes: in the psychiatric ideology, the cause 'must really be' genetic or a brain chemical imbalance. As he practices on the patient the more or less degrading and debilitating routines and treatments of the medical model - which he views as his being objective and technical - neither can the psychiatric official ever begin to suspect *his own professional activity* as a kind of politics. And when the medical model collapses under the weight of countervailing evidence - a regular occurrence - and it ought to be obvious that the principles of his own activity might be compromised, the psychiatric official still cannot admit that he may have got it wrong. As a means of defence he drags out morality, that shabby old apology for irresponsibility and bad faith: it must be the patient who is at fault.²⁵

24 Private care and treatment is regulated by the state, and largely agrees with the official 'medical model'.

25 Recall a seasoned ex-patient's observation that in psychiatry it is never the doctor's judgement that is wrong, but always *the patient who fails the treatment*: Coleman, R (n. 97, Ch 6). And as a character says in George Bernard Shaw's famous play: 'I'm one of the deserving poor... Think of what that means to a man...that he's up agen middle class morality all the time... What is middle class morality? Just an excuse for never giving me anything.' Shaw, GB (1912) *Pygmalion*, Act 2.

Despite all the supposedly medical jargon and ritual, and while the patient lacks the resources ever to do anything about disagreements he might have with his psychiatric managers, doubts and confusions about the medical model are always there to be raised in everybody's minds. The resort to morality is a vain attempt to resolve the contradictions eating at the centre of the ideology of the so-called medical model. For as soon as morality is invoked, psychiatric rumination and practice cannot be prevented from oscillating perpetually, confusedly and confusingly between two possibilities: that the patient is to be understood as essentially a witless, non-responsible object (a diseased brain), or that he is a responsible agent who could be in fair possession of his wits and should stop 'acting up' and 'make the effort to pull himself together' (he is a wilful deviant). Especially since he refuses to talk to any patient as an equal, and might perhaps thereby discern the material and psychological bases to his charges' misery and confusion, the psychiatric official can never be sure which of these two possibilities is true. The experts may bluff and bluster before family members or in courts of law, but actually they are always bemused by the enigma of the alleged illness, that 'object' they imagine they treat with medicine but which, at any instant, might suddenly and unaccountably burst forth in the likeness of a wilful subject who, after all, is able to make good sense.

This contradiction at the heart of mental health practice is never acknowledged by the authorities; to do so would be to admit that it calls into question the whole notion or 'model' of the so-said mental illnesses. Neither can the professionals conceive of their own values not being universal and undeniably factual. Value judgements are consequently introduced as objective definitions: social ideals are biologised as 'mental health', 'normality', etc.; naturally, these are the ideals of decent and responsible folk, of the ruling class, of righteous and right-thinking doctors and officials. Although often accompanied by a degree of puzzlement, unreason is thereby conceived as a sickness which descends upon or gestates within the person (i.e., a condition for which he bears no responsibility) *and yet at the same time* a moral failure (i.e., a nuisance or danger that the patient causes deliberately or could stop himself from committing). Depending on the contingent predisposition or mood of each official he encounters, a patient is likely to find himself defined willy-nilly as *either* sick or bad, *or* as both at once, *or* as one or the other at different times, *or* differently by different officials. The medical fallacy muddles and conflates value with fact, wish with actuality, persuasion and coercion with medicine. This causes the whole of the edifice of mental health care and treatment to exist in a state of ad hoc and utterly inconsistent moral and medical confusion.

With general medicine, there are generally clear organic signs for any illness. In psychiatry this is precisely not the case, and since it lacks a coherent and evidenced theory of mental illness, the official response is always on the verge of uncomprehending panic. For instance, when he is viewed primarily as a 'genuine' patient - and therefore ill - psychiatric routines purport to correct the malfunctioning and malignant object (brain/nervous system/mental illness), despite any rational subjectivity that the individual might display. The person is thereby reduced to the status of an afflicted object within which and upon which medical processes operate. But when he is viewed by his psychiatric managers as essentially 'manipulative' or 'attention-seeking' - as a blameworthy fraudster who 'acts up' and is not genuinely ill, or not as ill as he pretends - they simply wish that he would do as they want, and they may unconsciously vent their frustrations on him. In that case, the patient is likely to find himself accused, threatened and under sanctions. To cap it all, the sanction very often consists of a higher dose of the same medication which is supposed to be a form of beneficial treatment. But of course: in the ideology of the medical model, a greater quantity of illness (mental deviance or contrariness) has surely to be combated with a greater quantity of treatment.

Through this shambles of theory and practice shines the light of one certainty to which those who believe in the medical model cling for dear life: it is under the authority of *Medicine* that society has established the lawful bureaucratic-industrial processing of troublesome mental deviance. This means that whether or not their actions are unscientific or unreasonable, the doctors nevertheless have the power to define whatever they do as correct, or at least 'the best that can be done'. In the 'rule-of-thumb' rituals of psychiatric care and treatment, at the point of diagnosis and for a certain time afterwards the standard processes ignore and eliminate the person as an active and responsible subject because the medical ideology (which has the first and last say in the matter) conceives of the patient's

irrationality as a medical condition which is relatively unaffected by circumstances: it is the sign of an illness which, like any other, 'has to run its course'. What is also certain in the medical model is that, if it conflicts with what the psychiatrist wishes, whatever the patient intends is deemed irrelevant - except perhaps as another symptom of his mythical illness. And if (or when) it happens that the patient does regain sufficient reason and composure, or conforms again to social expectations, it is then presumed that 'the illness has run its course' or that 'treatment has now brought it under control', that the patient 'has recovered' or his illness 'has gone into remission'. Ambiguously, recovery is conceived as both beyond the patient's control (because he suffers from an illness requiring medical treatment) and yet somehow within his control (because he could at least 'make an effort'). There are no known lines of cause and effect in this tangle of pseudo-medicine and moralising. If the patient 'gets better', well then, the treatment must have worked; if he does not, then he must suffer from a particularly virulent strain of the illness (or a particularly deficient set of genes), or he does not try hard enough to recover.

We have suggested that blind faith in the medical model is inspired by the dazzling glamour of a million-and-one unrelated scientific-technical achievements and accumulated facts and theories, combined with the widespread *wish* for psychiatry to be a medical science. For the attempt to apply what are supposed to be the categories and techniques of natural science to everything under the sun, including everything psychological and social, is the token of a fundamental collective anxiety and neurotic wish to control each and every untoward event by means of a single comprehensive concept: the objective-quantitative-causal-mechanical-predictable. To reduce someone's life to the status of an object which may be freely experimented on, however, is to treat him like any other disposable commodity.

This kind of reductionism is both infantile and inhumane. In reality, every individual is emergent from physical and chemical processes, and his life *as a person* takes on a radically different order of complexity: it is always reflective and open-ended, and it may only be understood biographically, as located within a particular history. To try to translate the models and methods of natural science to the human sciences is to create at best muddle-headed confusion and at worst life-threatening ideology. Orthodox psychiatry is a type of that neurotic and absurd wishful thinking.²⁶ By touting the myth of its medical-scientific credentials, psychiatry becomes an organ of social control which has little to do with restoring peace of mind and autonomy to those who succumb to psychological trauma.

Instead, as we have seen in the previous chapters, the psychiatric medical model is unhelpful and may prove fairly disastrous for anyone subjected to official care and treatment. Patients might benefit from the sympathy and social intercourse of those staff and other patients they meet who happen, by chance, to be decent, friendly and caring. If they are removed from the wider community or offered material help to improve their social circumstances, psychiatry might also offer distressed and confused individuals that degree of respite and assistance which can relieve some of the pressures of their normal daily lives. It is true that there is some official recognition that it is beneficial to engage patients in pursuits such as occupational therapy or art therapy, or to offer physiotherapy, etc. Along with the talking therapies, however, all non-medical responses are considered peripheral to the main psychiatric project: they are ancillary, only incidental to what is supposed to be the real business at hand - medical treatment.

If it were not so scandalous, it might seem ironic that the confused mental health perspective dictates a system of care and treatment which inevitably tends towards a parody of the everyday world from which the patient emerged and which, in the first place, he found oppressive to the point of incapacitating distress and mental disorder. Inside the psychiatric system, the patient finds a scarcity of respect, understanding, freedom, civil rights, goods, money, privacy and emotional support. Also, he most often finds himself subjected to a new form of oppression - lawful coercion and treatment. This is because, despite the medical pretence which gives them their authority, the routines of psychiatric practice are first of all the response of social power to a particular kind of

²⁶ Reductionist ideology is not exclusive to psychiatry - it is endemic to the established human sciences.

deviance. Psychiatry cannot avoid performing a moral and political function. It is therefore unsurprising that practice tends to mirror the forms of persuasion and domination traditionally used to coerce or rehabilitate naughty children. Official theory glosses the fact, but anyone who works in the field invariably invokes a moral code centred on faith in, and submission to, psychiatric authority (the parent-substitute). According to the medical model, the extent to which any patient at last begins to enjoy 'better mental health', or 'recovers from his illness', is indicated by his adherence to strict social rules and by expressions of his willingness to conform. Conversely, in response to the deviant's recalcitrance or resistance to persuasion, psychiatric therapy dispenses quantities of restraint and intrusive chemical or physical treatments.

None of this is conducive to genuine therapy. A psychiatric patient's resourcefulness is only rewarded by the system when it takes the form of instant submission to official direction. Independent pleasures, such as free thinking, free association, free play and sex, are not encouraged. Finding himself in this situation, and in order to protect himself from further invasions of his person, the patient is only encouraged to be deceitful. The moral climate of psychiatry tends to be that of suspicion on all sides, a situation in which it is difficult for any patient to feel or get better, but in which his most promising tactic is perhaps *to appear to conform* to official expectations.²⁷

When someone undergoes an emotional or mental crisis, there is no therapeutic agency that can simply 'help him get better'. His recovery cannot avoid taking the form of *a moral journey* and *recuperation* by the consensus. We argue that it is not unreasonable to characterise psychiatry as an organisation of self-styled experts of the psyche who operate *under the guise of science and medicine*; the psychiatrist appropriates the soul and translates it into categories which are not necessarily helpful to the person in the throes of an emotional or psychological crisis, but which certainly appear convenient to doctors and other interested parties - families, neighbours, the psychiatric team, social workers, etc. There is no evidence that minds are routinely mended or healed under this dispensation; rather, having tagged each patient with a stigmatising label, psychiatry too often terrorises him and subjects him to potentially harmful techniques of containment and persuasion.

The invention of schizophrenia

While moralising plays a large but unacknowledged part in psychiatric practice, the enterprise is conducted by physicians, it is rationalised as 'scientific medicine', and the standard procedures appear medical: they are organised by reference to an elaborate and ever-expanding taxonomy of so-called illnesses - mental illnesses - and an array of allegedly beneficial technical responses. This development in the management of madness turned on a handful of critical events, and one of the most significant was the contrivance of the diagnostic category 'schizophrenia'.

It should be clear by now that we are far from suggesting that there are not some people who suffer from overwhelming emotional distress, who are very confused and announce bizarre ideas, and whose irrational and sometimes potentially dangerous behaviour is a cause for concern and requires an organised response. Because the doctors say so, most of us imagine that there must indeed be an illness called schizophrenia which afflicts those unfortunate people who present with a certain kind of extreme mental disorder. As we have seen, if no other diagnosis seems more appropriate, someone is said to suffer from schizophrenia when his behaviour is considered particularly irrational, persistent and intractable: doctors look for withdrawal, deviant or absent volition, especially worrying behaviour, and bizarre ideation. But while the essence or meaning of schizophrenic behaviour must of course be sought in the activity of the individual concerned, we will see that it also inheres in the response to him on the part of society and its agency, psychiatry.

In point of historical fact, 'schizophrenia' is the diagnostic category upon which the legitimacy of modern psychiatry is founded: once it was generally agreed that the condition is certainly an illness, the way was opened for the clinical naming and medicalisation of the management of every other type of worrying irrationality.

27 See the studies by Goffman, op. cit. (n. 28, Ch 3) and Rosenhan, op. cit. (n. 41, Ch 5).

And yet, as we have seen, there is no evidence that schizophrenia is a disease which was always 'out there', simply waiting to be discovered by medical science at the beginning of the 20th century.²⁸ Schizophrenia is an *imaginary* disease, a figment of the psychiatric imagination. The records show that although they may have meant well, the most influential psychiatrists of the day were not so much committed to genuine science as to serving their own interests by filling an irritatingly conspicuous hole in their medical rationale: they demonstrate that this pivotal diagnostic category was a fabrication. In truth, 'the disease of schizophrenia' is a hopelessly compromised ideological artefact - a pseudo-medical conceit, cobbled together and advocated by insufficiently cautious psychiatric zealots whose medical, theoretical and professional ambitions outran and distorted their scientific judgement.

Ideology flourishes in a climate of anxiety and amnesia. Nowadays, 'schizophrenic' is a term bandied about by all and sundry as a folk-mythic tag to denote anyone who appears *extremely and probably dangerously mad*. Meanwhile, almost every psychiatric official seems to take it for granted that schizophrenia is a specific real illness which was discovered in the course of medical-scientific progress. But this is not the case. To understand the devising of this imaginary illness, we have to take into account not only the kind of behaviour that attracts the diagnosis but also the development of an ostensibly medical response to all that kind of behaviour which is thought to be based in a particularly malign disease. Psychiatrists may suffer from a collective amnesia of the origin of the idea - not much more than a hundred years ago - but documentation around the alleged discovery of the chronic and degenerative disease of schizophrenia is still available in the form of research papers, correspondence and the minutes of symposia. And the record of the evolution of this diagnostic category shows that it did not emerge out of any conclusive medical-scientific evidence - *there was and still is no evidence for such an illness* - but only by way of the political processes of psychiatric professionalisation.²⁹

Without some understanding of the historical background, it might seem strange that a faction dominant within psychiatry could sweep aside all scientific caution, assert the discovery of a new disease, and then proceed to achieve a purely political victory on the matter. It seems that various circumstances came together to create an intellectual climate conducive to this achievement.

General medicine had made spectacular advances during the second half of the 19th century. At last it could demonstrate definite physical causes and regularly apply effective, scientifically proven remedies. These advances in bio-medicine had a profound effect on the psychiatrists, heightening their desire to discover an organic cause for mental disorder. This hope suddenly appeared eminently realistic when one set of discoveries made a particular impact on the new profession: identification of the organic basis to syphilis, and then, a few years later, a cure. During the first decade of the 20th century, the recognition of a major category of madness, General Paralysis of the Insane (GPI),³⁰

28 See Chapter 12 and its Appendix.

29 The information and many of the arguments of this section are from Hill, D, op. cit. (n. 86, Ch 1), 65-147 (Parts 2 and 3: 'The invention of schizophrenia', and 'Kraepelin and Bleuler from a social control perspective'); from Barham, P (1984) *Schizophrenia and Human Value: Chronic schizophrenia, science and society*. Oxford: Blackwell, 13-46, which provides information about the debates prior to the psychiatric profession's collective decision, at the beginning of the 20th century, to embrace the concept of schizophrenia as certainly *a disease with an organic cause*; and from Boyle, M, op. cit. (n. 93, Ch 1), 15-41.

Barham emphasises the socially constructed, value-laden and motivated nature of every category of human behaviour. It is therefore odd that he still seems to be duped by psychiatry's medical ideology: he fails to follow through to its logical conclusion his well-documented case that the construction of the diagnostic category 'schizophrenia' was not by means of any scientific discoveries but purely by *political* negotiation. Notably, he fails to question the notion of *illness* as applied to psychological and behavioural events; and he also offers no substantial reasons for quite unnecessarily and confusingly (but like many other critics) '...tak[ing] for granted the evidence of a genetic contribution to schizophrenic conditions in a large proportion of instances...' (page 7). There is no such evidence; there is only a fantasy which, for a variety of reasons, many people wish to believe.

30 See Chapter 1, above, in the section: A brief history of psychiatry; and especially text to n. 95, Ch 1.

encouraged the expectation that further progress would soon be made in finding organic causes and remedies for other kinds of mental disorder.

With the discovery of the organic cause of GPI, when it seemed that their ambitions were at last starting to be realised, the enthusiasm of many psychiatrists blinded them to evidence regarding other mental disorders which did not conform to their wishes. Another factor conspired with this professional desire to identify 'real mental diseases' and find cures. Insanity was a major social issue at the time, and the psychiatrists were unduly influenced by what most of the administrative class wished to believe: that there would soon be a medical explanation and remedy for every kind of madness. Corresponding to certain social circumstances, this wish grew vigorously during the last half of the 19th century. For in the course of two or three generations - by about 1870 - the rising capitalist class had moved from political exclusion to partnership with the ruling aristocracy. But just as expectations concerning science and medicine were rapidly rising, the newly enfranchised property owners began to suffer increasingly from two particular anxieties: the radical push from below by a growing and ever more organised working class, and an increase in commercial competition from other countries, both of which threatened a decline in their power and prosperity. In the face of these perils, the reformist optimism of the bourgeoisie which had been characteristic during the late-18th and early-19th centuries began to falter, and towards the end of the 19th century it had generally been replaced by pessimism and a reactionary attitude. This had an effect on psychiatric thinking: the question which pressed urgently for an answer was whether the social relations (in which the propertied, managerial and professional strata now had a full stake) or the afflicted individuals were responsible for the increased burden of madness.

By 1910 this question had largely been settled in the only way that power could allow: not by scientific proof - since there was and still is no evidence to support the disease hypothesis of any functional mental disorder (so-said mental illness) - but according to the wishes of the ruling consensus. In chorus, the most influential psychiatric authorities of the time ordained that schizophrenia *must be* a disease which somehow gestates within, or is contracted by, some unfortunate individuals. This was decided simply by the weight of what the most senior members of the profession asserted in lectures, symposia and letters to each other and to journals. There was some opposition within the profession, from those who would have liked to have seen the research evidence, but it soon evaporated. This political success - *this bluff* - was decisive in establishing the undoubted authority of the psychiatrists as medical experts who, just like any other kind of doctor, are able to discern diseases and manage, remedy or cure those disorders which happened to be located 'in the mind'. It also meant that considerations of psychological or social-psychological dynamics tended thereafter to be ignored or discounted as 'speculative' and 'unscientific'. Not least, by definitively endorsing with 'medical science' the isolation and nullification of anyone taken and treated by psychiatry, this deceit settled every moral or political question about the leading part the profession should play in administering troubling emotional and mental deviance.

The rise of psychiatry has to be viewed in this class-historical context. The profession was only able to establish itself securely on the basis of an ideology which appealed to most people because it *appeared* indubitably medical. In response to rapid industrialisation and urbanisation, and what seemed to be the appalling rising tide of the poor, the unemployed, the dangerous and the diseased, optimism amongst the ruling elements during the early-Victorian years had by the end of the century largely disappeared, replaced by an attitude of 'pragmatic enlightened pessimism'. This posture was rationalised by Social Darwinism and the rise of the racist pseudo-science, Eugenics: 'The struggle of the survival of the fittest' seemed to endorse the emergence of those ideas as significant elements in a supposedly rational ideology which deprecated the poor and the unfortunate, and vindicated the rich and successful. Influential people now tended to agree that the operations of the free market were naturally for the best, and that no general good could possibly result from artificially sustaining anyone who was congenitally unable to survive. Eugenics would provide the scientific basis for the containment - or better still a cull - of the degenerate and unfit. The highest authorities in general medicine simply expressed the prevailing ideology of the time when they routinely announced that

the ‘constitutional weaknesses’ of unfit individuals caused depletions of vitality and ‘failures of self-regulation’.

At the time, only a radical minority within polite society suggested that economic conditions and an inadequate political response (e.g., deficiencies in diet and sanitation) were the main causes of ill-health and contagion, and of misery and psychological distress amongst the poor. Throughout the 19th century, working people had been ever more subjected to the vagaries of the market and its periodic depressions; they were pushed out of the countryside and had to compete for work in factories in towns, and there was an erosion of both traditional paternalist obligations towards them and their rights of access to sources of sustenance other than wages. In the early-19th century, the only remedy for the ever increasing numbers who experienced poverty and distress had been the collapsing organisation of the medieval Poor Laws; these were designed to occasionally sustain a relatively static and evenly-spread rural population, not to cater permanently for expanding, mobile and ever-concentrating masses of the poverty-stricken. And during the last half of the century, funding and state provision had been unable to keep up with the rapid and massive changes in economic organisation and the redistribution of an ever-growing population.

Meanwhile, the County Asylums Act of 1808 had enabled local authorities to set up institutions to look after ‘pauper lunatics and idiots’. Under state patronage, psychiatry could begin to take on the respectability of a profession. With the Poor Law Amendment Act of 1834, the deserving poor were rigorously separated from the undeserving or ‘able-bodied’, so that the latter should not so much benefit as be disciplined and trained to be useful. In 1845, with the Lunacy Act and the County Asylums Act, provision for the pauper mad was mandated nationally, and began to grow. Those in the asylums who could be rehabilitated and made useful by ‘moral management’ were differentiated from the remainder who, in the eyes of rational administrators and utilitarian philosophy, could only be seen as hopelessly useless. Consequently, the institutions became overcrowded with those irrational individuals who had proved themselves an intolerable nuisance and who also chronically failed to adjust to the demands of clock- and machine-regulated work, i.e., those who had buckled more completely under the stresses of exploitation.

Due to the escalating costs of administering the Poor Law, after about 1870 ‘abuse’ of out-relief came under attack from the tax-paying classes, and means-testing was tightened-up. ‘Pauper lunatics’ offensive to bourgeois sensibilities - who touched on fears of contagion, disorder and riot - were perceived as direct evidence of a dangerous and constitutionally degenerate underclass. ‘Lunatics’ were now separated out from other claimants who, by working, could still prove their full humanity, which is to say, their labour value. Due to their supposedly intrinsic degeneracy and tendency to corrupt others, lunatics were now consigned indefinitely to asylums: according to the prevailing geneticist ideology, Social Darwinism, a lunatic was not expected ever to get better. In the twenty-five years up to 1870 the number of pauper lunatics in the county asylums of England and Wales increased threefold, but the proportion of inmates reckoned curable fell from perhaps 40% to less than 8%. These trends continued until the First World War.³¹ Of course, the powerful and the privileged were not about to question a social order which provided their own comforts, and it was generally agreed that this ‘silting-up’ of the asylums was due to an over-generous and probably misguided altruism towards individuals who were inherently and intractably degenerate.

These developments meant that whereas before 1850 most of those incarcerated in the asylums and private mad-houses were outrageously or dangerously mad, and kept there only as long as they displayed florid signs of madness, the tendency after that was to detain indefinitely as chronically insane and useless anyone who had undergone some sort of very worrying irrational episode and who still failed to measure up to the demands of the wage-economy: an inmate might have become tranquil, but due to technical advances in industry and agriculture there was no longer any possible employment for him. Doctors also began to discriminate mental handicap (idiocy) from mental

31 Boyle, M, *op. cit.* (n. 93, Ch 1), Chapter 2. The psychiatric profession became established during this period, the newest institutions were often called mental (or psychiatric) hospitals, and inmates were known as patients and treated medically.

disorder (lunacy), and the sub-categories of madness were contrived as an attempt to begin to explain the apparently chronic nature of much mental disorder. The insane were by then viewed as a special type of the useless or unemployable, i.e., the kind that is fully employed in disturbing, dangerously subversive and possibly contagious cerebration; moreover, since Darwin, it was imagined that these people were *constitutionally* degenerate. In all essentials, this impetus to define the types of madness as various modes and degrees of failure to measure up to the ideal of industrial-capitalist usefulness - the ideal of the fully adaptable unit of labour - remains as powerful as ever: if it seems that someone finds it impossible to adjust reasonably to his circumstances, it is not the environment (the social relations and conditions) that is subjected to scrutiny and criticism but only the moral-cum-constitutional fibre of the heretic-deviant.

In the 19th century, as today, doctors were not normally interested in any suggestion of a social cause; they simply treated the body in isolation. And to account for any mental disorder, the over-riding psychiatric consensus conflated an assumption and a pseudo-empirical discovery: irrationality results from the individual's defective and degenerative brain or nervous system; nobody (yet) knows how to remedy this disease (or these diseases), and extreme cases will almost inevitably develop into chronic and terminal dementia, i.e., the progressive, chaotic loss of mind, and ultimately its extinction. Conceived as a sort of mental anti-state of random cerebration, no doctor could imagine that it might be possible to recognise in dementia any kind of intelligible response to the problems of a life. In 1852, BA Morel was the first to discern a mental condition of severe intellectual deterioration which emerges in adolescence, and which, reasonably enough, he called *démence précoce*. This diagnostic category was only descriptive, and at the time it was not the focus of a debate within psychiatry about the nature of the aetiology of psychopathology - that is, its cause. By 1893, however, the notion of a constitutional disease basis to every more extreme kind of mental and behavioural abnormality was popular, and Kraepelin had gathered together *démence précoce* with the syndromes hebephrenia, catatonia and *dementia paranoides*; he called them 'the psychological degeneration processes'. In 1899 he proposed that this group comprised a single disease: *dementia praecox*. Within a few years this conception was refined by E Bleuler who came up with the term 'schizophrenia' (split-mind). The diagnosis applies to that category of individuals whose personal crisis appears to manifest as a naturally occurring, chronic and deteriorating mental disease of intellectual incomprehensibility and social uselessness.

It is not possible to understand developments in the terms and relations of any science - and especially any putative science of persons - apart from the wider historical context and the social, emotional and cognitive interests of the scientists themselves. Far from being purely the scientific discovery of an illness 'out there' and independent of any observer, schizophrenia was never more than *the improvisation of a pseudo-disease*, according to whim rather than science. The new, purportedly medical-scientific diagnostic category served to account for psychiatry's institutionalised hopelessness at a time when there seemed to be an ever-growing number of patients with a chronic mental disorder. By false pretences, this ersatz discovery also decisively satisfied two urges shared by the profession and by every 'responsible' citizen: definitively to make psychiatrists the arbiters, managers and therapists of all forms of madness and, by way of the doctors' pseudo-science, to rationalise a generalised contempt for anyone who succumbs to a mental disorder.

At the beginning of the 20th century there were still some psychiatrists who argued that the organisation of the asylums or mental hospitals themselves tended to encourage the production of the very behaviours they were supposed to remedy. These officials continued to advocate moral management for the insane in places of refuge deliberately organised to prevent the inmates from becoming institutionalised. In their view, the chronic mental patient was essentially a product of history - of social circumstances - and not the result of a disease which other doctors might *assume* existed but which had not yet been demonstrated. In the debates of the day, those who held this view nonetheless wilted before the determination of a greater number of more influential psychiatrists who refused to question what *they* considered entirely reasonable institutional arrangements. By pressing for a biological-determinist, apparently medical-scientific ideology, a majority in the profession also wished once and for all to end the grievous moral and political ambiguities of psychiatric function

and authority. This majority was jealous of the prestige of general medicine, and wished to be known as unquestionably expert and authoritative, just like every other kind of doctor.

The categories *dementia praecox* and schizophrenia were developed as typifications of those forms of individual irrationality which psychiatric theorists explicitly opposed to the ideal 'useful worker'. As well as a nuisance or a danger to society, extreme irrationality poses the greatest challenge to psychiatry. A psychiatrist prides himself on managing madness by employing the strictly rational and scientific-objective method of *really* getting to the truth of anything and everything to do with the condition of the individual, i.e., modern medicine: if he is to be credible he has to persuade us that he is capable of comprehending the *very* mad; and in radical dispute with rationality, psychotic speech and behaviour amounts to the most direct provocation to any paragon of reason and decorum - such as a doctor. Because of this, the psychotic was always the psychiatrist's greatest enemy; and since it is the case that authentic medical science *cannot* explain most madness, psychiatry was and still is obliged to resort to ideology.

Meanwhile, in the climate of pessimism during the quarter of a century before World War One, there was great professional interest in the idea of the inevitability of chronic mental deterioration. By 1910 it was generally agreed that very few of those characterised as suffering from *dementia praecox* (schizophrenia) would ever again become the 'useful social units' that they supposedly were before the onset of the mental disorder. On the grounds that it was only a hypothesis which was yet to be proved, a few psychiatrists still refused to accept the disease model. Yet those in the majority, who wished psychiatry to be purely medical, *simply refused to recognise research observations* if they showed significant recovery rates for 'premature dementia'. Until quite recently, studies which cast doubts on the notion of *dementia praecox*/schizophrenia as a chronic and inevitably deteriorating illness were regularly dismissed out of hand by the most influential psychiatric authorities, who simply alleged that any findings inconvenient to their own beliefs were mistaken - that the researcher must have witnessed only a temporary remission or perhaps another, less malignant kind of mental illness altogether.

This victory of the medical model, in the early years of the 20th century, was a confidence trick. *By the magic of undisputed medical authority*, the contrivance and naming of a type of irrational behaviour was conflated with an alleged explanation. In the light of the opinions of pessimistic but influential psychiatric authorities, and by ignoring any findings to the contrary, the professional consensus asserted a constitutional tendency to inevitable schizophrenic deterioration. Originally the diagnosis 'premature dementia' or 'precocious madness' was purely descriptive; no etiological claims were made for the category, nor was there talk of inevitable degeneration. However, this scepticism was rejected, not for good scientific reasons but for covert professional interests: as the pseudo-explanatory formulation of an undoubted disease, the diagnosis *dementia praecox*/schizophrenia sounded agreeably scientific and medical.

The popularity of the medical model stems from the combination of a universal anxiety and the overweening professional ambitions of the psychiatrists. Individuals who suffer from *dementia praecox*/schizophrenia embody much that is especially other and alien to respectable citizens. Anyone who exhibited the signs of this allegedly constitutional, degenerative and irremediable disease, as announced by Kraepelin, served as a type of folk devil at the time. Kraepelin describes this kind of mental and behavioural deviant as depleted in vitality, morbidly apathetic and stubbornly idle - and yet, at the same time, unpredictable, truculent and energetically subversive.³² But his 'discovery' was not at all an outcome of the application of the methods of natural science; it was a codification and self-fulfilling prophecy built upon psychiatric anxieties, wishful thinking and self-deception.

32 Hill, D, op. cit. (n. 86, Ch 1), Barham, P, op. cit. (n. 29), and Boyle, M, op. cit. (n. 93, Ch 1) all quote substantially from the writings of Emil Kraepelin and Emile Bleuler. Their quotations show that the so-said symptoms of *dementia praecox*/schizophrenia are not consistent; for instance, the symptoms might be either mania or catatonia. Of course, what else but contrariness is to be expected of the very mad?

Today, 'the schizophrenic' remains a popular bogeyman, even though he is seldom a danger to anyone but himself. It has long been evident that the initially dire prognosis for this purported disease was never justified. Recovery rates in those psychiatric hospitals where pessimism was built into the institutional arrangements certainly did confirm the pundits' warnings: followers of Kraepelin estimated recovery rates of only about 10%.³³ Even so, and despite precious little encouragement from the regimes of most institutions during most of the 20th century, the hypothesis of the inevitability of chronic and degenerative schizophrenia has *never* matched the biographies of most of those individuals assigned the diagnosis. A long-term follow-up study of a considerable number of Swiss patients diagnosed with schizophrenia in the early 1900s found that their clinical courses were far more varied than the orthodox notion of an almost uniformly poor prognosis.³⁴ Nearly half achieved a favourable outcome, and only 22% definitely had a severe outcome, including only 6% who suffered from 'catastrophic schizophrenia': acute onset and chronic severe psychosis. It is true that, over the decades, about one-quarter of the sample had spent at least half of their life in a mental hospital; yet nearly 50% had spent less than one year, and more than half were *still working* towards the end of their lives (at a mean age of 74 years).³⁵ In a five-year study, M Bleuler found that about 25% of those diagnosed with schizophrenia made a full recovery, more than 50% had intermittent recoveries, and only 10% remained severely psychotic and permanently hospitalised. He also recognised that there is little evidence for progressive and terminal deterioration, but much for mental and social adaptations which, admittedly, are often fairly eccentric. Moreover, after many years there were sometimes amazing sudden recoveries, and these appeared to correlate most often with major changes to the patient's family.³⁶ Unfortunately, none of this evidence seems to prevent doctors from almost invariably still advising the families of diagnosed schizophrenics that the patient will probably have to be medicated and under psychiatric management for the rest of his life.

In this hypothesis of a disease called schizophrenia, *the naming of a condition magically becomes its explanation*. The welcome almost every doctor extends to this idea is based in superstition, myth and ideology. The magic works because it allays everybody's anxiety by persuading them of the scientific and medical prowess of the psychiatric profession - everybody, that is, except perhaps the person in crisis, who finds himself assigned a permanently stigmatising label and indefinitely subjected to treatments which are often debilitating, disorientating, painful and harmful. How can the invention of an imaginary illness - schizophrenia, or any of the other so-said mental illnesses - do anything to enhance someone's emotional and mental wellbeing? On the contrary, it leads to endless confusions and feelings of helplessness.

Just the same, it is now a hundred years since the psychiatric profession chose to ignore evidence and reasonable psychological arguments about pathogenesis, recovery and remedy, and instead to presume and dogmatically insist on the actuality of a curiously elusive organic (brain) disease as the cause of *every kind* of serious functional mental disorder. The invention of the mythical disease of schizophrenia conveniently settled a century-long question of morality and politics. By maintaining that certain kinds of very troubled and troublesome individuals 'have a serious mental illness' which 'obviously' must be subjected to medical authority, psychiatry abstracts them from their historical contexts and takes away their full humanity; simultaneously, it absolves every other actor or social arrangement from any responsibility for the crisis in hand.

The elaboration of the category of the alleged disease of schizophrenia was not a wonderful scientific discovery. It was a fabrication born of the overriding anxieties and ambitions of a group of

33 See the comments on long-term studies made by Karon, BP, in Modrow, J, op. cit. (n. 35, Ch 2), xi.

34 See Barham, P, op. cit. (n. 29), 37-38.

35 Ciompi, L (1980) The natural history of schizophrenia in the long-term. *British Journal of Psychiatry* 13 413-420.

36 Bleuler, M (1978) *The Schizophrenic Disorders: Long-term patient and family studies*. New Haven: Yale University Press; also Bleuler, M (1978) The long-term course of schizophrenic psychoses. In Wynne, LC, et al *The Nature of Schizophrenia*. Hoboken, NJ: Wiley. M Bleuler was the son of the more pessimistic E Bleuler, who had devised the category 'schizophrenia'.

specialist physicians, and was then readily endorsed by everyone who was happy to defer to the psychiatrists' self-proclaimed expertise. The psychiatrists had wished very much to advance their interests by asserting their medical credentials, and the invention of schizophrenia (and then all the other mental illnesses) also conveniently answered society's demand for a way to deal with a pressing social nuisance while salving its own conscience. The political victory of reactionary psychiatrists over their more humane and optimistic colleagues confirmed by the great authority of Medicine the prejudice that the insane are constitutionally and irremediably deficient. Not least, this was a victory for the ruling class: then as now, most psychiatric patients emerged from the ranks of the poor, while most of the rest (from higher income groups) were relatively powerless dependents - women and the young.

The concept of schizophrenic illness (developed out of *dementia praecox*) was originally constructed not primarily so as to better define and treat a certain distressed population but rather to serve the entrenched but unacknowledged emotional, cognitive and economic interests of doctors and other social powers. The idea of this disease is still resolutely upheld for the same purposes. As a diagnostic category, schizophrenia was never a legitimate empirical or heuristic term in any genuine science. As the purported explanation of extreme irrationality, however, it immediately became a crucial term in a professional ideology which *imagines* and *proclaims itself* a medical science. The invention of schizophrenia was a defining moment in the establishment of the psychiatric enterprise as *indubitably scientific*; and since schizophrenia was immediately accepted by most doctors as an actual disease, thereafter it was easy enough to invent any other type of mental illness.

Psychiatric practice is not based in sound medical science, and the whole mental health project depends on motivated rationalisations. The candidate for mental health treatment is assigned to this or that category in a pseudo-medical ritual of diagnosis which magically *never fails* to identify a so-said illness (a mental illness) with a better or worse prognosis, for which there is always an appropriate medical treatment (even if the doctor cannot immediately find it); at the same time, the individual's *biography* and *the circumstances* of the crisis are ignored. This is in accordance with a tautology that is seldom questioned: *If someone needs to see a psychiatrist, then he must have a mental illness*. Faced with this self-fulfilling prophecy, there is nothing a very upset and confused person can say or do to persuade anybody that he does *not* have a mental illness. His best tactic is to submit to all that is demanded of him and act, as best he can, like a patient who is getting better.

The key terms in any ideology are always diffuse and ill-defined. No matter: since it is false reasoning, an ideology is bound to give rise to unresolved internal contradictions, and a poorly defined concept is more easily stretched so as to cover every inconvenient argument or piece of evidence. For example, in Chapter 4 above, we saw how patients are diagnosed as (accused of) 'having the mental illness called schizophrenia' *nearly as often when there are no symptoms as when there are*.³⁷

The professional urge to appear to be medical, rather than really be medical, skews and muddles all psychiatric thinking and practice. False beliefs in other areas of life often remain largely in the background: they are based in traditions and only called on occasionally, when unusual situations arise. The psychiatric medical model, on the other hand, makes explicit and expands a general fantasy concerning the nature of personality. This ideology is a particularly rococo form of fake science, and it is driven to become ever more involuted since it has to serve daily at the sharp-end of interpersonal conflicts and personal crises. Under constant public scrutiny, doctors must be able to offer a plausible explanation for anyone's emotional distress or irrationality; by always having an impressive-sounding 'technical' name for the particular failing 'in' the deviant individual (i.e., in his mental health), and by taking full responsibility for 'managing the illness', by means of the authoritative medical ideology they are also able to deflect attention from any possible criticism of social power.

As we mentioned, none of this is to suggest that numbers of unfortunate people do not develop broadly similar kinds of very distressing, psychotic and sometimes relatively long-lasting moods, attitudes, beliefs and behaviours which, for purposes of care and therapy, it might be useful to call

37 See Summers, A & Kehoe, RF, op. cit. (n. 13, Ch 4), and the text to that footnote.

‘schizophrenic’. It is merely to point out that *there is no evidence that schizophrenia is a disease, or that medication is a remedy*. The medical model does not provide an evidenced explanation for the condition; it only composes a rationalising excuse for refusing to consider possible social or psychodynamic causes. We should also note that the objections to the invented disease of schizophrenia apply equally to all the other so-called mental illnesses.³⁸

Alienated theory

Throughout this Volume we have seen that psychiatric practice is rationalised by an ideology which implies that medical science knows the nature and cause of worrying individual irrationality and can provide the necessary response. In the previous chapter we argued that since there is no evidence to support the idea that so-called mental illness really is illness, blind faith in psychiatric medicine can only be an irrational reflex to the fear of madness. And in this chapter we have examined the development of medical (or biological) psychiatry, and suggested that the trajectory taken by the profession was swayed by historical conditions particularly conducive to the perversion of authentic medical science. But while we are able to demonstrate that what most people believe about the nature of functional mental disorder and its remedy is confused, unproven, unhelpful to most patients and often harmful, it would be foolish to assume that the sane majority are wilfully punitive or hard-hearted. It seems to us that more is at play than simply a fear of madness: rather, *psychiatry is both product and reproduction of a generalised social alienation*. Within this wider context, psychiatric beliefs and organisation constitute a closed circle in which a shared neurosis and the normal social arrangements express, satisfy and sustain each other.

Alienation has its political, economic, social, cultural and personal aspects which we may recognise in a review of some characteristics of the general culture. During modern times, in the popular imagination, the natural sciences have become the arbiters of Truth. By now almost everybody more or less fully endorses this cultural imperialism, and is persuaded that only quantitative and predictive science can properly explain any problems that might arise.³⁹ In Chapter 13, however, we demonstrated that with regard to human relations this belief is not based in fact or logic: it is not the outcome of genuine science but only an ideological distortion which imagines and calls itself scientific - a kind of false consciousness which may be characterised as ‘scientism’ or ‘positivism’. We noted that, of course, it is always the ruling consensus which defines the contours and boundaries of Reality, i.e., the whole of rational experience. It is therefore safe to say that for urban-industrial culture, during the last two or three centuries - and earlier rather than later - the scientific worldview came to define Truth: it became the reigning Reality Principle and the arbiter of rationality and sanity. And to conform to what everybody believes, the principle and efficiency of every kind of social organisation must nowadays appear to be founded in Science, or at least precise quantitative accounting. On the basis of Science and its product - ever-developing technologies and an increasingly artificial environment - a technocracy was elevated to staff a growing service sector of experts.

In recent times, then, progress has been measured by the degree to which our environment has become artificial and ‘efficient’, either by eliminating the imperatives of nature - including human nature - or by their predictive anticipation and control. This is primarily an achievement of science. Each example of spectacular technical competence - motor vehicles, jet planes, space-flight, personal computers, smart bombs, medical advances, or simply the general affluence - serves to glorify the social order and pre-empt criticism. In the meantime, the power to adjudicate almost any personal or inter-personal problem was steadily appropriated by professionals who are likely to maintain that the uneducated response of the public cannot be trusted, and that only their own highly-trained expertise has any validity. At the same time, a heady mixture of pseudo-science and technospeak has been

38 Of course, any critique ought to be constructive and offer a better account of the genesis of serious emotional distress and mental disorder; a critic should also offer a better kind of remedy. We hope to provide both in Volume 2.

39 In practice, few religious believers deny many scientific findings or refuse to use the resulting technologies.

cultivated as an ideology of social and personal utility; this is the modern mumbo-jumbo and technics of social domination. As a result, it now seems as if no strategy or tactic of countervailing expertise could ever hope to mount a convincing challenge to the all-embracing scientific-bureaucratic-industrial rationality - a perspective which is inherently technocratic-managerial (i.e., anti-democratic) and which bemuses and bedazzles anyone who ever has a problem and wishes for the easiest solution.

All the same, it is not true that we do not *really* experience and know anything unless it is ratified by an expert. This was always recognised by some critics. As long as Science and Technology has dominated awareness, there was also the Romantic critique of that consensus which subscribed to the scientific-utilitarian Reality Principle upon which every positivist notion is erected.

Romanticism is the struggle to save the reality of experience from evaporating into theoretical abstraction or disintegrating into the chaos of bare, empirical fact.⁴⁰

Around two hundred years ago the Romantic Movement provided a critical counterpoint to that reductionism which puts all its faith in Science. While simply being alive is likely to open any of us to feelings of alienation - for example, intuitions of inevitable separation and death-in-life - the Romantics insisted that there is also a contemporary alienation which is the unavoidable psychic cost of applying the single vision of Science to the whole of reality. Under the dominion of materialism (greed, capitalism), science and technical power can only develop as a kind of single-minded psychosis in opposition to the sensory-emotional or visionary imagination. The natural sciences are underwritten by objectivity, which is the deliberate purge of personal experience from the production of knowledge. The spectacular success of technologies based in physics and chemistry dazzles us into believing that the only valid kind of knowledge - that is, the knowledge of *anything* - is that objective information delivered by quantitative-causal science. Positivism follows in the wake of authentic science: it is the attempt to employ the objective method to inappropriate circumstances, i.e., to almost anything personally or socially significant. In this project, positivism is a subset of the idolatry of modern culture, in the sense that the prevailing belief is that the only true knowledge of anything human must also be a quantitative, 'single-vision' knowledge of 'mere objects' - a reductive knowledge of objective facts which offers the possibility of prediction and control. In reality, of course, since few of us really understand science it is not knowledge so much as a hazy feeling about what is scientifically determinable that now defines the difference between what appears to lie inside the boundary of the 'really real' and what lies outside - what is only imagined, subjective and 'not real', and therefore deluded and irrelevant.

Doubtless it is the human condition to live with that self-questioning second reflection which recognises dualities within the self - the soul versus the body, reason versus passion, ego versus id. It is seduction by the glamour of Science, however, which invites us to elevate this psychic rift into a ruling theory of knowledge. Whatever is spontaneous, warm and personal is distrusted; only that which is once-removed, cold and other is supposed to be *really* real. This 'objective consciousness' is an act of alienation: it breaks the faith between the person and his own sensory experience, and between the person and his environment. And once this separation is achieved, the only person who is generally accepted as knowledgeable, rational, reasonable, pragmatic or mature is the 'detached' and 'unsentimental' observer who has no particular respect for any person or thing: 'the realist'. A scientist values his ability to depersonalise his conduct, and since he tends to conceive of everything as fundamentally reducible to objects - inert, alien, and purely functional - in the name of objective knowledge and for the sake of predictive control he may feel he is enjoined to manipulate anything or anyone *by any available means*. The flipside to this cultural choice, however, is the psychic price we pay for technological mastery and our apparent enlightenment by way of science: '...the experience of being a cosmic absurdity, a creature obtruded into the universe without purpose, continuity or kinship.'⁴¹

40 Roszak, T (1972) *Where the Wasteland Ends: Politics and transcendence in post-industrial society*. London: Faber & Faber, 278.

41 Roszak, T, op. cit. (n. 40), 162-163, 168-170.

A machine serves a function; it is other and non-communicative. The machine analogy may be seductive when we wish to manipulate things - since it promises predictive control - but it is not appropriate for comprehending anything specifically human. Rather, in the interests of domination and exploitation, this metaphor serves only to mystify what actually goes on. Where there is blind faith in 'single vision' Science we find explanations which, in the name of objectivity and predictive control, reduce everything to 'nothing but'. In psychiatry and psychology, for example: nothing but molecular movements, nothing but hormones, nothing but neurochemistry, nothing but genes, nothing but stimulus and response, nothing but sexuality... When science or the human sciences find nothing but objectified nature, it is because that is what they look for - a universe in which the only meaning is predictable regularity, and in which everything else is 'contamination', 'experimental error', 'side effect', 'epiphenomenal' or 'subjective'. Reductionist thinking may be based in a variety of motives. Originally, it was the wish to deflate pre-scientific obscurantism, but now perhaps it is driven more by fear of difference and the desire to dominate: the wish for a quick and easy fix.

Reductionism is based in estrangement from nature, including human nature; it is the belief that, so as to determine the truth, anything we wish to understand must be reduced to its physical or chemical components and relations. Scientific objectivity views the world only in terms of quantity. It rejects any considerations of value, harmony, meaning or purpose: these entities are said to be 'purely subjective' or 'metaphysical'. It discounts as irrelevant the world actually inhabited by persons - the world of quality, perception, sensibility and the imagination. It certainly cannot tolerate the exuberant life of feelings and the emotions. Reductive pseudo-science is a style of mind which would have us 'see in the pearl nothing but the disease of the oyster'.⁴² The prevailing scientific ideology is reductionist, and it brings a high psychic and environmental cost: natural history is the projection at large of man's own emotional history, and when emptied of emotional life the entire phenomenal world is reduced to a desert which only has value in its casual exploitation.

Alienated social practice

To summarise: nowadays, everyone tends to put their faith in Objective Science as the arbiter of every truth, and this contraction of the collective imagination encourages psychiatrists to pursue misguided science and pseudo-medical remedies. Attempts to apply the method of objective-quantitative science to personal and social processes, where it is generally inappropriate, commit basic logical and category mistakes identified long ago as leading to sham science, i.e., positivism. The psychiatrists may proclaim their 'eclecticism' - meaning that, if it seems to work, they will employ any therapy based in any perspective - but in fact the medical model reigns supreme, and the discipline arrived at its present position by being an ideology which *gives the impression* of science; rather than genuine medical science, psychiatric theory, research and practice is nearly always a form of reductive *scientism*.

Obviously, the way in which functional mental disorder is managed will depend on how it is conceived, and the system of care and therapy is nowadays organised by reference to the belief that every mental health patient is ill - that he has a mental illness which, like any illness, is likely to run an expected course and hopefully respond to the appropriate medical treatment. In preceding chapters we have seen how this unfounded, ideological approach to the nature of mental disorder translates into shockingly flawed standard practices. As a consequence of the coercive powers of psychiatry, it might be unsurprising that throughout this book there have been many indications that, in its main effects, and apart from providing minimal assistance to some individuals in crisis, the current organisation seems rather to inspire stigmatisation, degradation, iatrogenic and psychological harm, and even overt abuse.⁴³

Is there something in everyday experience which prepares everybody to take it for granted that official mental health practice *must* take the specific form that it does? In Chapter 10 we discussed

42 Kathleen Raine, quoted by Roszak, T, op. cit. (n. 40), 264. For a critique of reductionism, see Roszak, T, op. cit. (n. 40), 247-271.

43 See especially Chapters 4, 6, 9 and 10, above.

two social-psychological experiments which seem to illustrate the way in which blind obedience and spurious medical science might combine to establish management routines and standard treatments which, for the patients, are pernicious rather than helpful. Milgram's compliance experiment found that when they imagined they were conducting bona fide training, and were assured by an apparent expert that he took full responsibility, two-thirds of a random sample of otherwise psychologically normal subjects would go so far as to physically harm a 'trainee' (victim) by administering ever more powerful electric shocks - or so far as they could tell, perhaps even kill him. Within a few years, that degree of compliance to authority and negligence towards vulnerable persons - or outright abuse of them - was confirmed by Zimbardo's experiment, in which psychologically normal subjects were randomly selected to play the roles of guards or prisoners in an apparently real setting. Within a day or so, a high proportion of the guards were behaving sadistically towards the prisoners, and just as quickly *all* of the prisoners became passive and depressed - several to a very worrying degree.⁴⁴ At about the same time, Rosenhan's experiment demonstrated the arbitrary nature of psychiatric diagnosis: that there are no objective criteria for establishing the presence or absence of a so-said mental illness, that diagnosis depends on doctors' expectations when they employ the bogus medical model, and that as soon as someone is given a psychiatric diagnosis he is caught in a bind whereby *anything* he might say or do is likely to be interpreted as only one more sign of his alleged mental illness.⁴⁵

What was suggested in Chapter 10 bears repeating. Even when it seems clear that the way someone is treated is harmful, and even in matters of life and death, the need to believe an authority *very often* outweighs the urge to be compassionate. In addition, when individuals are authorised to wield power over a vulnerable population this tends to incite abuse, *whatever the prior dispositions of those exercising that power*.

This is exactly the situation with psychiatry. Doctors are the arbiters of care and treatment, everyone believes that they are fully competent, and consequently nurses carry out a consultant's orders irrespective of any visible ill-effects in the patients, or of their complaints. No matter how pleasant and well-intentioned they may have been when they began their careers, a combination of blind faith in the medical model and concentration of power and responsibility into the hands of the doctors encourages *every* psychiatric official to be irresponsible, callous and punitive. As the experiments by Milgram and Zimbardo indicate, this does not mean that recruits to psychiatric work are especially heartless. It is simply that psychiatric patients are particularly vulnerable, and that, in a hierarchical organisation, staff who have been worked on ideologically (e.g., to believe in the medical model) cannot recognise the harm they do; or if they begin to have doubts, they dare not make their own decisions or question a bad decision passed down from above; or, worst of all, they may become habituated to the power they wield, to the point of enjoying and abusing it.

Apart from our criticism of the various specific elements of psychiatry, and the conclusions drawn from the social psychological experiments we have just mentioned, is there anything else in the general social experience which might also predispose mental health workers to take it for granted that official practice *must* take the form that it does?

Recall the quotation at the top of this chapter: whatever we imagine about any particular aspect of personal or social life is conditioned by our routine, daily experience of the most fundamental of our social relations, which is to say, of the political-economy. Milgram comments on his compliance experiment:

Very often it is not so much the kind of person a man is as the kind of situation in which he finds himself that determines how he will act... When an individual merges...into an organizational structure, a new creature replaces autonomous man, unhindered by the limitations of individual morality, freed of human inhibition, mindful only of the sanctions of authority... With numbing regularity good people were seen to knuckle under the demands of authority and perform actions that were callous and severe. Men who are in

44 See text to footnotes 15 and 16 in Chapter 10, above.

45 See text to footnote 41 in Chapter 5, above.

everyday life responsible and decent were seduced by the trappings of authority, by the control of their perceptions, and by the uncritical acceptance of the experimenter's definition of the situation, into performing harsh acts... A substantial proportion of people do what they are told to do, irrespective of the content of the act and without limitations of conscience, so long as they perceive that the command comes from a legitimate authority..⁴⁶

Bearing in mind Milgram's findings, at this point it might illuminate matters by situating our analysis of the standard mental health response within the context of the wider political-economy. In this age of democracy (or, at least, democratic aspirations), general practitioners and the mental health services are supposed to do what they can to help anyone suffering from a mental disorder. According to the community of the sane, moreover, psychiatric care and treatment is self-evidentially necessary and beneficial. However, polls of psychiatric patients or ex-patients regularly report a clear majority who are unhappy with the services provided and find no benefit from them. What's more, in previous chapters we offered much evidence that the routine mental health response is indeed oppressive to patients and does not usually help them recover their mental and emotional equilibrium; neither is it more successful at managing distress and mental disorder than non-medical methods. It therefore seems clear that no matter how it may imagine or present itself, psychiatry serves first of all not the distressed and the mentally troubled but its own interests and those of its paymasters: it must keep the peace.

Beyond the critique which we have so far offered, could it be that psychiatry *can hardly avoid* taking an alienated form? It seems to us that if we are to comprehend the full potency of the myth of mental illness and its correlate, the myth of efficacious psychiatric medicine, we have to entertain the possibility that the present organisation of psychiatry is most likely not some kind of aberrant and malignant growth on the body of a fundamentally humane society. Rather, the psychiatric and mental health organisation emerges *as a matter course* or '*naturally*' out of *generally alienated* forms of human association, thinking and feeling: psychiatry is one institutional element within a society marked by alienation. In other words, the general social relations are deleterious to the individuals who constitute them, and it would be surprising if psychiatry did *not* enunciate an ideological model of science, objectivity and medicine, and did *not* authorise an alienated kind of activity.

It seems to us that in order to fully comprehend standard mental health practice and the myths around it, we need to have a clear idea of the contradictions in the wider society. Although Marx elucidates psychological consequences, he does not elaborate his theory of alienation in detail with regard to any particular institution outside of the sphere of the production and distribution of wealth. In more recent times, C Wright Mills employed the concept of alienation to comprehend events in the realms of intellectual work and state bureaucracy, as well as in the wider community and in private life.

Critics tend to comment on the irrationality of normal social and political attitudes, and Mills is no exception:

[t]he current situation in America is by way of being something of a psychiatric clinic... Perhaps the commonest and plainest evidence of this unbalanced mentality is to be seen in a certain fearsome and feverish credulity with which a large proportion of the Americans are affected..⁴⁷

Credulity is a form of delusion, and represents a rift between thought and action: someone who is credulous cannot act coherently in terms of what *he* thinks, and his thoughts do not relate to anything

46 Milgram, S (1969/83) *Obedience to Authority: An experimental view*. New York: Harper-Collins. Also see text to footnote 15 in Chapter 10, above.

47 Mills, CW (1953) Introduction. In Veblen, T. *The Theory of the Leisure Class*. New York: New American Library, viii. Mills talks of the USA in the early-1950s, but it seems to us that in terms of political-economy, technology, ideology and public credulity nothing has essentially changed, and in many ways Britain simply lags behind the USA. Most of our quotes from Mills' writings appeared in Perlman, F (1970) *The Incoherence of the Intellectual: C Wright Mills' struggle to unite knowledge and action*. Detroit: Black & Red.

that *he* actually does. What is the reason for this absence of mind from politics, management and intellectual work, the general failure of nerve, and the generally fearful and conservative mood?

The psychological heart of this mood is a feeling of powerlessness - but with the old edge taken off, for it is a mood of acceptance and of relaxation of the political will. The intellectual core of the groping for conservatism is a giving up of the central goal of the secular impulse in the West: the control through reason of man's fate.⁴⁸

There is no opposition to public mindlessness, in all its forms, nor to all those forces and men that would further it. But above all, among men of knowledge, there is little or no opposition to the divorce of knowledge from power, of sensibilities from men of power, no opposition to the divorce of mind from reality...

Public relations displace reasoned argument; manipulation and undebated decisions of power replace democratic authority. More and more, as administration has replaced politics, decisions of importance do not carry even the panoply of reasonable discussion in public, but are made by God, by experts, and by men like [the President]... The height of such mindless communications to the masses, or what are thought to be the masses, is the commercial propaganda for toothpaste and soap and cigarettes and cars.⁴⁹

America - a conservative country without any conservative ideology - appears now before the world a naked and arbitrary power, as, in the name of realism, its men of decision enforce their often crackpot definitions upon world reality. The second-rate mind is in command of the ponderously spoken platitude. In the liberal rhetoric, vagueness, and in the conservative mood, irrationality, are raised to principle. Public relations and the official secret, the trivialising campaign and the terrible fact clumsily accomplished, are replacing the reasoned debate of political ideas in the privately incorporated economy, the military ascendancy, and the political vacuum of modern America.⁵⁰

The cause of the intellectual deficiency or imbalance of a complacent population is 'the alienation of personal from political life, ...the divorce of political reflection from cultural work.' This separation creates a context in which 'human development will continue to be trivialised, human sensibilities blunted, and the quality of life distorted and impoverished.' The trivialised, blunted, distorted and privatised person is, for all emotional and moral intents and purposes, '...an idiot'.

...[T]his spiritual condition...[is] the key to many modern troubles of political intellectuals, as well as the key to much political bewilderment in modern society.⁵¹

[This idiocy is characterised by] ...mute acceptance - or even unawareness - of moral atrocity; the lack of indignation when confronted with moral horror.⁵²

Mills suggests that the origin of this particular collective or widespread mental disorder lies in the experience of World War, when

[m]an had become an object; and insofar as those to whom he was an object felt about the spectacle at all, they felt powerless, in the grip of larger forces, with no part in those affairs that lay beyond their immediate areas of daily demand and gratification. It was a time of moral somnambulance.⁵³

And today,

[i]n the expanded world of mechanically vivified communication, the individual becomes the spectator of everything but the human witness of nothing. Having no plain targets of revolt, men feel no moral springs of revolt. The cold manner enters their souls and they are

48 Mills, CW (1954) The conservative mood. *Dissent* Winter, 22; reprinted in Horowitz, IL (Ed 1963) *Power, Politics and People: The collected essays of C Wright Mills*. New York: Oxford University Press.

49 Mills, CW. On knowledge and power. In Horowitz, IL, op. cit. (n. 48), 599 and 609. We could add psychiatric medicines to the list.

50 Mills, CW (1956) *The Power Elite*. New York: Oxford University Press, 360-361.

51 Mills, CW, in Horowitz, IL, op. cit. (n. 48), 24, 389, 390 and 386.

52 Mills, CW (1958) *The Causes of World War Three*. New York: Simon and Schuster, 77.

53 Mills, CW, op. cit. (n. 52), 77.

made private and blasé... It is not the number of victims or the degree of cruelty that is distinctive; it is the fact that the acts committed and the acts that nobody protests are split from the consciousness of men in an uncanny, even a schizophrenic, manner.

The atrocities of our time are done by men as 'functions' of a social machinery - men possessed by an abstracted view that hides from them the human beings who are their victims, and, as well, their own humanity. They are inhuman acts because they are impersonal. They are not sadistic but merely businesslike; they are not aggressive but merely efficient; they are not emotional at all, but technically clean cut.⁵⁴

This is '...the schizophrenia of the cheerful robot, of the technological idiot, of the crackpot realist, [who all] embody a common ethos: rationality without reason.'⁵⁵ The institutionalised splits between thought, action and feeling create '...a great cultural vacuum, and it is this vacuum that the mass distributor, and his artistic and intellectual satrap, have filled up with a frenzy of trash and fraud.'⁵⁶ Cultural middlemen - designers, advertisers, propagandists, media hacks, hired professors, scientists and artists - extract material rewards from this entirely normal and officially sanctioned schizophrenia.

The world people are going to believe they understand is now, in this cultural apparatus, being defined and built, made into a slogan, a story, a diagram, a release, a dream, a fact, a blueprint, a tune, a sketch, a formula; and presented to them. Such part as reason may have in human affairs, this apparatus, this put-together contraption, fulfils; such role as sensibility may play in the human drama, it enacts; such use as technique may have in history and in biography, it provides... In [modern society] the cultural apparatus is established commercially: it is part of an ascendant capitalist economy. This fact is the major key to understanding both the quality of everyday life and the situation of culture in [society] today..⁵⁷

These perceptions seem to hit the mark. But it is our belief that none of this represents a remarkable new historical phenomenon, and certainly not one limited to Mills' time and place. Technocratic-managerial ideology may have been enhanced by governments lurching into the welfare-warfare policies of the first half of the 20th century, but loss of spirit (or alienation) is something which has to be resisted by each rising generation, under ever-changing oppressions. Originally, 'alienation' had only a philosophical meaning, but whereas Mills refers vaguely to the impetus of 'an ascendant capitalist economy', Marx had long before made the concept integral to his detailed critique of political-economy. Marx also suggested some of the social and psychological implications: estrangement from one's self and from others is not a malaise suffered only by intellectual workers and managers in the wake of a terrible war - there is *always* a terrible war, or preparation for one.

Rather, alienation is

[t]he social power, i.e., the multiplied productive force, which arises through the co-operation of different individuals as it is determined within the division of labour, [and] appears to these individuals, since their cooperation is not voluntary but natural, not as their own united power, but as an alien force existing outside them, of the origin and end of which they are ignorant, which they thus cannot control, which, on the contrary, passes through a peculiar series of phases and stages independent of the will and the action of man, and is even the prime governor of will and action..⁵⁸

We become who we are through what we do, and the main theatres of human activity are arranged around production - the activities by which, in cooperation with others, the world is worked on so that life may be sustained. When they produce the means of subsistence and gratification, people make

54 Mills, CW, op. cit. (n. 52), 78.

55 Mills, CW, in Horowitz, IL, op. cit. (n. 48), 393.

56 Mills, CW, in Horowitz, IL, op. cit. (n. 48), 383-384.

57 Mills, CW, in Horowitz, IL, op. cit. (n. 48), 377.

58 Marx, K (1969) *Basic Writings on Politics and Philosophy* (Ed Feuer, LS) London: Fontana, 296.

material objects which embody human creativity: through labour, individuals are objectified in the man-made objects which are brought into existence. If the producer cannot recognise his activity in the objects he makes, and with which he finds himself surrounded, and which become the very conditions for his existence (i.e., goods, industrial capital, infrastructure, services, the whole made-over environment, and the reflection of all this and the social relations), his product is alien to him: it is not his own and 'stands opposed to him as an autonomous power'.

Under the conditions of capital (production for profit), workers have no say in the processes of production, and what they produce is appropriated and disposed of by others. Work is imposed; it is not a project taken up of the worker's own volition. Consequently, he finds no expression for his creative talents and no satisfaction, and he is indifferent to the quality of what is produced. Work is no longer an end in itself but a form of slavery - wage slavery, in which the worker sells the package of his energy and skills as a commodity like any other. This alienates him from his 'species being': he is exhausted of creativity and decision, and there is nothing specifically *human* about work under capitalism - a machine (or a child) will be employed if it is able to do the work at lower cost. Because capital tends to transform all social relations into the market relations of exchange, the worker is also alienated from those around him; and the worth of everything and everybody is gauged in terms of its value as a commodity. In both work and exchange, a person is reduced to the lowest common denominator, to the status of any other exploitable object. Meanwhile, the impersonal mechanisms of exchange, profit and accumulation appear to take on a life of their own, thereby disguising both the human origins of capital and the exploitation on which it is built. Hence, in an inverted and partial manner, the positivist ideology of the human sciences (including psychiatry and psychology) does convincingly reflect the truth of human being: in our social (or useful) existence most of us, most of the time, *are* 'just like objects', like cogs in a machine.

In this conception, alienation is *a form of social relation*. There is always a subjective correlate, of course: a *feeling* of alienation - of a vague and generalised discontent, of powerlessness, isolation, depersonalisation, estrangement from one's self and one's potential, of meaninglessness, and - as Mills points out - *dissociation* of the mind and the emotions from each other and from activity.

And so, although it is a part of the matter, alienation is more than the experience of intellectual workers or managers who are separated from the practical activity of physically processing objects. More generally, under the relations of capital, it is an attribute of the production or processing of commodities for the market.

More than this, Marx argues that alienation is masked and thereby sustained by the most general and the most taken-for-granted and intractable form of ideology: commodity fetishism. What does this mean? A commodity is a thing which may be exchanged; a fetish is an object worshipped for its magical powers as being inhabited by a living spirit or principle. Commodity fetishism specifies the situation where people conceive and stand in awe of their social relations and their exchangeable products as if they were indubitably natural processes and things which have a compelling existence quite separate from the human activity which constitutes them. This delusion is consequent to people no longer making or processing objects for their own use but only in exchange for money. Since the society of producers only make impersonal contacts one to another by means of money (the abstract and universal medium of exchange), money and the things that are bought and sold become the only visible manifestations of society. Social relations around production and distribution are then masked by the fetish of the commodity.

The mystery of the commodity form is simply that it mirrors for men the social character of their own labour, mirrors it as an objective character attaching to the labour products themselves, mirrors it as a natural property of these things...

In religion, the products of the human mind become independent shapes, endowed with lives of their own, and able to enter into relations with men and women. The products of the human hand do the same thing in the world of commodities. [This is] the fetishistic character which attaches to the products of labour as soon as they are produced in the form of commodities [i.e., where there is a high division of labour and appropriation of the product for profit]... [T]his fetishistic character of the world of commodities is the

outcome of the peculiar quality of the labour which produces commodities... [Monetary] value changes all products of labour into hieroglyphs. Subsequently, people try to decipher these hieroglyphs, to solve the riddle of their own social product - for the specification of a useful object as a value is just as much a social product as language is.⁵⁹

Fetishism is...the very form of social separation. Wherever there is opposition between individuals and the totality of them and their relations, this opposition takes the form of a fetishism of the totality. Opposition between the whole and the individuals takes place by means of parts of the whole which appear to be isolated, or which maintain illusory relations with the whole society and with each other. Deceived consciousness is the fundamental moment of fetishism. With it [for all intents and purposes], things become what they seem. The absence of consciousness takes the form of consciousness.

The fetishism of the commodity is concentrated in its value... It is the yoke of value that weighs down human brows... Value is the relation between two quantities... Value is...the exorbitant autonomy of the commodity... Value exerts itself implacably, while the deceived gaze only meets things and their prices.⁶⁰

Generally, then, everyone's productive power is abdicated to Capital. Simultaneously, everyone's political power is abdicated to the State, which is the personification of the power of the community, the estranged power of individuals to decide collectively the purposes, means and methods of their social activity.⁶¹ In brief, labour is so far divided, the market so pervasive, and the power to make important decisions so given over to representation, that *social alienation is unquestionably normal*.⁶²

The fetishism of the office

What has this to do with mental health care and treatment? Everything, since it is not only the patient who is alienated from himself, from others and from reality: *it is also, in a different but complementary manner, the psychiatric official*. The concept of alienation allows us to cut through to the heart of the enigma of mental health provision which, *in spite of the officials' best intentions, always tends to oppression*.

By accepting the legitimacy of an office to wield a specific social power, people abdicate their own powers over that part of their life; and the authority of the office creates the illusion that capacities or powers are not in the individuals who wield them, but instead in the personifications.

Furthermore, by internalising the power of the personifications, by conferring on them the legitimacy of authority, human beings simultaneously internalise their own powerlessness. Every act which lies within the sphere of influence of a personification is out of bounds for an individual. Individuals not only view the wielding of their own powers over the environment as illegitimate or morally wrong; they come to feel themselves unable to wield these powers: the personifications are able to do everything; the individual is unable to do anything... And what the individual can no longer do includes everything that has

59 Marx, K (1946) *Capital (4th edn)*. New York & London: Dutton, Vol 1, 45-46 and 50.

60 Voyer, J-P (1973) *Reich: How to Use* (Trans by Knabb, K) San Francisco: Bureau of Public Secrets. After Marx, and apparently independently, Freud explains the psychological use of a fetish as an object which substitutes for another with high value: fetishism is a form of denial, a psychological defence in which the fetishist disavows his knowledge of what he desires (e.g., because it is forbidden) and instead concentrates his attention on the substitute. See Freud, S (1927/77) Fetishism. *The Penguin Freud Library* 7. Harmondsworth: Penguin, 345-358.

61 Marx famously recognised that under capitalism the state is the executive of the bourgeoisie (the owners).

62 Intending only to recognise things for what they are, our wishes for the social relations of capitalist production, distribution and the general culture are irrelevant. We will return to the questions raised in this section when we consider specific modes of child-raising and the formation of normal and abnormal types of personality under the conditions of competitive hierarchy. See the section: The conditions for the development of normal character, in Chapter 23 (Volume 2).

become the prerogative of a special office: a profession, a specialised field, a discipline, a qualification, a licence.⁶³

With regard to the powers of his office, the exemplary functionary does no more and no less than *a standardised job*: the person who properly performs the duties of his office is *disinterested*, *objective* and only *efficient* or *machine-like*. And so, to the extent that he identifies the powers of the self with the powers of his office, the official personifies his assigned social powers and negates himself as a human being.

An individual who becomes what 'we electricians' or 'we teachers' or 'we doctors' are, becomes a thing which responds in a specific standard manner, which performs its special expected routine, whenever it is activated by money. *This internalisation of personified powers is the cement that holds together the social relations.*⁶⁴

At this point in our argument we are trying to comprehend why the management of individuals incapacitated by emotional distress and irrationality takes the form that it does. That is to say, why is psychiatry so inhumane, so blind to its effects, and so resistant to criticism - and all in the name of compassion and healing? Especially pertinent to these questions is the tendency for the internalisation of personified power to go furthest in those employed to manage people or work only with ideas: their daily activity separates them from any practical work with *things*. An official does not have contact with society's productive forces; he never has to transcend the powers of his office since, in his daily dealings, he is not called on to exercise his imagination in order to cope with the demands of resistant reality. A manager of persons, for example, is authorised a certain power, and those over whom he is delegated this power are legally powerless to resist any of his legitimate demands.

Beyond this, when someone becomes a plumber or a van driver - when he internalises the powers of the office of plumber or van driver - he does not internalise the thoughts and feelings, an entire identity of that office: what a plumber or van driver *thinks* or *feels* about anything is irrelevant to the performance of his role. However, limitation of the powers of an office only to the forms of external behaviour - e.g., plumbing or van driving - does not apply to the offices of the bureaucratic and ideological establishment. On the contrary, when someone internalises the powers of an ideological office *his entire self is absorbed by the office*. For example, 'what we psychiatrists think' *is considered absolutely relevant*: it is authoritative, certified and licensed by the controllers of the office of psychiatrists. In those areas of activity which are organised not to process material objects but to service persons, social relations and ideas, the powers of the office extend fully to *everything thought and felt about the topic at hand*. Hence, 'we psychiatrists' and 'we mental health workers' also feel and express *the official emotions* socially delegated to their offices.

Divestment of every attribute of the autonomous self for the sake of investment in an office is not simply a matter of monetary gain: access to authority also provides emotional rewards. Immersion in an office is *a kind of mental disorder*, a result of the alienation of the self from itself and from everybody else, but it is often *experienced* as a form of well-being - a privilege, prestigious, and thoroughly worthwhile.⁶⁵ The experience of being privileged and justified is lodged in the office: generally, for the sake of wielding social power, a person *aspires* to an office (and hence the negation of his self-powers), and the achievement of a position is accompanied by internalised, official self-satisfaction. The official may act as 'part of the machine', but at least he performs an executive function whereby he stands above and operates events (i.e., administers those persons who fall within

63 Velli, M (1974) *Manual for Revolutionary Leaders*. Detroit: Black & Red, 19-21.

64 Velli, M, op. cit. (n. 63), 22. Our emphasis.

65 That is, at least until stress or disillusion sets in. For example, the medical profession is known for higher than average rates of narcotic addiction and suicide. See Mika, T (2001) Treatment helps addicted physicians. *Journal of the American Medical Association* 286 3071; also Schernhammer, E (2005) Taking their own lives: The high rate of physician suicide. *New England Journal of Medicine* 352 2473-2476; and identifying even higher rates for psychiatrists, see Hawton, K, et al (2001) Suicide in doctors: A study of risk according to gender, seniority and specialty in medical practitioners in England and Wales, 1979-1995. *Journal of Epidemiology and Community Health* 55 296-300.

his official remit), and thereby he gains apparent and socially sanctioned *value* and *significance*. At the present level of personification, then, the professional *embodies* a collection of skills and knowledge, and whether at work or off-duty, the official role is at the centre of his being. Unlike someone who earns a living by plumbing or van-driving, and also happens to have ideas about human affairs, the person who holds a prestigious office *is* an economist, a teacher, a psychologist or a psychiatrist, and what he thinks or feels is always consequential, always much more than 'mere opinion'.⁶⁶

Whoever occupies an ideological office personifies a segment of the spiritual life of the society. As we saw, two-thirds of the volunteers to Milgram's compliance experiment (described in Chapter 10, above) were willing, in the names of Science and Education, to administer an electrical shock to a fellow human being beyond voltage levels clearly marked 'lethal'; although they were sometimes reluctant, they would do so *despite the screams and pleas of their apparent victims*, as long as they were reassured by the person in charge, who claimed he was an expert and said he would take full responsibility.⁶⁷ In other words, rather than as feeling individuals, the majority of the real subjects of the experiment acted as objects, as appendages to a technique, as unfeeling robots or 'cogs in the machine'.

Velli makes the following observations on the hypnotic effects of personified social powers:

The alienation of human powers takes its most acute form amongst the representatives of modern spiritual life. The personification of an intellectual office, of a department of knowledge, possesses a specific virtue or potency, a special field in which its powers are developed to the level required by the task to which it is assigned. It is able to articulate perfectly the thoughts of a specific office. It is able to evaluate whether it finds itself in front of one or another of a given set of problems, to choose the approach suitable to the given problem, and to correct itself if it errs. However, when it evaluates, chooses, or corrects itself, it is not exerting its own powers but the powers of the office: its forms of evaluation, choice and self-correction are integral parts of the program in which it was instructed. The powers of a living human being are precisely what it lacks. In the face of social productive forces, it waits for instructions. The products of human labour are an alien world to it, and it therefore lacks both the human imagination and the will to appropriate these forces as instruments for self-expression. In the face of a human being, furthermore one who protests and pleads with its 'innermost human self', its 'moral core', it reveals itself as an inanimate object in which there is no sense of community with human beings, a machine which completely lacks the rudimentary species-solidarity without which the human being could not have survived until today.

Personifications of social power seem to animate the world. Only expected official activity is experienced as real activity. The unofficial projects of an individual seem to happen in a social vacuum, cut off from the real life of humanity; they are pastimes, hobbies, wastes of time; they are experienced as empty intervals of inactivity. The estranged power of the community - the State, the Government - is experienced as the only real community. Estranged productive power - capital, money - is experienced as the only real productive agent. Personified power is internalised as the only form of human power. In other words, generations...are convinced that State offices fight wars, that money works, that inanimate objects animate social activity... [This] hallucination, ...that personified power is the only form of human power, cannot easily be explained in terms of the individual psychology of generations of human beings... [It has to be] explained in terms of the social relations these individuals are born into. Although money...has not, in fact, been seen to build, produce, repair, speak, or entertain itself, it is in fact through the

66 Professionalisation is a trend first remarked towards the end of the 19th century. Constituting the elements of a service industry to businesses or the state, most of the major professions were well established by the early part of the 20th century, and 'officialdom' has multiplied and bifurcated ever since.

67 Milgram, S et al, op. cit. (n. 15, Ch 10). See text to that footnote in Chapter 10, above.

mediation of money that producers relate to each other and to the productive forces. Although a State office has not, in fact, been seen fighting wars or building roads, it is only through the mediation of an office that wars are fought and roads are built. The impression that the representatives, the personifications of human powers actually perform social activities is a hallucination.

However, it is not a hallucination but a fact of modern life that people relate to each other and to the material environment only through the mediation of personified powers. Although the money and the offices do not possess social powers, they are universally accepted as equivalents or substitutes for the social powers. Money is not labour power or productive force, but is accepted as their equivalent. The State is not the community of individuals which it rules, but is accepted as the equivalent of the community. Although money or social offices do not perform society's activities, social activities can only take place through them. Since individuals are social, namely human beings, only to the extent that they take part in social activity, and since they can engage in social activity only by wielding the dominant forms of social power represented by money and wielded by offices, individuals become social beings by estranging their human self-powers and by wielding the estranged human powers represented by money and wielded by offices. As a result, individuals are social and human beings only in an inverted form, as wielders of personified powers.⁶⁸

Social existence - what one does and what one is - and social significance - how one is estimated - are determined by the personified power the individual wields (or by the lack of any such power). A hierarchy is inevitable when money is the representative of human productive powers and the state represents the community. Out of all proportion to their intellectual or practical abilities, people become many times more or less powerful, and many times more or less significant than each other. Consequently, it seems that the more one represents, the more one *is*. Just as it appears that the offices of capital and the state perform activities which are actually performed by individuals, so it seems that those who possess a great deal of money or occupy high office are endowed with very special capacities and powers - that they *are* more than others. Conversely, of course, those who own next to nothing and who are expected only to be passive or obey orders appear to be virtually worthless and less than fully human.

The concept of alienation throws light on the evidence that those individuals who are separated from productive work and who wield personified powers are prone to succumb to a generally unrecognised kind of mental disorder.

Extremely articulate, highly educated and very cultured individuals engage...in activities which, if performed by a working man, would lead to his commitment to a psychiatric hospital... It is not amongst workers, but amongst chemists and physicists, sociologists and economists, that the concentration camps are designed, the napalm bombs are invented, the germs and poisons developed, the calculated slaughters patiently devised. These people are not considered deranged; each is considered an expert in a field. They are not lodged in insane asylums; they are lodged in each others' company in cities which are built by the estranged power of producers but are geographically removed from the centres of production. They are amongst the best housed, best fed and best entertained members of society. Yet their behaviour exhibits a complete dissociation between their apparently human powers of perception and the inhuman consequences of their actions... The child-like innocence, the helplessness in the face of productive instruments, combined with meticulous rationality and calculated scheming when the same individual operates the same instruments by remote control - in short the mental derangement of these individuals, is a direct consequence of the dislocation of personified productive power from the productive process where it originates.⁶⁹

68 Velli, M, op. cit. (n. 63), 27-29.

69 Velli, M, op. cit. (n. 63), 33.

Whereas a foot-soldier fully experiences the consequences of his actions - for example by facing and shooting or bayoneting an enemy individual - the technician who drops bombs from a plane or drone, or who presses a button to fire a missile, could only really grasp the significance of his actions if his own house and family were blown up. As for the academic who devotes his life to war-gaming for the Government, or who dispassionately explores the scientific possibilities of chemical jellies burning on living flesh - he only theorises, only runs a computer model, simply conducts experiments with chemicals and animals. The mental disorder of those who wield personified social power is aggravated by the lack of species solidarity which accompanies the internalisation of the behaviour, thoughts and feelings of an office. Lack of empathy with fellow human beings is a symptom of the 'objectivity' of the 'categorising-and-directing-machine' which is the proper mode of activity of the official; this feeds back into an inability to comprehend those being administered; in turn, this leads to the cold and 'scientific' nature of all those official policies which fail to mesh with the personal or social situations for which they are designed:

The measures lose their social, namely human, frame of reference; they are the calm and carefully pre-meditated designs of a maniac, a deranged robot, a mechanical monster that has slipped out of human control and begins destroying human beings helter-skelter with a mechanical indifference which, among animate beings, would characterise only a deity or an ape.⁷⁰

It seems to us that the noxious effects of personified power will magnify when officials are ideologically convinced that the individuals subjected to their control are somehow not fully human or do not merit compassion. This belief is likely to be held already by the wider population from which the officials are recruited, but it may be enhanced during training. For example, the citizens of a country at war are very likely to believe that of the enemy, many people feel that way about criminals (especially paedophiles and murderers), and it seems clear that there is in general at least a subliminal feeling that anyone who 'has a mental illness' has somehow forfeited his full humanity. When these kinds of belief obtain, officials are often able to abuse and harm people, or even encouraged or ordered to do so, as a matter of routine and with public approval, and not only at a distance but face-to-face.⁷¹

We can add a few brief comments to the above analysis. First, there has been a considerable amount of social psychological and ethological research into the nature of empathy since Mills' time. If not before, it is now clear that empathy is not purely cognitive: it has an affective dimension and involves a kind of emotional engagement. Frans de Waal is persuaded by his own research and a survey of the studies in the field that empathy and compassion is instinctive, at least to all the higher species of animals - as well as in humans, it is certainly present in the behaviour of all the great apes (despite the prejudice expressed by Velli in the quotation above). Moreover, empathy is a feeling long before it is a cognition: that it is a kind of emotional contagion is demonstrated by wards full of new-born human babies who, if one starts, all begin to cry in unison - and girls more so than boys.⁷² These and other findings seem to indicate that chronic indifference must be a habit that people learn. As we have seen, the conventional wisdom and mandated attitudes and procedures throughout the mental health services are those of the so-called medical model, in which, as a matter of course, officials are indoctrinated with the belief that they must deliver a medical-technical response by practicing a kind of scientific detachment or objectivity, whatever the patient's opinions or feelings.

70 Velli, M, op. cit. (n. 63), 34.

71 In Chapter 1, above (n. 93), we mentioned that sterilising 'degenerate' patients was popular with many of the world's psychiatrists until eugenics was discredited by evidence that, in the name of euthanasia, Nazi colleagues had murdered at least 250,000 of their charges. It is also known that in Nazi Germany, imperialist Japan, the Soviet bloc and the USA, under the direction of the state, hundreds or perhaps thousands of regular physicians carried out an unknown but great number of deliberately inhumane and usually fatal 'medical' experiments, mainly on criminal or political prisoners or prisoners of war, but also often on unwitting civilian populations. It is likely that some such experiments continue to this day. This is documented in a film available on YouTube: Pohlmann, D (2010) *Doctors of Death*. Mainz: ZDF.

72 de Waal, F (2009) *The Age of Empathy: Nature's lessons for a kinder society*. New York: Harmony Books.

This suggests that the weight of all that taken-for-granted ideology, magical thinking and ritual must surely work on psychiatric officials so as to spur them to *positively repress* any empathy they may have with the patients.

Secondly, as indicated in an expanded form in the Appendix to Chapter 28 (Volume 2),⁷³ the far-reaching technical developments of the last century-and-a-half have so altered the social relations that the ratios and inclinations of the psyche have also changed. Certain tendencies may be discerned which reinforce the alienation described by Mills. Primarily, 'technification' of every aspect of life distances everyone from immediate contact with real things and processes, and from their awareness of, and concern for, the consequences of their individual and social actions. As Guy Debord puts it:

...everything once directly lived and experienced moves away into a representation.⁷⁴

This has profound effects whenever we imagine anything - be it a part of nature, society or an individual; it has effects throughout the culture - throughout science, education, the media, and social and psychological conjecture (of course including psychiatry). Specifically, it diminishes feelings of personal autonomy, including feelings of responsibility or guilt. However, a high degree of technical mediation and alienation within the normal processes of everyday life may be experienced as a persistent frustration; and this tends to cultivate an aggressive attitude towards every social, environmental or individual problem that ever arises. A self-stroking cycle is thereby sustained, in which technological mediation begets an aggressive mindset in which every personal responsibility is hived off to state-certified technicians; thereby a reflex is enhanced always and only to *confront* or *attack* every discernible problem with apparently ever-improved technical means. And it is of course far from the interests of either capital or the administrative class to discourage these tendencies.⁷⁵

Finally, a functionary is unlikely to do anything to upset the hierarchy of personified social power: because it provides him with his livelihood and his significance, he extols his own and all other offices. In all, what we are talking about here is - *the fetishism of the office*.

Dereliction of duty and the abuse of patients

Phylis Chesler comments on the demoralisation of physicians faced with an endless parade of poverty and death, but what she says must apply as much to psychiatric officials trying to manage madness. She suggests that every doctor will have been goaded through years of training by ambition, parents, competitors and academic taskmasters, in the end only to find that

...even the money is not enough. The burden of battling is staggering. Each day death triumphs; each day more patients insist that doctors know what to do; each day there are more patients. This unhinges all but the gentlest of healers, the saints, the exceptions. Most doctors withdraw, turn cold and contemptuous: a child's most frightening tantrum.⁷⁶

In the previous section we discussed the psychology at play in the transactions of a competitive and hierarchical society. But apart from these considerations, undesirable consequences also regularly issue from the fully conscious calculations of self-interest - and sometimes self-preservation - made by employees. In any organisation, it is generally each individual's first concern *not to act in any way that might jeopardise his own position or career*.

There is considerable sociological research to show that bureaucracies tend to become inflexible and their formal purposes perverted due to unanticipated consequences of their structures: essentially, there is always a degree of conflict between the aims of an organisation and the private interests of its members. For example, specialisation fosters a narrow outlook which cannot meet new problems, but it is not in the interest of any official ever to admit it; or the officials tend to apply the rules

73 See Appendix to Chapter 28: Social Analysis and Paranoia (Volume 2).

74 Debord, G (1967/77) *The Society of the Spectacle*. Detroit: Black & Red, para 1.

75 See Appendix to Chapter 28 (Volume 2), with references to Debord, G, op. cit. (n. 74), Vaniegem, R, op. cit. (n. 87, Ch 13), and Marcuse, H (1968) *Negations: Essays in Critical Theory*. Harmondsworth: Penguin, Ch 8: Aggressiveness in advanced industrial society. Freud's ideas about an innate predisposition to aggression are discussed in Chapter 22 (Volume 2), especially in the section: The feminist critique.

76 Chesler, P (1978) *About Men*. London: The Women's Press, 180.

ritualistically, and elevate ‘the smooth-running of the organisation’ above the goals it is supposed to serve, so that exceptional or changed circumstances are not dealt with appropriately; again, it is often easiest for subordinates to follow orders even when they can see they are misguided. On the other hand, adherence to the rules and purposes of the organisation is likely to take second place to an employee’s own perceived interests (and those of complicit colleagues) wherever this is possible - individuals and informal cliques try to maximise their freedom of action by paying lip-service to the rules, and bend them to suit their own purposes whenever they can.⁷⁷ In addition, officials are able to distort or withhold information so that their line-managers cannot know exactly what is going on - for example, ‘not upsetting management’ may be seen as more important than always fulfilling the aims of the organisation. Reform is difficult: new or re-organised bureaucracies or departments within them tend rapidly to fall into routines in which tasks are fulfilled only minimally or ineffectually.⁷⁸

Where the object of an organisation is to manage or process vulnerable persons, such as with hospitals, boarding schools and prisons, the consequences of conflicts between the official goals and the self-interests of the officials are *frequently* detrimental to the subjects, and the general run of routinised management or care is often likely to fall short of humane standards. This was recently confirmed by the government’s own health ‘watchdog’, the CQC, which found that mental healthcare professionals ‘...can appear to lack compassion and warmth in how to care for and speak to people who are having a crisis’. Its survey found that patients going through a psychotic episode *most often* find their mental distress is compounded by unhelpful attitudes among doctors and nurses: only 14% said that the care they received had provided the right response and helped to resolve their mental health crisis, while 40% said the response was entirely inappropriate and had not helped at all. The survey found that the behaviour of hospital emergency department (A&E) staff in particular was ‘quite shocking’. GPs generally received good ratings, but many respondents said the police and ambulance services were much better at helping than the three key types of NHS teams: A&E, community mental health, and crisis-resolution home-treatment. 86% of those who received care and support from charities or volunteers felt their concerns had been taken seriously, but only 37% said they felt this from A&E staff.⁷⁹ That psychiatric providers are often casually negligent is also indicated by a disquieting lack of concern about premature deaths and the disproportionate number of such deaths under some authorities.⁸⁰

More than this, it is regularly attested by the surfacing of horrific, long-running scandals that for officials in ‘the caring professions’ there are always opportunities for neglect and outright abuse, and for evading detection or escaping investigation and prosecution if an offence ever does come to light.

Social-psychological experiments confirm what Lord Acton observed more than a century ago:

Power tends to corrupt, and absolute power corrupts absolutely...⁸¹

During the last thirty years or so there have been a number of enquiries into systematic abuse in care homes for children and for adults with learning or physical disabilities, and also several concerning psychiatric facilities, especially psychiatric prisons (Special Hospitals).⁸² Given the habitually alienated mindset of many officials, in which self-interest and a minimal standard performance are prioritised above sympathy and empathy, neglect and abuse are *normal* outcomes of

77 See Merton, RK (1957) *Social Theory and Social Structure*. New York: Free Press, Ch 8.

78 Crozier, M (1964) *The Bureaucratic Phenomenon*. London: Tavistock.

79 Public services must ‘wake up’ to gaps in mental health crisis care, warns CQC (2015) www.cqc.org.uk/ 12 June; Campbell, D (2015) A&E staff attitudes to patients in mental health crisis ‘often shocking’. *The Guardian*. 12 June.

80 Trigg, N (2015) Mental health early deaths ‘worrying in one in four areas’. *BBC News* 18 Nov; Buchanan, M (2015) NHS trust ‘failed to investigate hundreds of deaths’. *BBC News* 10 Dec; NHS England publishes report into Southern Health (2015) www.england.nhs.uk/ 17 Dec.

81 Dalberg-Acton, JEE (1887/1907) Letter to Bishop Mandell Creighton, April 5, 1887. In Figgis, JN & Laurence, RV (eds) (1907) *Historical Essays and Studies*. London: Macmillan; Bendahan, S et al (2015) Leader corruption depends on power and testosterone. *The Leadership Quarterly* 262 101-122. Acton’s letter continued: ‘Great men are almost always bad men...’

82 E.g., *Committee of Inquiry into Complaints about Ashworth Hospital*, op. cit. (n. 50, Ch 5).

any caring organisation: they should be expected, and specific measures ought to be taken to guard against them. All the same, in any organisation where there is a duty of care, if an offence is reported - by a victim or a properly responsible official - the report will imply a shortcoming in management, and bringing the perpetrator to justice and helping or compensating the victim will normally meet fierce and successful resistance from the authorities.

After he died, it turned out that Jimmy Savile, a famous entertainment 'personality', had sexually abused probably thousands of young people, including many children (some as young as five) in various institutions such as hospitals, psychiatric units and the BBC (at *Top of the Pops*, etc.). Over four decades, one-half of the country's police forces had received at least one complaint about him, but none had ever made a proper investigation, nor (until very late in the day) did any force pass on its information to another. It also became clear that a great many adults - many of whom had a duty of care - were aware of his activities, or at least suspicious, but very few ever intervened or reported what they knew or suspected to any authority. Apart from this almost universal complicity, a number of Savile's friends and employees regularly aided and abetted him. Because of his celebrity status, charity fund-raising activities and willingness to work as a voluntary helper, one of the many institutions Savile was free to enter and roam was Stoke Mandeville Hospital, where he took it on himself to act as a porter whenever he wished, and was given his own living quarters. One of his victims says that in 1977, when she was a twelve year-old patient, Savile walked her off the ward, took her down a corridor to another room, and raped her. Dazed, confused and in pain, when she got back to the ward she told the nurse in charge: 'Your porter hurt me here', indicating her groin. The nurse replied: 'Don't say anything. I'll get in trouble.' Savile sexually assaulted the girl again that night, when she was in bed. She then witnessed him assault another patient in a nearby bed. At the time, this young victim posted notes to tell the doctors, but there was no response.⁸³

It is unlikely that anyone trying to make their way in any kind of institution will openly question or in any way disturb the status quo. Every profession insists that its trainees parrot and comply with the orthodox line. As Chomsky put it:

The people who make it through the institutions and are able to remain in them have already internalised the right kinds of beliefs: it's not a problem for them to be obedient, they already are obedient: that's how they got there..⁸⁴

That Stoke Mandeville nurse can hardly be blamed for not wanting Savile's crime reported. We can be almost certain that she was correct when she told the raped child that she, the nurse, would get in trouble, and she would also have been quite sure that nothing would have been done about the abuser. Health organisations are far from immune to the pressures of competition and domination. In a recent survey of 300,000 NHS staff, one-quarter reported being bullied, harassed or abused by management during the previous year. The survey of these victims revealed nearly three-quarters with increased stress and panic attacks, while one-third had been pushed out of their jobs, and as a result many developed serious mental health problems. The most common forms of abuse were 'undermining behaviour' and 'persistent criticism'. Just over one-third said they were persecuted by fears or threats, and that their career had been deliberately sabotaged; one-in-ten had been subjected to violence or aggression. 54% did not report bullying by managers for fear of reprisals; of those who did report it, 44% said the bullying still persisted afterwards. Of the officials who had been bullied, 55% said it had been triggered by their raising a legitimate concern. One NHS manager said:

The culture is driven by exerting undue pressure on others to get things done. If you don't, you are targeted and eventually you end up with stress and depression. The organisation becomes defensive and takes the corporate line to protect themselves from a legal challenge, and puts it down to your perception. You are then managed out of your job through contrived actions designed to make you leave. All this leaves you broken and with no strength to fight. You go if you can find another job. Otherwise you suffer in silence..⁸⁵

83 Davies, D (2014) *In Plain Sight: The life and lies of Jimmy Savile*. London: Quercus, 327-331.

84 Chomsky, N (2002) *Understanding Power*. New York: The New Press, 248.

85 Johnson, S (2016) NHS staff lay bare a culture of bullying. *The Guardian*. 26 Oct.

The extent to which officials abuse their powers is rarely researched. Regarding sexual abuse, in one anonymous questionnaire survey of a random sample of 460 physicians, 5-13% (varying by medical specialism) reported engaging in erotic behaviour with patients, with 5-7.2% admitting they had engaged in sexual intercourse.⁸⁶ In the nature of the organisation of psychiatric powers and rights - the almost unaccountable power of the officials and the near absence of patients' rights - no-one has any idea about the levels of the neglect or deliberate abuse of psychiatric patients. And compared to most other kinds of patient, how much more vulnerable is a psychiatric patient?

We are aware of only two instances in which a psychiatrist was found guilty of the sexual abuse of a patient. In 2000 and 2003 two former consultants of a hospital at York were separately found guilty of the sexual assault or rape of many female patients, over a period of more than thirty years. In the 1980s, when one patient and just two members of staff had dared to make formal complaints, management had closed ranks to protect the doctors, refused to properly investigate the allegations, and instead victimised each complainant. In the end, however, in 1998, one abused former patient went to the police. A thorough police investigation located 120 women who independently testified that they had been sexually assaulted or raped by one of the doctors, and at least 30 by the other. Understandably, considering the prejudice and stigma attached to psychiatric illness, only a handful of these ex-patients dared face hostile cross-examination in open court.

In 2004 the systematic cover-up of this abuse was the subject of an NHS Inquiry which was itself a whitewash. Nonetheless, the inquiry did reveal that, over the years, more than fifty officials, up to the highest levels of management, had direct knowledge of many patients' complaints against both doctors. Of the two members of staff who had tried to stop the abuse and get a proper investigation, one gave up as soon as she was threatened by management and the other was in the end silenced by being sacked on trumped-up charges. It illustrates our argument that this 'whistleblower' found no support but only hostility and obstruction from her colleagues, from other doctors, management and the local and regional NHS executives, from the paid officials of her union, and from the panel of the Governmental Inquiry. The only solidarity was expressed by local members of the union who were not nursing or medical staff - kitchen staff, porters, etc., who were sickened by the whole affair.

And there still is no effective protection for whistleblowers. In 2016 a former chairman of the BMA organised a group of medics and campaigners to write a letter to *The Times* to attest that despite the recommendations of the Francis Report, in 2013, there had been 'no meaningful change in the hounding of whistleblowers' by NHS managements; in 2018 the Health Minister admitted it.⁸⁷

The fetishism of psychiatric medicine

In all modern societies, as a matter of course, worrying emotional and mental deviance has come under increasing bureaucratic-technical control; and, with the rise of medical science, management of individual irrationality was almost bound to find its rationalisation in the myth of an indubitably medical-scientific explanation and response. A section of the medical profession provided a plausible ideology and fairly easily captured this social function. Now, after a century of supposedly scientific psychiatric medicine, most of us imagine that only a doctor is competent to decide the appropriate response both to the person who suffers from a mental disorder and to the helpless people around him. Conflict, high emotion and irrationality certainly pose great difficulties for the individual in crisis, who tends to become isolated in his distress, and for families or others who are affected, and everyone finds the medical model a welcome relief from any responsibilities they may feel. Given the

86 Kardiner, SH, Fuller, M & Mensh, IN (1973) A survey of physicians' attitudes and practices regarding erotic and non-erotic contact with patients. *American Journal of Psychiatry* 130 1077-1081.

87 *Kerr-Haslam Report*, op. cit. (n. 10, Ch 10); Virden, P, op. cit. (n. 26, Ch 10); see also text to footnotes 10, 25 and 26 in Chapter 10; *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report)* (2013) London: Stationary Office; and Jarman, B et al, op. cit. (n. 27, Ch 10), Martin, D, Allen, V & Marsden, R, op. cit. (n. 27, Ch 10), Campbell, D, op. cit. (n. 27, Ch 10). We discuss the *normal* complicity with abuse on the part of NHS managers and staff, and the vilification and persecution of whistleblowers, and suggest how best to address these problems, in Chapter 28 (Volume 2), in the section: The regular victimisation of whistleblowers.

general understanding of what experts do, and what science and medicine is, a layperson is likely to believe that the competence of the psychiatric official lies precisely in his dispassionate, disinterested, objective and efficient employment of standard procedures: everyone imagines that personified social power constitutes a kind of efficient machinery, set-up to process problematic 'things' - in this case, 'sick brains'.

It therefore appears to everybody that since his expertise is officially authorised, *only* a doctor will have the correct answers - and the overriding right to offer answers - to any and every serious problem of emotional, psychological or interpersonal conflict.⁸⁸ A psychiatrist is the personification of sympathy and rational assistance for those who suffer from psychological malaise. But he is only free to process the patient in accordance with the presuppositions and agenda of his office. Programmed to discriminate types of abnormal thinking, feeling and behaviour, he must act strictly as a technician so as to fix or at least manage each problem: he is required to do no more and no less than apply his medical training so as to assess the symptoms, decide a diagnosis and, by reference to texts and formularies, prescribe and oversee the administration of suitable treatment.

It is beyond the medical remit to enquire too deeply into any possibility that the cause of a personal crisis might be the oppressive life of the person who is now a mental health patient. A doctor treats *illness* (mental illness), and he is required to 'go by the book'; he is not to think too much or make personal decisions. In other words, training and certification pursuant to the medical model positively *prohibits* a psychiatrist from inquiring about many of the patient's most urgent needs. Apart from the imperative of detachment and allegedly medical-scientific objectivity, the psychiatric expert is also separated from the patient by his own quite different social experience and his long and intensive training - the more so the more senior his position - and he is licensed to wield great power over someone who, due to his emotional distress, confusion, social isolation and legal position, is unable to resist. Since the patient is powerless, it is certain that the psychiatrist is never forced to think beyond 'the illness' - to contemplate the upset and bewildered *person* and his emotional, psychological, material and social problems.

Moreover, apart from the myopia resulting from his medical indoctrination, it is unlikely that the psychiatric professional ever suffered from the kind of extreme anxiety and mental turmoil that the patient experiences, and so he finds it hard or impossible to imagine that the patient's condition could really be due to psychological trauma and stress. Psychiatric textbooks allow that stress 'may be a precipitating factor' in a crisis, but beyond that, it is not likely that the psychiatric official could even conceive of mental disorder as an extreme form of alienation. Since, by consensus, *he* is a reasonable person, and since *he* finds the social relations rewarding enough, the official *cannot imagine* very significant dysfunctions or 'sickness' in the social order. In which case, it only occurs to him that it is the suffering and incoherently protesting individual who *must be sick*. In addition, and since someone becomes a mental health patient precisely due to his irrationality, officials are often disposed to interpret the individual's mental turmoil, protests or pain (emotional or physical) as unreal - as *only imagined*. An official who believes in the medical model is bound to view any patients' disturbingly aberrant beliefs and behaviour as meaningless, nothing more than the random signs of a condition (a mental illness) which the individual somehow *contracted*, or of faulty biochemistry or genetic make-up, whereby the person *has a congenital condition* or 'propensity' which now issues as schizophrenia (or some other type of mental disorder).

Because they are employed to exercise an alleged dispassion, objectivity and technical expertise, the psychiatrist and his assistants not only cannot but *must not* encounter the patient as another person in extreme need of human warmth, sympathy and understanding. Rather, they must view the entire mental health project as processing diseased brains which happen to generate different types of random ideation and behaviour which psychiatry is able to recognise as belonging to one or other of a variety of disorders. In the medical perspective, the person and his unique and complex biography is only incidental to his 'sick brain'. And since he is not himself an expert, and has been delivered to

88 Although, under the direction of the psychiatrist, nurses and some family members may be delegated certain limited powers.

care and treatment because of his irrationality, it goes without saying that every patient begins his psychiatric career in a condition of profound incompetence, error and ignorance with regard to anything of an emotional, cognitive or volitional nature: in the jargon, he 'has a mental illness' and 'lacks insight'. As a matter of 'humanity' (or 'smoothing the way', so as to elicit his co-operation), the patient should of course be treated with courtesy - but always firmly and medically.

In short, medical psychiatry could only develop in a society in which human power is divided and personified. Psychiatry exists because it is taken for granted that anyone who becomes so upset and confused that he becomes a social nuisance or a danger is also *essentially* ignorant and powerless in the face of his own distress and confusion, that those around him could not possibly organise themselves to provide help, and that only medical experts have the right and duty of management and treatment. The competent psychiatric official simply carries out the standard medical procedures.

As we have seen, however, functional mental disorder is not illness (mental illness), the mental health project is largely misconceived, and the standard procedures are not based in genuine science. Velli points out that the ideological functionary is cut off from production - from practice tempered by the limitations of nature. Psychiatrists wield exceptional and almost unaccountable legal power over their patients, and their practice *never* has to stand the test of reality.⁸⁹ Each patient is delivered to psychiatric authority precisely because of his irrationality, whereby it is deemed that he is intrinsically unable to express his real needs or find an answer to them, and so there is *nothing at all* to force psychiatric theory or practice to correspond to *any* of the patient's circumstances and needs, as he or any lay witness might construe them. Within the limits of the medical model, i.e., so long as some other psychiatrists agree that it constitutes a valid technique, a psychiatrist is free to rehearse any unevidenced theory whatsoever in support of the performance of any so-said medical-scientific ritual. In effect, this means that apart from too often killing or otherwise harming too many patients too often in too obvious a manner, a psychiatrist is free to do with his patients more or less what he wishes.

In modern societies any object or process which happens to become too much of a nuisance generally finds a social response which is technical and aggressive. Psychiatric care and treatment is no exception to this cultural trend: it, too, is conceived and practiced in terms of aggression. Psychiatrists first announced their indubitably scientific status by reference to the 'magic bullet' of the arsenic cure for syphilitic GPI, and for much of the 20th century they would refer to the array of psychiatric treatments as their 'armoury'. It is not so long since it was fashionable to hack blindly at offending brains with the crude methods of psychosurgery. Today, and still in the absence of either a plausible scientific hypothesis or proof, drugs and electricity are employed to 'attack' and 'drive out' the bad stuff supposedly 'in' the patient - all the bad ideas, bad chemicals or bad brain cells that are supposed to constitute the illness.

In the preceding chapters we have seen that there is no psychiatric technique that can be justified as rational medicine. They are all scientifically dubious, and there is no evidence that they remedy mental disorders. Instead, they function as a kind of magic which aims to subdue the whole person or otherwise alter his mood by means of a so-said medical intervention into his allegedly malfunctioning brain, so as to obviate 'symptoms', i.e., whatever feeling, behaviour or ideation is deemed dangerous, inconvenient or upsetting. A nuisance, that is, not always to the individual himself so much as always *to others*: to family members, the public, psychiatric workers, and other officials. These rituals of chemical and electrical attack on what is said to be 'bad' inside the patient's brain are not focussed on a specific known disease process - since none exists - but are nothing other than legal assaults. Psychiatric care and treatment may be popularly perceived as a form of organised compassion and assistance, but it is not always without a strong element of sadism. Joseph Berke suggests that:

89 How else explain the regularity of psychiatric diagnoses in the absence of symptoms, and the dubious efficacy of medical psychiatric treatments? And despite regular deaths by overdose in psychiatric custody, and much evidence of organic harm (e.g., the TD epidemic), due to the legal defence: 'acting in good faith', in the UK no official has ever successfully been prosecuted or sued for harming a patient by the application of a psychiatric treatment.

...the force which motivates these outbursts of socially sanctioned violence [i.e., medical psychiatric treatments] is the wish to locate and destroy that which people find intolerable to perceive and accept as part of themselves: their envy, jealousy, greed, hatred, love and so forth... People who become psychosurgeons lend their technical expertise to the State for purposes of violent social control because the operation gives them the opportunity to annihilate in others (by means of projective identification and concrete action) psychological attributes which they cannot stand in themselves. The patient's relatives collude with the operation for similar reasons. Ergo, the lobotomised patient is an interpersonal scapegoat on many levels.⁹⁰

Of course, doctors do not have to use surgery in order to lobotomise their patients: drugs and electroshock are often sufficiently powerful. And not only are those treatments generally uncontroversial, their use is often *demanded* by anyone who considers himself a responsible citizen.

As a last resort, psychiatric officials are able to call on the coercive power of the state - the police. More than any other kind of official, though (e.g., teachers), the psychiatric worker is already given extraordinary powers to make the objects of his expertise - his patients or 'clients' - agree with his professionally approved fantasies. In this case, the fantasies concern the indisputable existence of mental illnesses and the undoubted efficacy of medical treatment; and when patients submit to these fantasies, the officials are thereby apparently proved correct. Since there is no compulsion to test any psychiatric idea against reality, theory and practice are immediately able to dissociate, and the whole ostensibly remedial project ascends into a toxic derangement. Easily restrained and 'kept in the dark', a psychiatric patient is unable to resist treatment or research; this makes him readily subjected to forms of practice justified by positivist ideology, in which he is routinely treated as a mere object, the unfortunate carrier of an illness. Worldwide, and over the years, tens of millions of psychiatric patients have been subjected to assault, restraint, incarceration, induced coma, lobotomy, electroshock, sterilisation, behavioural therapy, poisoning and maiming. Many have died, and regularly continue to die, as a result of over-sedation. Much of this treatment continues unabated. In the name of Medicine, and with full public approval, this mayhem is perpetrated officially by well-trained functionaries who simply carry out the standard technical procedures to the best of their abilities.

We believe our argument cannot be easily dismissed as 'only another point of view'. In Chapter 4, when we reviewed a television documentary proclaiming the 'good practice' of two psychiatric officials, we witnessed their casual use of disdain, deceit, prejudice and cruelty. The reader will recall that when the psychiatric captive objected, perfectly reasonably, that his mental condition was not unsound and that he suffered from the ill effects of compulsory drugging, the consultant dismissed his complaints as 'fabrication' and 'lack of insight'. Then, *despite the absence of symptoms*, he diagnosed 'a schizophrenic illness'. Eventually, this doctor re-prescribed the very drug which had already caused the patient pain, disorientation and parkinsonian symptoms - and who knew or cared what other harm? There was no shame in this routine employment of oppressive and mutilating official power; on the contrary, it was celebrated as commendably progressive psychiatric practice.

Perhaps it is only senior psychiatric officials who are likely to be out of touch with the lives of the patients? Perhaps the more junior the psychiatric worker and the more contact with the patient, the more likely there will be a shared social background, and this might lead to more possibilities for the development of a genuine human encounter? This is possible, but unlikely. Every mental health official is subjected to medical indoctrination and is expected to follow the dictates of the relevant authority. Precisely so as to invest himself in his office, in the name of 'medical objectivity' the functionary must deny both his self-powers and the full humanity of his 'clients'. As predicted by Velli, in the television documentary discussed in Chapter 4 the psychiatric nurse made only perfunctory sympathetic noises to the patient in response to clear signs of the harmful drug effects - and drugged him again, anyway. We saw that both officials had clearly invested themselves fully in their offices: both abdicated their human self-powers and seemed to have no qualms about aggressively processing an entirely imaginary object - the so-said mental illness. The only personal

90 Berke, JH, op. cit. (n. 15, Ch 7), 107 and 114.

contributions of these fine public servants were self-serving and obstructive to the patient's physical health and peace of mind: the doctor puffed himself up as an expert who, despite the lack of evidence, knew best; at various times both he and the nurse tried to trick the patient; and together they intimidated him and made him the butt of a cruel racist joke.

Those psychiatric officials laboured under a delusion, a socially sanctioned mental disorder. It would be clear to any disinterested observer that they acted carelessly and callously, that they caused harm, and that their actions were intellectually and morally indefensible. They collaborated to manage the patient as only an object - his purported illness. Except to authorise his eligibility for a minor disability benefit, it was not clear that they did *anything at all* in the patient's interests. For his part, the patient was not taken in. Inasmuch as he actually suffered at the hands of this doctor and nurse, he could not believe that their actions were in any way directed to helping him. He protested as best he could against each attempt to degrade, dehumanise and harm him. More than this, he correctly viewed their treatment of him as ill-advised, exploitative, lying, evasive and (due to the drugs) mentally blunting, painful and physically harmful. *All this made the patient appear by far the sanest party to that particular set of psychiatric encounters.*

And yet any psychiatric official who fails (or refuses) to follow the standard procedures of his office puts his career in jeopardy, *even though he does no harm and may be able to show that he does good.* In recent history this was illustrated by the career of the famous psychiatrist, RD Laing. He advocated a humane approach, and used to engage with patients by listening to them and responding with sympathy and empathy. Worse than that, however, Laing made himself a notorious heretic by denouncing the oppressive objectifications of the psychiatric medical model. This enraged most of his peers. Regardless of his committing no professional misconduct, the guardians of psychiatric orthodoxy hounded him for years until they finally contrived to remove his licence to practice.

Rather than helping distressed people with their problems, psychiatric officials are trained to view their work as the application of standard medical procedures to illnesses (mental illnesses). It seems to us that psychiatric officials are encouraged to become callous functionaries both by the nature of any hierarchical, industrial-bureaucratic organisation and by the allegedly dispassionate-objective, medical-scientific, technical nature of the mental health project. It is regularly affirmed by surveys of patients and ex-patients that most psychiatric officials are routinely careless and uncaring. As we saw in the previous section of this chapter, even the government's Care Quality Commission finds that too often psychiatric officials 'can appear to lack compassion and warmth in how to care for and speak to people who are having a crisis', and that the behaviour of emergency department (A&E) staff in particular is 'quite shocking'.⁹¹

Obviously, no survey can reflect the opinion of a patient who goes on to commit suicide after a 'quite shocking' psychiatric response. Inadequacies in the mental health response have been well-known for many years, and the lack of any concerted attempt to remedy matters is itself a symptom of a collective carelessness with regard to the patients. Evidence of the terrible consequences of a lack of adequate funding, and of official indifference or callousness, rarely merits a mention in the national news but occasionally it surfaces in the local news. Recently a man was found at home having '...deliberately killed himself by cutting off his hand with a hacksaw, although more could have been done to prevent his death, a coroner has concluded.' This person had already been diagnosed with psychosis, and had repeatedly complained to his doctor about tinnitus, insomnia and his pacemaker being controlled by outside forces. He had taken an overdose, cut his wrist and called an ambulance. The mental health nurse at A&E admitted that the man had said he couldn't cope any more, and was anxious about going home. Just the same, she sent him home by taxi, but phoned his local crisis team to get someone to visit him that night because 'there was a significant risk'. Meanwhile, the crisis team nurse testified that she had phoned the patient and '...I wasn't aware of any particular risk, but I knew there was some concern. I explained I would come to see how he was

91 See text above which cites: Public services must 'wake up'... op. cit. (n. 79) and Campbell, D, op. cit. (n. 79). According to the latter, the director of the charity Healthwatch England commented that its recent research polled 3,000 people diagnosed with mental illness, and it entirely confirms the findings of the CQC.

and see what support could be offered, and told him he would be assessed the following day.’ Another psychiatric nurse, also from the local crisis team, said that the patient was not seen the next morning since a doctor was not available until the afternoon. The man was phoned at 1pm, and finally visited by someone from the crisis team at 7.45 in the evening - by which time it was too late. The local mental health trust’s management ‘had since raised concerns’ because the patient was not seen at home for 20 hours; a spokesperson said: ‘The delay may have resulted in potential suicide prevention opportunities having been missed.’⁹²

In this chapter we did not intend to substitute an ideology of social determinism for the general belief in psychological determinism. In a democracy, an alienated social formation can only persist as the expression of an unacknowledged but universal neurotic need, and as long as it ministers to it. General neurosis and social formation sustain each other in a feedback loop: the neurosis calls forth the establishment of an allegedly rational social formation to deal with an apparent problem; the existence of the seemingly benign social formation serves to affirm that what everybody feels and imagines is entirely rational; and thereby the neurosis is reinforced. Of course, there are always some who see through the medical model. They are the exceptions to a rule based in social reality: under the condition of alienated social relations, the only sure path to survival (or social success) is to continue to suffer psychological trauma and to respond to it by means of amnesia or conscious repression; this ensures that the trauma is not only unacknowledged but is *unimaginable*.

With regard to the tenacity of the prevailing psychiatric ideology, perhaps the most intractable problem is that it is not simply in terms of a strong commitment to the medical idea, or to his reputation, job security and salary, but in terms of *the vital economy of his emotions* that an official cannot afford to acknowledge the true significance of the stresses and psychological traumas endured by those individuals driven to psychiatric crisis. Were this permitted, *it would immediately revive the official’s own repressed memories of childhood trauma*.⁹³ This might help explain why mental health officials routinely deny the force of emotional and psychological trauma in the genesis and perpetuation of a personal crisis, *even when there is a record of an obviously traumatic event in the patient’s case-notes*. For it is routine throughout psychiatry to say that it might be known that a patient has suffered abuse, neglect, abandonment, loss or some other awful psychological trauma, but this should not be discussed with him or anyone else since at most it is only a precipitating factor to his illness, it only upsets him and encourages the production of his symptoms - and *his real problem is that he has a mental illness*.

The psychiatric medical model serves as a rationalisation that is disinterested in the patient’s humanity. In any decent society, the importance of an event would be measured by the extent to which it troubles, overwhelms and incapacitates the person concerned; and in any realistic appraisal of the available evidence, mental disorder is the result of psychological trauma. In which case, the motive for refusing to broach the subject of the emotional and psychological trauma which lies behind every mental disorder is not to help the patient recover by not upsetting him but *to protect every other interested party, including the psychiatric officials, from becoming inconvenienced or upset*.

By now it should be clear that all the fallacious ideas, irrational psychiatric beliefs and unhelpful practices disclosed and commented on throughout this Volume are the effects, in generally unacknowledged but particularly virulent and injurious forms, of *the fetishism of Official Medicine*.

92 Angear, V (2015) Man died after cutting off hand, says coroner. *North Somerset Times* 10 June. There is no systematic audit of the number of psychiatric patients committing suicide while still supposed to be in care, let alone immediately subsequent to inadequate official action.

93 It may figure as a factor in their psychology that doctors are disproportionately recruited from private schools, or from state schools which emulate them. This means that, rather than the free experience and expression of the emotions, most likely the ruling principles of their schooldays were instrumentality, repression and puritanical ideas about dutiful suffering. During childhood, they may also have experienced higher than average levels of abandonment, bullying or other forms of abuse or emotional neglect.

Chapter 15: CONCLUSION: MEDICAL MYTH & MEDICAL POWER

Mental disease is fictitious disease. Psychiatric diagnosis is disguised disdain. Psychiatric treatment is coercion concealed as care, typically carried out in prisons called 'hospitals'.

Thomas Szasz¹

It is more than fifty years since the psychiatric medical model and its 'common sense' assumptions were thoroughly debunked by various telling and famous critiques, while less publicised research began to reveal the grave organic and psychological ill-effects of routine care and treatment. Further details of the anti-therapeutic nature of the conventional mental health procedures were documented during the following years, including conclusive evidence for the devastating and irreversible physical effects of some widely prescribed psychotropic drugs. However, very few doctors or psychiatric workers have ever acknowledged any of that well-founded argument and evidence, or, of course, significantly changed their practice.

Moreover, officials continue to wield great and almost unaccountable power over anyone unfortunate enough to have been made into a psychiatric patient due to evidence of a serious functional mental disorder. In its present form, psychiatry re-victimises and indelibly stigmatises every patient. Whatever the officials imagine they do, it is clear that the first psychiatric interest is not therapy but containing the distressed individual's deviance so as to keep the social peace. As a result, rather than cure or help people, mental health processes tend to make emotional distress and mental disorder chronic; too often standard treatment causes serious ill health, organ damage and even death; furthermore, the medical model invites emotional, physical and sexual oppression and abuse of the patients.

As a summary, we briefly revisit our argument concerning the misconception of functional mental disorder as a type of illness, and the emotional, psychological, political, economic and ideological reasons for the persistence of this unwarranted belief.

Anti-psychiatry - the classic critique

At the beginning of the book we discussed those logical, conceptual and empirical inconsistencies which combine to undercut any claims for the validity of the medical model of mental illness and treatment. The psychiatric medical model founders on three main counts. First, it commits a category mistake when it misconstrues worrying individual irrationality as illness. By definition, there is no discernible organic cause for any of the functional mental disorders - the so-called mental illnesses; if an organic cause were ever discovered for such a disorder, it would no longer fall within the purview of psychiatry but would be re-categorised as a somatic (neurological) illness, and treated as such. Second, since this is the case, and however much psychiatrists might protest their medical-scientific credentials, it is a fact that, unlike general medicine, psychiatric diagnoses, prognoses and treatments are not based in science; they are notions and rule-of-thumb guesses and rituals that together might *have the appearance* of genuine medical science, but in fact they are based in nothing more substantial than an unreflective 'common sense'. Third, and as a consequence of points one and two, the so-called medical model of mental illness is not a properly formulated scientific hypothesis supported by empirical evidence, and it cannot be made into one; it remains only a powerful but entirely vague wish.

¹ Szasz, TS (2007) Defining psychiatry. *The Freeman* 57 22-23 (July/Aug).

In this first Volume we have offered a detailed critique of the dominant medical ideology, and documented its invidious impact on those forced to endure psychiatric management. Chapters 13 and 14 explored the unspoken assumptions that underpin today's misguided methods of care and treatment; they also discussed key events in the emergence of psychiatry out of general medicine, and suggested likely motives for the tenacity of the widespread misperception of the nature of personal crisis and individual irrationality such that, by mid-20th century, the medical profession was at last able to achieve unchallenged authority in the field.

Psychiatrists gained control of the management of incapacitating emotional distress and mental confusion due to the persuasive weight of the myth which announces that every serious mental disorder is a kind of illness, and that the processes of psychiatric diagnosis, prognosis and treatment are scientific. This confirms one of Nietzsche's perceptions:

Madness is something rare in individuals - but in groups, parties, peoples, ages, it is the rule.²

Since the psychiatrists have never answered any criticisms, let alone changed their methods in response to reasonable arguments or the research evidence, it also seems clear enough that, as we mentioned:

Power tends to corrupt, and absolute power corrupts absolutely...³

In modern societies, psychiatrists have almost unaccountable powers to determine the treatment of their patients. With no risk of facing any effective opposition, the law permits them to satisfy the neurotic wish for every apparent mental, emotional or behavioural disorder not to be a personal or social problem but rather a curious type of illness that has no demonstrable cause and no organic signs - a mental illness. Due to the satisfactory fulfilment of the role of sequestering more extreme emotional and mental deviance, by the beginning of the 20th century the psychiatric profession was regarded with sufficient respect as to be able to convert its wishes and delusions into a crucial 'discovery' which it maintained was the product of medical science. The consensus was perfectly willing not to question the psychiatrists when they exchanged their scientific integrity - which is to say, the truth - for increased reputation and power. As we have seen, the invention of the disease of schizophrenia was a deliberate deceit;⁴ it was also vital to the establishment of that 'medical' ideology which warrants the legal powers of the modern psychiatrist with respect to anyone he may plausibly 'diagnose' as 'having a mental illness'. A psychiatrist is able both to accuse someone of having a mental illness and pass down a sentence of detention and treatment; indeed, this is what the public expects of him. This extraordinary conflation of the roles of prosecutor and judge depends for its legitimisation on the so-called medical model of mental illness and treatment: it is because of the myth of mental illness and the myth of the efficacy of their medicine that psychiatrists are left to their own unaccountable devices. This confirms the perception of a notorious ideologue:

The broad masses of a nation...will more easily fall victim to a big lie than to a small one.⁵

We should not be surprised that the psychiatric profession easily persuaded the public that every form of emotional distress or mental or behavioural disorder is a kind of illness. Myth does not lose its grip in an age supposedly governed by Science and Reason; it is most likely simply to change its terms into those which *appear* rational and scientific. Ignorance and credulity continue to pervade every corner of life, and the more vulnerable or insecure the public, the more willing it is to bow before any unaccountable Authority which advertises itself as 'objective' and 'scientific', and seems able to provide a ready solution for pressing personal or interpersonal problems.

If anyone doubts this could be so, we point out that it is clear that it is by no means only manifestly *political* ideologies or deceptions which have significant social effects. Ignorance begets wishful thinking and myth, and in every generation and through many institutions this gives rise to

2 Nietzsche, F (1886/1973) *Beyond Good and Evil* (Trans Hollingdale, RJ) Harmondsworth: Penguin, 85.

3 Dalberg-Acton, JEE op. cit. (n. 81, Ch 14).

4 See the section in Chapter 14: The invention of schizophrenia.

5 Hitler, A (1936/39) *Mein Kampf*. London: Hurst & Blackett, I. x.

harmful practices: every kind of social organisation has its political aspect, which is rationalised by ideology.

For example, on pain of excommunication and consignment to Hell, every Catholic is obliged to affirm the dogmas of Immaculate Conception and Papal Infallibility. The edicts which established these dogmas are not ancient or even medieval. The Virgin Birth was pronounced a closed question in 1854. The idea is of course absurd, but it serves the regressive wish for Jesus to be supernatural (to be God-the-Son) and his mother 'pure'. This dogma also works deeper and more sinister purposes: when democratic forces threaten patriarchy, it heightens anxieties and divisions by institutionalising hatred of sexuality, of women, and generally of freedom and equality. As recently as 1870, under the same reactionary pope (Pious IX), the First Vatican Council promulgated the doctrine of Papal Infallibility. This was a masterstroke: nothing that any pope may wish to decree is any longer open to question. During the 20th century, the consequences of this meta-dogma have proved as oppressive and murderous as the work of any political dictatorship. As one example, misogyny intensifies: conflict is caused between men and women when the Church's reactionary strictures on contraception are coupled with the notion of papal infallibility; more than this, million upon million of the world's poorest women are consigned to pain, drudgery and premature aging from excessive child-bearing, untold numbers die in childbirth, and millions more suffer or die from clandestine abortions.⁶ It is therefore clear that in modern times the urge to believe a myth announced by an authority still has the power to outweigh any amount of evidence provided by science, logic or plain fellow-feeling.

Regarding the myth which underpins psychiatry, the error is to reify or conceive as 'a thing' - an illness - what in reality is the emergent life of a person who suffers emotionally and psychologically from certain oppressions. When a doctor diagnoses a neurosis or psychosis, he does not somehow (presumably by means of his medical expertise) discern *something else* - an organic anomaly, a real illness. Rather, the symptoms *constitute* the disorder: the mental disorder is not anything other than the contingent, transitory or habitual composition of the person's feelings, beliefs and behaviour. Just because today someone manifests signs of abnormal ideation and behaviour, that does not mean that he *must* and *will* manifest those 'symptoms' tomorrow *because he has a disease* called depression, schizophrenia, bi-polar, OCD (or whatever). At the moment, he may be overwrought, confused or deluded, agitated or apathetic; this does not mean that he cannot, under more helpful and encouraging circumstances, find a steadier, more rational and less miserable personal disposition.

With an individual who is psychotic, the urgent feeling that (for example) 'My mother is poisonous' becomes the absolute and literal conviction that 'My mother is poisoning me'. When they assert the truth of the medical model, psychiatric professionals commit precisely the same logical or conceptual mistake as all the psychotics who become their patients. This is the error of *misplaced concreteness*, which is to say, they take the metaphor for reality. No doubt, mistaking metaphor for reality is encouraged by the fact that the so-said mental illnesses are troubling emotional and mental conditions which in some ways may seem *rather like* illnesses. With regard to any question at all, however, there is *very often* a difference between appearance and reality, and the purpose of science or analysis is precisely to make that discrimination. To believe that all of the many categories of psychiatric diagnosis refer to the many discrete mental diseases which happen to have been regularly discovered during the last hundred years is simply to take metaphorical illnesses for actual illnesses; moreover, these are alleged illnesses for which, mysteriously, there are no organic traces and stubbornly elusive organic causes. In psychiatry, this conceptual error is elevated into a convincing conceit which also rationalises pessimistic (and unevidenced) self-fulfilling prophecies that take on all the authority of genuine medical prognoses. No matter how well-intentioned the medical experts, insisting on the undoubted veracity of every diagnosis of a mental illness is an exercise in ideological

⁶ Vatican I did not say that every papal pronouncement would be infallible, only those specifically said to be; however, it is doubtful that most Catholics recognise this theological nicety. As another example of the reactionary political effects of religious autocracy claiming infallibility, we might mention the apparent connivance of Pope Pius XII with fascism, Nazism and the Jewish holocaust.

persuasion which does not help vulnerable people recover their emotional and intellectual balance so much as add to their confusion and distress.

These matters were thoroughly clarified during the 1960s by a number of critics of the false assumptions, poor theory and routinely unhelpful and abusive practices of psychiatry. The arguments at that time may be summarised as follows:

Psychiatry is a type of social control in which certain kinds of individual irrationality are called 'illness' - 'mental illness' - and when they become a serious nuisance they are most often worked on medically and under duress. Intimidation, incarceration and involuntary treatment of people regarded as mentally ill infringes their human rights.⁷ It is not insanity that creates the need for psychiatric treatment and mental hospitals, but rather the institution of psychiatry creates the need to perceive anyone in the throes of an acute or chronic emotional or psychological crisis as 'ill'. The diagnostic categories of psychiatry are not the products of a neutral and objective medical science; rather, they express a set of dominant values disguised as scientific absolutes regarding health and disease. The employment of psychiatry's pseudo-medical categories tends to stigmatise and blight the lives of those to whom they are ascribed: the career organised for the patient is an exercise in his forcible subjugation and degradation. And whereas it has not been demonstrated that the various medical treatments for mental disorder offer any clear benefits to those they are supposed to help, it is certain that electroshock and many drugs deplete the patient's energies and resources, punish him or (as placebo) beguile him; and apart from this, too often they wreak serious and often irreversible organic harm. There is no evidential basis to the notion of mental illness, nor for the idea that those suffering from overwhelming emotional distress or mental disorder are best served by medical treatment. On the other hand, the assumptions, assertions and rituals of the official mental health response combine to provide a convenient ideological defence of the status quo: together they pre-empt criticism of the social relations, thereby denying any role to the oppressions that actually push vulnerable individuals into psychological crisis.

The psychiatrists do not answer these criticisms. This is because they cannot: logic and science are not on their side.

- First in an article and then in his book, *The Myth of Mental Illness*, the psychiatrist Thomas Szasz highlights fundamental errors in conceptualisation which grievously skew the organised response to all those emotional and mental crises which are in fact triggered by contentious problems of living.⁸ Szasz observes that a mental state may be disordered, disturbed or disturbing, but only brains, not mental states, may legitimately be described as diseased or ill. Hence, although there are discernible diseases correlating to some instances of undesirable mental states (and very likely causing them), and so we may usefully talk of 'organic mental disorders' (actual brain diseases), it is simply untrue and confusing to say that the great residue of undesirable mental states and irrational behaviours are signs of mental illness. With respect to the functional mental disorders, the great majority of the psychiatric caseload, 'illness' is simply not an appropriate appellation. The myth of mental illness is profoundly flawed, subjective, misguided, and politically motivated. And yet it is the false assumption which underpins orthodox psychiatry, an enterprise which claims that it is scientific, medical, objective and politically neutral.

Szasz points out that the notion of illness is always normative: it depends on the ethical value of healthy organic structural and functional integrity. This question of normative evaluation is unanswerable with regard to so-said mental health - such judgements can only ever be matters of opinion. Health, normality or deviation may only be asserted about a mental state in terms of a theory of psychology, society, ethics or law. When anyone employs the term 'mental illness', it is an attempt to identify and then rectify psychosocial, ethical or legal deviation, and in what is assumed and purported to be an ethically neutral, objective and technical manner. Yet it is absurd to expect to

7 Against the backstop of the possibility of coercion, when a person accepts psychiatric treatment voluntarily this is generally a formality and something of a sham. We discuss this issue in Chapter 28 (Volume 2).

8 See Szasz, TS, op. cit. (ns. 1 and 12, Ch 3).

solve problems with medicine when their very existence is recognised on strictly non-medical grounds. A person may seem to be morally or cognitively deviant - and perhaps he also has preoccupying and apparently intractable problems of living - but by definition, whenever he is diagnosed as 'having' this or that 'mental illness' *there is no discernible organic pathology*. And if there are no such things as mental illnesses, it follows that whatever the perceived or believed effects, in itself psychiatric medicine is unable to remedy incapacitating psychological or emotional distress. Inasmuch as the concept of mental illness underpins the legal pressing of so-said medical-scientific attentions on that majority of psychiatric patients who suffer from a functional mental disorder, very often against their will, diagnosis is in those cases a moral and political evaluation, a covert form of domination with only false claims to medical disinterest and objectivity. The deceit of psychiatric diagnosis is an abuse of the human rights of most psychiatric patients.

There is no evidence to justify the implication or bald avowal that what are known as the functional mental illnesses are as real and objective as bodily diseases. That contention

...is actually a kind of psychiatric propaganda; the aim is to create in the popular mind a confident belief that mental illness is some sort of disease entity, like an infection or a malignancy. If this were true, one could *catch* or *get* a mental illness, one might *have* or *harbor* it, one might *transmit* it to others, and finally one could *get rid* of it. Not only is there not a shred of evidence to support this idea, but, on the contrary, all the evidence is the other way and supports the view that what people now call mental illnesses are, for the most part, *communications* expressing unacceptable ideas, often framed in an unusual idiom.

...[W]hereas the term 'bodily illness' refers to physico-chemical occurrences that are not affected by being made public, the term 'mental illness' refers to psycho-social events that are crucially affected by being made public.⁹

It prejudices justice to fail to recognise that a psychiatrist is *not* a detached, neutral observer of an organic event susceptible to medical remedy, but always and inevitably a partisan judge of his patient, and one who is concerned primarily and essentially with conflicts about goals and values. People used to believe in witchcraft and possession by demons. Nowadays there is widespread belief in the myth of mental illness, and people fear and make scapegoats of psychiatric patients. The myth of mental illness is a socially tranquillising, symbolic-magical and ideological construct which most people take for granted as medical-scientific truth. This myth conveniently deflects attention away from pressing problems of living for which no-one wishes to take responsibility.

- The sociological research of Erving Goffman complements Szasz's critique. At the same time as Szasz, and equally influential, Goffman describes how the institutional arrangements of psychiatry condition the beliefs, attitudes and behaviour of both the patients and the staff.¹⁰ He indicates a number of strange attributes of psychiatric medicine which need to be interrogated if we are ever properly to understand mental disorder and its remedy. He observes that, with respect to the vast majority of psychiatric cases, the medical justification masks and denies the essential custodial function: that, unlike a normal medical response, the patient is governed involuntarily and hence tends to be alienated from his ostensible helpers; that psychiatric attention is not like any other sort of medical help since it is shameful and stigmatising and has repercussions throughout the person's social life; that in no other type of medicine is anything and everything that the patient may say and do - but nothing specifically - of vital interest to the officials; and that, correspondingly, the psychiatrist has a diffuse, arbitrary and absolute prescriptive mandate over the patient's entire life; that psychiatric diagnosis is said to be medical, and yet much of the treatment - such as general life

9 Szasz, TS, in Brown, P, op. cit. (n. 28, Ch 3), 17 and 18.

10 Goffman, E, op. cit. (n. 28, Ch 3). For a key extract, see Brown, P, op. cit. (n. 28, Ch 3), 25-45.

on a ward - is not medical;¹¹ and that psychiatric diagnosis is not a genuine medical procedure - by definition *there are no physiological tests* for the functional mental illnesses.

This is not all. These days a structured interview technique is employed, and no doubt it is quite useful as a standardised method for assessing risk and need for care. Nevertheless, the first object of the interview is to decide exactly which mental illness the patient is supposed to exhibit: never mind how little or how deficient the doctor's knowledge of him, the psychiatric interrogation is primarily to yield information so as to fix the patient with a diagnostic label; in turn, this will indicate the recommended (allegedly medical-scientific) care and treatment. In general medicine, therapy is normally a physical or chemical technique which can quite predictably alter specific measurable balances within the body. By contrast, successful treatment for a mental illness is not indicated by any organic signs: someone diagnosed with a functional mental illness is deemed cured *only when he convinces his psychiatrist that he has learned to alter the way he relates to his world*. Also, the ability to persuade a patient to change his mind - from irrational to rational - is not in fact a technical skill only commanded by an expert such as a doctor who, anyway, has far less contact with the patient than ward staff or community nurses. Besides, the conduct or misconduct of a psychiatric patient only illustrates his response to his current situation and nothing necessarily about how he would or could act under different circumstances, such as back at home in the old conditions, or perhaps under improved conditions, or elsewhere, in quite different conditions.

Szasz and Goffman both note another remarkable quality of psychiatric treatment: it does not address specific and known causes with technical means, in the way that general medicine treats physical illness. Rather than finding indications, it applies medication broadly so as to learn about contra-indications: i.e., the patient is medicated and then observed for his subsequent behaviour. In practice, of course, after the initial diagnosis it is not often a doctor but whichever responsible member of staff has seniority or a strong opinion about the matter who usually plays the biggest part in judging the state of the mental health of the patient, and in deciding his fate - his treatment and care. (Nowadays, it is often that member of an interdisciplinary team who is officially the patient's 'key worker', and who is not necessarily even a psychiatric nurse.) This is medically bizarre: society is normally careful to have real (organic) health determined only by a fully-trained doctor. In general medicine, moreover, it would be considered absurd to try to remedy an illness by means of persuasion, threats or rewards and punishments, such as loss of privileges or increases in medication. This may seem a strange way to view therapy (and especially medication), but it is how some psychiatric officials and many psychiatric patients see it. (During the latter part of the 20th century, in response to Behaviourist psychological theory, a privileges-based, 'punishment-and-rewards' policy for the therapy of recalcitrant patients was introduced in many psychiatric facilities.) Furthermore, since he is removed from the situation in which he first showed signs of mental deviance, the hospital or clinic cannot be the place in which to determine the patient's malady. And yet, having failed to assess the full conditions for the patient's deviance, the doctor normally sends him back to the very environment which called forth his aberrant ideas and behaviour in the first place.

Applying diagnostic categories of pathology to ideas or behaviour deemed 'inappropriate' constitutes an irremediably value-laden and ethnocentric form of assessment. A psychiatrist persuades himself (and everyone else) that he is primarily a medical technician, but in fact he is a quasi-judicial functionary who defines a certain type of person as non-responsible and hence, 'for his own good' (and perhaps for the public's safety) to be restrained, subjected to invasive procedures, and persuaded or forced to change his beliefs and conduct.

Neither Goffman nor Szasz argue that there should not be intervention in certain kinds of personal crisis, but only that this kind of policing and judging should not masquerade as medicine. Obviously, sometimes action has to be taken, but doing entirely the wrong thing and lying about it hardly helps anyone who is made into a psychiatric patient. Both critics agree that the key element in defining a

11 Although nowadays psychiatrists are probably less interested in the therapeutic benefits of human association, and might argue that drugging and observation together constitute the medical treatment.

person as mentally ill, rather than simply deviant or in conflict with others, is the feeling that it is impossible to communicate with him. Then how could it help matters to lie to him?¹² When psychiatry is called upon, it strives to maintain a front of neutral technical efficacy yet constantly runs up against the fact that someone is made into a psychiatric patient because he offends witnesses, and it is everybody's belief that offenders should be sanctioned and corrected. Psychiatry tries to reconcile two opposing views: when motivated members of the public are likely to see only misbehaviour, it sees pathology and tries to practice ethical neutrality; and yet the psychiatric pretence of technical neutrality is constantly undermined by moral exhortation to the patients.

Goffman's work goes on to show that since he has to submit to its absolute and unaccountable power, the person in crisis and subjected to psychiatry is inevitably coerced into adopting the stereotyped responses, the role and identity of 'psychiatric patient'. The candidate is made to embark on a standardised psychiatric 'career' by means of rituals which, as the normal psychiatric procedures and expectations, in effect degrade him while purporting only to assess him in order to care for him. (We witnessed this process in Chapter 4, above.) Once he is delivered up to the power of psychiatry, anything that the patient does or says is open to interpretation as a symptom of his alleged illness. The only certain way to escape the clutches of psychiatric power is to be docile and play the role expected of someone who has a mental illness but is gradually getting better. Even then, depending as he does on the whim of the officials, the psychiatric patient needs good luck.¹³

- A large part of Goffman's research provides evidence to confirm a sociological axiom proposed nearly a century ago by IM and DS Thomas: 'If men define situations as real, they are real in their consequences.'¹⁴ In other words, a consensus about the nature of any part of social reality determines consequent institutional arrangements, individuals' behaviours, and senses of their own and others' motives and identities. In the light of this perception, others explored further consequences of the attribution of a mental illness.

- It is common for mental health officials to maintain that a patient's mental deviance is the result of a brain deficit or a chemical imbalance due to some innate biological difference. As we have seen, there is no evidence for this. On the other hand, with 'labelling theory', the criminologist EM Lemert points out that deviance does not inhere intrinsically in certain kinds of behaviour but only in those instances specifically *defined* or *labelled* as deviant: not *every* behaviour which violates a social rule is recognised as particularly deviant, but if a social group wishes to submit it definitively to control, *any* behaviour may be defined as deviant. It therefore depends on the response of powerful others whether someone's behaviour is considered 'normal', 'harmless eccentricity', 'momentary and excusable aberration', or 'so offensive or dangerous as to require sanction'. More than this, there are significant but generally unanticipated and unrecognised social, emotional, cognitive and behavioural consequences when someone is defined as *intrinsically* deviant. Labelling often *produces* or *amplifies* deviance. Someone said to be deviant by nature often responds by coming to accept that definition as constituting an essential part of his identity: rather than resist a powerful consensus, it is often much easier to take on the role of deviant, and become 'locked into' it. Others picked up on Lemert's

12 Szasz, TS (1958) Politics and mental health. *American Journal of Psychiatry* CXV 509.

13 For example, rates of diagnosis and types and amounts of treatment vary significantly between NHS regions, or even between hospitals in the same area. Again, there are now always cost-cutting political directives to 'free up beds'; this creates pressure to find higher rates of recovery. However, in the 1980s general unemployment was high in the UK, and a post at a Special Hospital could be attractive due to the good pay and job security. When there was talk of reforming those institutions, it was rumoured that amongst the specialist workforce there was no motive to view any patient as 'improving' or 'ready for release'; on the contrary, there was a great interest in keeping the facilities full of patients (inmates), thereby protecting the officials' jobs.

14 Thomas, WI & Thomas DS (1928) *The Child in America: Behavior problems and programs*. New York: Knopf, 571-572.

argument and examined interesting implications of 'The Thomas Theorem' with regard to any kind of deviancy; these included critics of psychiatry.¹⁵

The idea that someone is known as a deviant not necessarily due to his behaviour but *always* as a result of social imputations and social control obviously has profound implications for the conception and practice of psychiatry. As we have seen, in cases of so-said mental illness there is no evidence for any disease. The ascription of 'mental illness' to certain instances of deviance - at the point of the medical diagnosis - is therefore a necessary step in everybody *misperceiving* distressed and confused individuals as 'ill' rather than being in the midst of an emotional and mental crisis which might run its course or be remedied by non-medical means. We have also seen that when a mental illness is imputed to someone - when he is assigned a mental health diagnosis - there is even no need for any evidence of mental disorder: if any two psychiatrists say that a person is mentally ill then, for all practical intents and purposes, he is.¹⁶ Added to which, the person so defined might easily believe the psychiatrists - after all, everybody else does - or, driven by one or more of a variety of other possible motives, he may take on the role and act it out.

'Labelling theory' teases out the implications of prejudice, and these can as well apply to colour (race), sexual orientation, age or class discriminations as to behavioural deviance (crime or mental disorder). When it actuates a significant social response, in terms of expectations, a moral scheme and an organisation to combat the perceived problem - which it often does - prejudice easily becomes a self-fulfilling attribution. Officially defining someone's undesirable emotional or psychological state as exceptionally problematic because it is the result of an illness (a mental illness) is bound to influence everyone's beliefs, perceptions and behaviour. For example, it is likely to magnify feelings of insecurity, emotional distress and mental turmoil that the person already experiences; it does this by stigmatising him, by highlighting and perhaps amplifying his unwanted idiosyncrasies, and by encouraging him and everyone else to believe that he is *essentially*, i.e., *irremediably* defective.

- During the 1960s some sociologists became interested in the multitude of unspoken assumptions which underpin normal everyday social interactions, such as implicit rules for inter-personal distance, posture, eye-movements and eye-contact, tones and levels of voice, and permissible topics of conversation. Disruption of any of the rules for intimate association tends to generate anxiety amongst even the most level-headed. Thomas Scheff discusses this in relation to the idea of mental illness:

There is a social, cultural and interpersonal status quo whose existence is felt only when abrogated. Since violations occur infrequently, and since the culture provides no very adequate vocabulary for talking about either the presence or abuse of its invisible understandings, such disruptions are considered disturbing. The [person's] loyalty to his culture's unstated conventions is unthinking but extremely intense.

The concept of illness and its associated vocabulary - symptoms, therapies, patients and physicians - reify and legitimate the prevailing public order at the expense of other possible worlds. The medical model of disease refers to culture-free processes that are independent of the public order... Most of the 'symptoms' of mental illness, however, are of an entirely different nature. Far from being culture-free, such 'symptoms' are themselves offences against implicit understandings of particular cultures... For the convenience of the society, offences against the [countless unnamed understandings] are usually lumped together in a miscellaneous, catchall category. If people reacting to an offence exhaust the conventional categories that might define it (e.g., theft, prostitution, drunkenness, momentary lapse, 'a black-out', etc.), yet are certain an offence has been committed, they may resort to this residual category. In earlier societies the residual

15 See Lemert EM (1951) *Social Pathology: A systematic approach to the study of sociopathic behaviour*. New York: McGraw Hill. Lemert introduced labelling theory; it was particularly developed by Becker, HS (1963) *Outsiders: studies in the sociology of deviance*. New York: Free Press.

16 See text to footnote 13, in Chapter 4, above.

category was witchcraft, spirit possession or possession by the devil; today it is mental illness. The symptoms of mental illness are, therefore, violations of residual rules.¹⁷

No organic basis has been found for the functional mental illnesses.

It is quite possible, therefore, that many psychiatrists' and other mental health workers' 'absolute certainty' about the cause, site, course, symptoms, and treatment of mental illness represents an ideological reflex, a spirited defence of the present social order.¹⁸

That mental illness only exists in the eyes of the beholder, that it is *essentially* a label attached by powerful others to a rule-breaker who, in his distress, exhibits behaviour considered emotionally excessive or mentally strange, harmful and 'ill', is indicated by the plausible example of

...a woman who neglects her children, has sexual relationships with men other than her husband, becomes angry and violent, or consumes large amounts of alcohol... [She] is at risk of being labelled mad. She is categorised for not playing her designated social role. A man is not in danger of diagnosis of madness for those very same behaviours, which are seen as a part of the accepted male role.¹⁹

This example is not far-fetched. Until the Second World War, unmarried mothers in the UK often had their new-born babies forcibly taken from them, and were consigned indefinitely to mental hospitals and mental handicap hospitals by the diagnoses 'moral turpitude' or 'mental defectiveness'. Some were still held in psychiatric facilities in the 1980s. No action was ever taken against the irresponsible impregnators, who presumably were considered morally and mentally normal.

Scheff is particularly interested in the offence against public order known as schizophrenia. At least diagnostic categories such as mania, obsession and depression have a clear enough vernacular sense, but schizophrenia is psychiatry's vaguest and least clearly defined category: 'Schizophrenia...is a broad gloss'. The broadly defined symptoms have no clear relationship to each other²⁰ and are best understood as offences against implicit social understandings about appropriate emotional expression.

The appropriateness of emotional expression is, after all, a cultural judgement. Grief is deemed appropriate in our society at a funeral, but not at a party. In other societies, however, such judgements of propriety may be reversed... Behaviour deemed bizarre in one culture is deemed tolerable or even necessary in another.²¹

What constitutes meaningful ideation and behaviour as against irrationality often varies quite significantly between societies, and between groups within a society; so does what constitutes proper social involvement and improper withdrawal. In Scheff's opinion,

The broadness and vagueness of the concept of schizophrenia suggest that it may serve as *the residue of residues*.²²

That 'mental illness is a label attributed to persons who break residual rules' is a proposition diametrically opposed to the medical model. Still, it is supported by a series of hypotheses which, on the face of it, seem entirely reasonable. 'Residual rule-breaking' may arise from diverse sources - organic, psychological, situations of stress, acts of innovation, or wilful defiance. Relative to the rate of diagnosed and treated mental illness, the rate of unrecorded residual rule-breaking is probably high. In other words, those caught and treated for mental illness are often unlucky enough to break the rules at the wrong time and before the wrong witnesses. There is also no doubt that *most* instances of residual rule-breaking are normalised by ignoring or rationalising them, e.g., by saying 'He's tired and over-wrought'; or they are indeed only transitorily significant - the person's mania abates when he gets a good night's sleep. Stereotyped images of mental disorder are learned in childhood, and stereotypes of insanity are continuously but inadvertently re-affirmed in everyday social interaction.

17 Scheff, TJ (1970) Schizophrenia as ideology. *Schizophrenia Bulletin* 2 15-19. Reprinted in Brown, P, op. cit. (n. 28, Ch 3), 46-59; the quotations are from 47 and 49-50.

18 Scheff, TJ, op. cit. (n. 17), 50-51.

19 Ussher, J (1991) *Women's Madness: Misogyny or mental illness?* Harlow: Harvester Wheatsheaf, 135.

20 We discussed the symptoms of schizophrenia in Chapter 12, above.

21 Scheff, TJ, op. cit. (n. 17), 51-52.

22 Scheff, TJ, op. cit. (n. 17), 52.

Those labelled deviant are often rewarded for playing a stereotypical deviant role, but often punished when they attempt to return to a conventional role. A person who breaks residual social rules because he is in the throes of a personal crisis may well be highly suggestible and quite readily accept the label of 'being mentally ill'. Amongst residual rule-breakers, labelling is the single most important cause of careers of residual deviance, which society calls 'having a mental illness'.²³

In *most* cases, rule-breaking runs its course, is compensated or allowed for, or is channelled into a socially acceptable form. However, when someone who breaks a residual rule is labelled, i.e., diagnosed by a doctor - which is to say, *officially stigmatised as intrinsically different as well as deviant* - he is launched onto the *career* of 'someone-who-has-a-mental-illness'. Thus, whether or not a mental disorder becomes chronic - as 'a mental illness' - depends critically on aspects of the situation not necessarily internal but very often external to the deviant; these include his visibility, the tolerance of those around him, the availability of alternatives to psychiatric labelling, and the person's power in relation to those who might stigmatise, restrain and force treatment on him.

We have already discussed the controversial invention, definition, use, reliability and research of the diagnostic category 'schizophrenia'; we noted its entirely unproven status as a disease.²⁴ 'Schizophrenia' is a label attached to those residual rule-breakers whose behaviour is otherwise hard to classify. Most social change occurs through the gradual erosion of custom and questioning of local power, yet even the slightest deviations from implicit cultural expectations stir deep anxieties in those whose own emotional insecurity commits them unreservedly to the status quo. This is why so much emotional heat is generated around the concept of schizophrenia, and why so much is vested in the wish for it to be an actual disease. And yet the social order is, in fact, largely arbitrary; it is certainly not based in self-evidential justice. This impels conformists who feel threatened to look to extra-social sources for their legitimacy. The Church used to provide that kind of comfort, but nowadays most people look to Science to deliver absolute certainty.

To the extent that medical science lends its name to the labelling of non-conformity as mental illness, it gives legitimacy to the status quo.²⁵

With Scheff, we find that anyone caught and labelled schizophrenic is indeed, in his own manner, creative and innovative - but also too upsetting to those around him. In turn, his significant others cannot abide uncertainty, difference, and the challenge to their power and their definition of what is and what is not real. These influential witnesses welcome the psychiatrist's diagnosis of the deviant as 'having a mental illness', especially since official invalidation of the person in crisis simultaneously validates the point of view of the conformists (the powerful), and thereby allays *their own* anxieties. Psychiatric researchers might respond that they are not at all concerned with preserving the status quo but only in scientific questions about the causes of mental illness. Bearing in mind that 'mental illness' is not a scientific concept but only has mythical status, that is as absurd as saying that the researchers would be neutral and scientifically objective if they were to investigate the biochemical, genetic or viral causes of witchcraft.

- In the UK, the most prominent critics of orthodox notions of mental disorder and its appropriate treatment were the psychiatrists RD Laing and David Cooper. They were celebrated (or vilified) as the leaders of anti-psychiatry.²⁶ By the end of the 1950s, Laing was at the psychoanalytically-oriented Tavistock Institute and Cooper was director of Villa 21, an experimental therapeutic unit for young schizophrenics. Laing, in particular, became famous with the publication of his studies of

23 Scheff, TJ, op. cit. (n. 17), 54. The evidence supporting these hypotheses is reviewed in Scheff, TJ (1966) *Being Mentally Ill: A sociological theory*. Chicago: Aldine.

24 Especially in Chapters 12 and 14, above.

25 Scheff, TJ, op. cit. (n. 17), 58.

26 The term was coined by David Cooper. See Cooper, D, op. cit. (n. 89, Ch 12). Although their views were similar for years, Laing denied ever being anti-psychiatry. Cooper called himself 'an existentialist-Marxist', and came to believe that madness is a product of social oppressions only really to be remedied by a social revolution. Disagreeing with what he thought was its growing interest in spiritualism rather than politics, Cooper left the Philadelphia Association in 1971.

schizophrenic young women, beginning with *The Divided Self*.²⁷ In order to provide a facility run along the lines of their ideas of permissive therapeutic community, in 1965 Laing, Cooper and others established the Philadelphia Association, with premises at Kingsley Hall in the East End of London.

Laing and Cooper were not averse to using the word 'madness'. In fact, they insisted it was a mad (irrational) society - and particularly a certain type of oppressive family structure - which lay behind the genesis of psychosis. It seemed to them that the utterances and attitudes of the person who presents with a psychosis, although immediately bizarre and enigmatic to most witnesses, are in fact allegoric representations of his or her lived experience; they are not the absolutely absurd, random and inconsequential symptoms of an underlying, essentially medical disorder. Psychotic beliefs and behaviours constitute a kind of personal symbolism which may only be rendered intelligible by reference to the individual's unique and peculiarly oppressive biography; it is possible to understand the apparently confused speech and behaviour as the attempt to communicate worries and concerns, but in situations where the vulnerable person feels or is justifiably aware that this is either impossible due to others' inability to comprehend or is resolutely denied or prohibited by the person's most significant others. Generally, someone who succumbs to a psychotic episode is forced to live through psychologically traumatic events, and is unable to conform to others' conflicting expectations: when he is a dependent, the 'lose-lose situations' which he regularly encounters in his daily life finally overwhelm him with mental turmoil and emotional distress, to which he responds with desparately aberrant beliefs, speech and behaviour.

The perceived symptoms of schizophrenia are therefore to be interpreted as expressions of profound emotional distress, issuing in a crisis of identity. In addition, it is a further and heinous oppression to attempt to suppress the expression of these symptoms by incarceration and forcible drugging or shock treatment. A psychosis is potentially cathartic, and it must surely be an essential moment in that particular individual's personal growth or transformation; as such, the symptoms have a definite and important therapeutic value. By implication, any other kind of functional mental disorder is also a form of personal misery and confusion which nevertheless, if it can be accepted as such and lived through - if it can be expressed, faced and comprehended - holds the potential for cartharsis and for the individual's recovery as a changed, less miserable, less confused, more enlightened and more autonomous person.²⁸

- In 1961, the neurologist and psychiatrist Franco Basaglia was made director of a big state psychiatric hospital in Italy. He found horrific conditions when he arrived: inside the locked wards, rigid schedules were run for the benefit of the attendants rather than the patients (e.g., ridiculously early bedtimes), patients were tied to their beds and left to lie naked in their own excrement, etc. Instead of therapy, there was physical abuse, isolation, the straitjacket, ice-packs, bed-ties, ECT and insulin-coma shock - all intended to punish refractory patients and terrorise and subdue the others.

Basaglia was aware that conditions were not always quite so bad elsewhere, but it seems to him that every society is happy to have psychiatry medicalise serious personal or social problems, thereby further oppressing the distressed in the name of cure. He also agrees with Goffman (and progressive psychiatrists in a line all the way back to the days of 'moral management') that much of the stereotypical mad behaviour found in asylums is a consequence of the conditions in the institution: many of the characteristics of the patients, thought to be inherent to mental illness - such as schizophrenic 'word salad', vacant staring and obsessive behaviours - disappear when patients leave the asylum. In which case, until both staff and patients are freed from the beliefs, attitudes and culture of the asylum, no-one will know the true nature of any mental disorder, or exactly how it may limit the individual who suffers from it. Basaglia also feels that without closing down the mental hospitals, professionals would unwittingly reconstitute the same oppressive atmosphere in community facilities: as long as confinement is still possible, the officials will continue to regard themselves as ultimately

27 Laing, RD, op. cit. (n. 11, Ch 9).

28 The ideas of Laing and Cooper are explored in more detail in Volume 2, especially in Chapters 19 and 20.

responsible, and patients will continue to view their own agency and liberty as dependent on the wishes of the officials.

Basaglia argues that psychiatry is only a particularly overt example of pervasive, unequal and oppressive power relationships. In every institution - from family to school, factory, office or hospital - there are those who hold power and those subjected to it, and this leads to the exclusion and humiliation of the powerless. Normal social arrangements breed mental illness by forcing the unwary to incorporate and submit to the very enemy who destroys them. This is achieved by means of the lies and violence which pervades the entire oppressive fabric of the institutions of modern societies. Psychiatric confinement is an extreme example, but it seems to Basaglia that people can be so habituated to domination that they forget how to live autonomously, and if then given their freedom they find they have lost the capacity to do so. Unless people struggle against oppression they lose hope of regaining any human dignity.

In Basaglia's view, the main function of psychiatry is to remove from view society's rejects and failures so that nobody has to confront the injustices and inequities which give rise to that kind of deviance. Doctors, nurses, psychologists, social workers and sociologists are crucial administrators of the violence of the established power structure: together, they systematically medicalise personal and social problems, soothe conflicts, break down resistance, cobble-up temporary solutions to crises, and generally convince people to accommodate themselves to oppression. Therapists are no more than technicians who buttress the very power that excludes them, too, albeit with less dire consequences than those experienced by the psychiatric patients.

Basaglia wished to radically change the treatment of mental patients by 'de-psychiatrising' the way they are managed. He refused to accept that the patients in the institution were irretrievably sick, or his role as paternalistic custodian; he felt that the inmates were ill because they had been deprived of their human rights and excluded and abandoned by civil society. As far as he could see, the degree to which any patient was dehumanised was not a symptom of his illness but rather a consequence of the brutality and humiliation that institutional life imposed on him: as a victim of the same power imbalance that had made him a social reject in normal daily life, he was revictimised when made into a mental patient.

The way forward is to change the institution and change the awareness of every participant to the psychiatric project, both inside and outside the hospitals. To these ends, Basaglia unlocked the wards, dispensed with uniforms for staff and patients, and opened the gates and doors and invited anybody in. Diagnostic distinctions were ignored, and inmates and staff were encouraged to relate to each other as human beings rather than disease-types and officials. Traditional kinds of therapy were replaced by group meetings with no overt therapeutic purpose; these ranged from intimate gatherings to meetings of the whole community. Patients were encouraged to participate in planning and decision-making, and staff and patients were invited to focus together on 'consciousness raising' - making everyone aware of the patients' oppression inside and outside the hospital. This was similar to the idea of therapeutic community proposed by Maxwell Jones in the UK, but Basaglia's novelty was to make *political* awareness a central issue. He wanted people to realise that someone with a mental disorder is the object of social violence: as a person who lacks social or economic power, he is seen as a failure by a society that seeks to remove its contradictions from the public gaze, and so he is subjected to the violence of being forcibly removed and excluded from normal social contacts.

It seemed to Basaglia that therapy could only work as an encounter between equals: the less equal the power, the less the possibility for genuine therapy. Private therapy may be helpful since the patient can freely enter or end the relationship, but this is not the case with psychiatry, where the patient has no genuine choice of treatment or therapist. Therapy is a political activity since it will not work if it does not locate the source of the individual's crisis in the personal and social conditions which provoked it. A therapeutic community is good for making people aware of the difference between a democratic community and the world outside. The need for therapy is created by the prevailing social institutions, however: unless they change, there is little hope of reducing the

incidence of mental illness. In the meantime, radical therapists must resist the temptation to slip into new routines or sink into disillusionment or defeatism in the face of the magnitude of the problem.

Basaglia claimed a 50% success rate with his patients, and as the most influential figure in the political pressure group, *Psichiatria Democratica (PD)*, his work culminated in a monumental legal change. By 1978, *PD* had succeeded in gathering enough support from the political left and the Church to get a law passed to gradually abolish all the mental hospitals (Law 180). Italy was the first country to take such a step. Despite many difficulties with pushing through the full *PD* program, work cooperatives run by and for individuals with psychiatric disabilities have since been heralded as models of social enterprise.²⁹

- Finally, as well as the critiques of specific ideas and practices already discussed in this book,³⁰ the whole of psychiatric theory and practice was also put in question by the work of Michel Foucault. In his explorations in the history of systems of thought, he recognises that the self has no material existence but is instead *an idea* constructed within a web of social relations which articulate power. Understanding the development of the idea of the self - or its alleged deformations - is a matter of formulating the history of a series of interpretations based in the material interests of the powerful. Because the sense of identity is part and parcel of the notion of what is rational, Foucault essayed 'genealogies' of those areas of rationality impacting most on conceptions of the self. By investigating the idea of individuality in the histories of madness, medicine and punishment, Foucault shows how systems of power make us victims of specialised areas of knowledge. Most of us believe in the self as a kind of thing - i.e., that we each somehow possess (or, pathologically, are possessed by) certain traits or characteristics - and so we willingly endorse technologies and the associated professions which in reality subjugate us; yet since we are also flattered by the prevailing romantic-heroic notion of individuality, we are also convinced that we define ourselves (or at least are able to do so), and this conceit blinds us to those relations of power which, in practice, really do define and control us.

In his first book, Foucault examines the Western history of the ideas, practices, institutions, art and literature concerning madness.³¹ He suggests that during the later Middle Ages, when leprosy was gradually disappearing, the mad became a more visible nuisance and replaced lepers as the main group excluded from society. Foucault dubs the European movement towards locking-up and institutionalising every 'unreasonable' person, which began in the 17th century, 'the Great Confinement'. By the 18th century, madness came to be seen as the inverse and wilful subverter of Reason, and finally, by the end of the 19th century, as unwilling behaviour - 'mental illness'. In this development, madness was silenced by official Reason: it lost its power to point to the truth and signify the limits of social order. The new 'scientific' or 'humanitarian' treatments of the insane were no less controlling than previous responses: Tuke admitted that he used threats of punishment to make the mad learn to act 'reasonably', and Pinel employed aversion therapies such as freezing showers and the straitjacket. This was considered the 'scientific' use of brutality to force inmates to internalise the approved pattern of judgement and punishment.³²

29 The only item in English by the founder of *PD* seems to be Basaglia, F (1964) *The destruction of the mental hospital as a place of institutionalisation: Thoughts caused by personal experience with the open-door system and part-time service*. London: First International Congress of Social Psychiatry; also see Mebane-Francescato, D & Jones, S (1972) *Radical Psychiatry in Italy: 'Love is not enough'*. *The Radical Therapist* 2 5, in Brown, P, op. cit. (n. 28, Ch 3), 531-539; For recent assessments of *PD* and the Italian reform see *Dismantling the Asylums: The Legacy of Franco Basaglia* (n.d.) www.PsychOdyssey.net; also Foot, J (2015) *The Man Who Closed the Asylums: Franco Basaglia and the revolution in mental health care*. London: Verso. For a discussion of therapeutic community, see Jones, M (1968) *Social Psychiatry in Practice*. Harmondsworth: Penguin Books.

30 See especially Chapters 12 to 14, above.

31 Foucault, M, op. cit. (n. 86, Ch 1).

32 Foucault takes the story of the management of madness in 'modern times' only up to the early years of the 19th century. He maintains his critique applies to contemporary psychiatry since the axioms of the management of madness have remained those established by that era.

In his second book, Foucault traces the development of the medical profession, and specifically the emergence of the publicly mesmerising power of *the medical regard* - so-said clinical detachment, objectivity, etc..³³

The various critiques of the psychiatric medical model and the myth of mental illness, on the grounds of medical science, logic and sociological and historical analysis, have yet to be answered - and they appear broadly unanswerable. Those who defend medical or biological psychiatry tend simply to round on critics and accuse them of cruelly giving insufficient attention to the urgent problem of remedying the incapacity of the patients. This entirely misses the point. Criticism intends to display the faulty logic which recommends standard practices which exacerbate emotional distress and confusion by attributing mythical illnesses to those who are vulnerable and already suffer from psychological trauma, stress, anxiety and mental turmoil, all of which are usually due to social processes of conflict, violence or terror.³⁴

The mental health industry meanwhile continues to extend its reach. The psychiatric profession and the drug companies maintain their propaganda efforts; with regard to purported neuro-chemical or genetic causes, and the efficacy of medical treatments, both parties continue to be 'economical with the truth'. Consequently, most of the public is still persuaded that incapacitating emotional distress and mental disorder is always *essentially* a problem of the individual's mental illness, and should be dealt with by restraining the deviant and subjecting him to ersatz medicine..³⁵

The legal powers of psychiatry

As a result of the prevailing misconception of the nature of functional mental disorder, and its embodiment in the organisation and methods of psychiatry, Thomas Szasz insisted that

...we have, in our day, witnessed the birth of the Therapeutic State. This is perhaps the major implication of psychiatry as an institution of social control..³⁶

The medical profession took on increased legal powers during the 19th century, and its authority was consolidated during the 20th century so that nowadays psychiatrists have extensive and, in effect, unaccountable powers of restraint and treatment. Psychiatry was always a form of surveillance and control. It is true that in formal terms most patients are voluntary yet psychiatric officials are always able to resort to coercion, i.e., in the jargon, they are able to 'section' patients..³⁷ (This is only qualified by another psychiatrist agreeing that there is no other viable and less restrictive alternative to compulsory detention.) Once a person is detained, as long as he operates within the professional code of practice a psychiatrist may be influenced by his own scruples, by the general moral or political climate, by his fellow psychiatric workers, and even by the wishes of the patients he works on. However, the law only *compels* him to be so influenced in two respects. First, by the restriction of a Mental Health Review Tribunal, which consists of a panel made up of a psychiatrist, a legal professional and a lay-person; a tribunal is only able to decide on continued detention or discharge, not treatment. And then, in certain circumstances concerning compulsory treatment, a psychiatrist's decision is vetted by a Second Opinion Approved Doctor (SOAD); however, in practice there is rarely disagreement between first and second opinions.

33 Foucault, M (1963/94) *The Birth of the Clinic: An archaeology of medical perception*. New York: Random House.

34 The evidence for this assertion is demonstrated throughout Volume 2.

35 An effective non-medical response to micro-social conflict and emotional or psychological crisis is discussed in the closing chapters of Volume 2.

36 Szasz, TS (1963) op. cit. (n. 18, Ch 1), 212.

37 Two medical practitioners are required to ratify compulsorily detention, on the application of an Approved Social Worker or the nearest relative. In an emergency (i.e., for up to 72 hours) the application is made by an Approved Social Worker or the nearest relative, and ratified by one medical practitioner. See *The Mental Health Act (1983)*, op. cit. (n. 70, Ch 1), Part II: Compulsory Admission to Hospital and Guardianship, Ss. 2, 3, 4, 11 and 12. The same powers (but different section numbers) are kept for *The Mental Health Act (2007)*, op. cit. (n. 70, Ch 1).

In this first Volume we have seen that, so far as most of the patients are concerned, the great power of psychiatry is counter-productive, demoralising and often harmful. A psychiatrist's legal powers mean that he may ignore reality with impunity - i.e., ignore both the scientific research and patients' reports of their own experience - and plough on regardless, pretending to everybody that he performs just the same kind of function as a doctor of real diseases. Unfortunately, even if wielded with the best of intentions, 'all power tends to corrupt, and absolute power absolutely'.

Compulsory detention may of course be necessary in cases that seem to involve great risks. The problem is that psychiatric detention and involuntary treatment (often viewed by patients as punishment) is not decided by any normal legal process but only according to the precepts of the all-pervasive medical model, and a patient has no recourse to *habeas corpus*. On the wave of the optimism generated by new psychotropic drugs which at the time seemed completely benign, the 1959 Mental Health Act removed the remaining vestiges of civil justice,³⁸ thereby delegating psychiatric decisions solely to 'the discretion of the doctor'. This removal of judicial authority or redress from psychiatric decision-making has led to the casual and routine diagnosis of mental illness *even in the absence of symptoms*.³⁹ In general medicine, such a cavalier attitude towards diagnosis and medical intervention would be an absolute scandal.

In the meantime, after two decades of their use, it became undeniable that the new psychoactive drugs were not cure-alls, and that some of them had caused a global epidemic of irreversible harm to the nervous systems of tens of millions of patients. Partly due to this, and partly due to the anti-psychiatry critique of the 1960s, interested parties were consulted by the UK Government, and in 1978 a White Paper recommended that decision-making should be shared fully within multi-disciplinary teams made up of the various types of psychiatric worker. This idea was fiercely resisted by the psychiatrists' professional association. A general election intervened, and the radical ideas of the White Paper were abandoned by the incoming Conservative government. The 1983 Mental Health Act may have introduced the policy of sharing decision-making within teams - and this is now firmly entrenched in practice - but it was mainly intended to fulfil the agenda of an alliance between the Royal College of Psychiatrists, the drug companies and right-wing public opinion, which was no more than to tidy-up certain legal loose ends from the 1959 Act. The 1983 Act did keep the right of patients to appeal to a Mental Health Tribunal, and because of the many abuses revealed since the previous Act, it introduced the Mental Health Commission. The overall intention, however, was to affirm, broaden and clarify the powers of the psychiatrists to treat patients without their consent, and to consolidate medical power by reaffirming the final responsibility of the doctors for deciding every matter of diagnosis, restraint, care and treatment.⁴⁰

Perhaps the most significant change since the 1983 Mental Health Act has been a Department of Health Directive in 1991, whereby for each patient an individual 'integrated health plan' must be devised and regularly reviewed; this is under the responsibility of the patient's 'key worker'. In practice, this official is most likely a psychiatric nurse, next often a social worker, and only next a psychiatrist. Doctors are also generally in a minority on the psychiatric and social work teams which are then assigned responsibility for each patient. These innovations might seem to provide an opportunity to contest the dominance of the medical model. Even so, it remains the case that whether they agree with him or not - and most do agree - if he insists on it, every official is constrained to execute upon the patient the dictates of the psychiatrist. And a psychiatrist nearly always prescribes a medical intervention.

In the UK, at some time or another, one-in-six women and one-in-nine men will find themselves subjected to psychiatric authority. The 1983 Mental Health Act permits doctors and a social worker to make a compulsorily detention, and it allows a doctor to impose treatment, even if the patient is

38 I.e., resort to a magistrate; resort to the Board of Control was abolished in 1946.

39 See footnote 13, Chapter 4, and the text to it.

40 See Bigwood, L (1986) *The emergence of major aspects of policy in the 1983 Mental Health Act concerning the compulsory detention of persons in psychiatric hospitals*. MA Thesis: York University.

deemed competent to understand its nature and does not consent.⁴¹ Most entries into the psychiatric process are, formally speaking, voluntary. Yet this is always in the context of an implicit or explicit threat of coercion. Someone said to be in need of psychiatric help is forced to take up the career of a patient (or 'client') who 'has a mental illness'. This career is conditioned by the decisions of a whole string of agents who, as they become engaged with the individual, may adopt positive or negative attitudes towards him. Those who may play a part in the fate of anyone said to be 'mentally ill' include: the public - family, friends, neighbours, bosses - who may or may not call in professional help, and may or may not believe the psychiatric ideology; non-psychiatric professionals - usually general practitioners, the police, clergy, and all sorts of social workers and care workers; and finally, psychiatric workers - psychiatrists, nurses, psychologists, care workers, occupational therapists, etc.

Implications for civil liberties are particularly highlighted by what appears to be the selective use of Section 136 of the 1983 Mental Health Act. This permits the police to detain a person who, in public, 'appears to be suffering from mental disorder and to be in immediate need of care or control'. Civil rights campaigners have long contended that this part of the law is used disproportionately against young black males to whom individual policemen happen to take offence but who could not plausibly be detained on a criminal charge.⁴² In this way, young black men are captured by a system that refuses to listen to them and simply shuffles them into a psychiatric career which is most often bound to serve them worse before things may get better.⁴³

Those psychiatric patients who refuse treatment in the community may be compelled to submit to treatment (i.e., usually drugging) or be brought back into detention: Sections 2, 3, 4 and 17 of the 1983 Act already provided the authority demanded by those wishing for legislation for community treatment orders. However, in response to a few sensationalised cases of violence committed by former psychiatric patients, there was a moral panic during the course of 1995, and in spite of sufficient existing powers this led to the hastily legislated Mental Health (Patients in the Community) Act.⁴⁴ This added a consolidating power of 'supervised discharge' so as to give access to former in-patients if it was deemed necessary by the relevant consultant psychiatrist. Bidding to enforce the attendance of patients at psychiatric facilities, if they see fit, it also gives supervisors the authority to take and deliver a patient to a place of treatment; the supervisor is usually the community psychiatric nurse responsible for co-ordinating the patient's care.

Psychiatrists have long possessed full authority to apply any constraints or treatments which they see fit and can justify as 'medical'. Both psychiatric law and civil law concerning citizens' rights to prevent possible breaches of the peace have been tested in court cases. Section 139 of the 1983 Mental Health Act affords full legal protection to anything a psychiatric official may do to a patient, so long as he can plausibly argue that it was done in good faith and 'reasonable care' was intended; it also protects officials from 'frivolous litigation', and they have this protection whatever they may do to a patient, even if what they do is based in false information, and even if the patient is killed by the administration of many times the recommended maximum dose of an injected sedative.⁴⁵ No other agents of the state are given this degree of licence. Mental health legislation does appear to impose more constraint on staff when they deal with voluntary patients, which category constitutes most of those treated. In practice, however, this is nullified by the reality that every voluntary patient is caught up in a Kafkaesque fiction: as soon as he becomes a psychiatric patient he may easily be

41 See *The Mental Health Act (1983)*, op. cit. (n. 70, Ch 1), Part III, Ss. 58, 62 and 63.

42 Section 136 of *The Mental Health Act (1983)* permits the police to detain someone 'in a place of safety' for up to seventy-two hours if they consider him mentally disordered and a danger. Afro-Caribbeans have been subjected to Section 136 at least two-and-a-half times as often as whites, and its use has been especially disproportionate on young black males. See Burl, J, op. cit. (n. 51, Ch 5); Francis, E, op. cit. (n. 51, Ch 5); Brindle, D (1989), op. cit. (n. 51, Ch 5); and Brindle, D (1991), op. cit. (n. 51, Ch 5).

43 See the section: Prejudice upon prejudice: the arbitrary nature of psychiatric diagnosis, in Chapter 5, above.

44 *The Mental Health (Patients in the Community) Act (1995)* London: HMSO.

45 See Harris, B & Edmond, J (1989) Is the rights-based project the right base for any project? *Asylum* 3 2 3-7; McLaren, F (1989) A reply. *Asylum* 3 4 21-24. Also see text to footnotes 50 and 51, below.

compelled to submit to any kind of treatment, either by being 'sectioned' or by the threat of it. That is to say, everybody concerned is soon made aware that *any* patient may be compulsorily detained and treated, if that is what the psychiatrist wishes.

One purpose of the old mental hospitals was to assure the public that every dangerously insane person was kept safely locked up. In the last two decades of the 20th century, public fears were aroused by the idea that the big old hospitals should be abolished and that most psychiatric patients would live in the community and be free to walk the streets. Despite the policy of closing as many hospitals as possible,⁴⁶ the incidence of involvement in criminal violence by those diagnosed with a mental illness has in fact fallen dramatically during the last twenty-five years. At the moment, a psychiatric out-patient cannot immediately be subjected to forcible treatment; but if he will not comply with arrangements for his aftercare, such as taking medication, he may be assessed for re-admission to a hospital or unit and then forcibly treated.

This is already an alarming inroad into civil liberties, but a decade ago the Government, many psychiatrists and the law-and-order lobby wished to strengthen the ad hoc Act of 1995, and there was a proposal to legislate clear-cut Community Treatment Orders (CTOs) which would unambiguously enforce medication for selected psychiatric patients when they live in the community. When it came to legislation, however, almost every organised voice in the field was raised against CTOs - including that of the Royal College of Psychiatrists. The result was a legislative fudge whereby The Mental Health Act of 2007 only amended the 1983 Act in minor ways. Instead of CTOs, there is now an order for Supervised Community Treatment (SCT). This is 'intended for patients following a period of detention in hospital, and it is expected to allow a small number of patients with a mental disorder to live in the community while subject to certain conditions under the 1983 Act, to ensure that they continue with the medical treatment that they need.' In effect, an SCT permits the patient to be brought back into a facility if he fails to comply with his treatment. This was already permitted under the 1983 Act and by subsequent Department of Health regulations, but the new legislation made the procedure easier for the officials. Whereas the legislators had suggested that SCTs would only be applied to a few hundred patients each year, by 2010 there were 4,600 such orders, and 30% were for patients not known for non-compliance with their treatment. In practice, SCTs are often used for 'freeing up beds' - for prematurely releasing patients who, when they quickly relapse, are then recalled. Many patients complain that it takes too long to have a treatment order removed, and this forces them to take medication they believe they no longer need. SCTs are also a looming threat of re-detention hanging over the heads of former patients trying to rebuild an independent life.⁴⁷

There does not seem to have been a thorough audit of the whole of the UK's mental health services for decades. According to the Care Quality Commission, on average, one-in-four NHS patients require mental health treatment. In England, for the year to March 2014, there were nearly 3 million adults on local GP registers for depression, and approximately half a million for 'serious mental health problems'. The latest available data shows that during the year to March 2015, 1,836,996 people were in contact with secondary mental health and learning disability services; this was nearly 4% of the population. There are no figures for how many were hospitalised; all we are told is that, in England during the year to March 2015, individuals in contact with mental health and learning disability services spent a total of 8,523,323 days in hospital, and this was an increase of 4.9% compared to the previous year.⁴⁸

However, we do know that detention under mental health legislation has increased in recent years, both absolutely and proportionately. The latest available English statistics are for 2014/15. At

46 From a UK peak of 154,000 in 1954, by 1988 the total number of psychiatric beds had fallen to about 67,000. The numbers then fell dramatically again so that by 2004 there were 32,400, of which 13,261 were acute care beds for adults, a further 2,500 were in secure units, and the rest were 'long stay' beds (i.e., for non-acute care or people in other age groups). Warner, L (2005) *Beyond the Water Towers: The unfinished revolution in mental health services, 1985-2005*. London: Sainsbury Centre for Mental Health, 35.

47 See text to footnote 11, Chapter 11. Confusingly, SCTs are generally known as CTOs.

48 *Fundamental Facts about Mental Health* (2016) op. cit. (n. 20, Ch1), 71.

the end of March 2015, 25,117 patients were detained; of these, 19,656 were in hospital and 5,461 were treated under a CTO. Compared to the end of March 2014, this was an increase in the number of patients subject to the Mental Health Act of 1,586 (up 6.7%), and 20% more than at the end of March 2011. During the twelve months to March 2015, there were a total of 58,399 detentions under the Act, an increase of 5,223 (9.8%) over the previous year; this compares to a 5.5% rise during 2013/14 and a 3.7% rise during 2012/13. Detentions on admission to hospital increased by 2,903 (up 8.3%) and there were 1,991 (14.1%) more detentions following an informal admission. The total number of detentions increased in NHS hospitals by 3,995 (up 8.2%) compared to the year before, to reach 51,969, and in independent-sector hospitals by 1,268 (up 24.6%) to a total of 6,430.

This increase in psychiatric detentions was mainly by Part II of the Act (Civil Detentions), with little change in the number under Part III (Court and Prison Disposals). Section 2 of the Act provides for an individual to be legally detained for assessment and treatment of a mental disorder; since it permits officials to detain a patient for treatment, section 3 is commonly known as a 'treatment order'. Uses of Section 3 following the use of Section 2 increased every year between 2010/11, when it was used 6,617 times, and 2014/15, when there were 10,787. Over five years, this represents an increase of 4,170 (+63%) in the use of treatment orders. By March 2015, instances where the notorious section 136 of the Act was used to make a short-term detention to a hospital as 'a place of safety' had increased by 2,400 to 19,400 (up 14.1%), compared to the year before.⁴⁹

How does a psychiatrist arrive at a diagnosis? 'Good mental health' involves notions of emotional and mental balance and autonomous functioning - the ability to perceive consensual reality, to act competently or appropriately, and to be able to resist a certain amount of stress. None of this is clear-cut. For instance, someone who displays too much autonomy may be considered mad: Galileo disagreed with the consensus of his time and was forced to keep quiet, Giordano Bruno was burnt at the stake for his cosmological ideas and humanism, and Gauguin was ostracised for his moral deviancy. Again, how much stress is considered normally tolerable, and how can a psychiatrist appreciate the types and degrees of stress to which any patient is subjected? The behaviourist concept 'maladaptive behaviour' leaves the definition of 'normal' to the powerful. The law is vague - for all intents and purposes, it hands over to psychiatrists the power to draw the boundaries of the categories as they see fit, case by case. No Act of Parliament defines crucial terms such as 'mental illness' and 'mental disorder'. While the 1983 Mental Health Act does specify 'psychopathic disorder' as 'abnormally aggressive behaviour' and 'seriously irresponsible conduct', whether to include a particular person's behaviour within this category is left to the discretion of the doctors. Rather than simply a response to his bizarre ideas, diagnosis is generally consequent to an individual's inability to perform an expected role and also intelligibly or 'reasonably' to account for that fact. In practice, what is viewed as the symptom of a mental illness is any of that apparently unpremeditated and irrational behaviour (i.e., that behaviour for which there seems to be no rational motive) which, according to a psychiatrist, departs too far from the norm.

The problem of psychiatric power is not so much that too many doctors and workers in the field maliciously and wilfully engage in the conscious abuse of their powerless patients - although some do, and in itself this is a serious issue of the absolute power of psychiatry which any civilised society would properly address.⁵⁰ Rather, it is that, coupled with the misplaced preoccupation with supposedly sick brains which is mandated by the medical model, the opaque and unaccountable nature of psychiatric power invites systematic neglect of the patients and casual cruelty towards them. That the standard mental health treatments (drugs or electroshock) are not more effective than placebo or no technical intervention at all, and that care and treatment tends to be callous and dismissive of the patient's feelings is rationalised by an ideology consisting of notions and practices which fraudulently imply that they are scientific *and which are subject to no accountability, never*

49 *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2014-2015, Annual figures* (2015) NHS Digital 23 Oct.

50 See the section: Dereliction of duty and the abuse of patients, in Chapter 14, above (text to footnotes 77-87).

have to answer criticisms, and never do so. At a crucial stage in its development, the psychiatric profession succumbed to the temptation to resort to a parody of scientific medicine which negates its commitment to authentic medical science and genuinely responsive care. Having done so, it gained increased powers with each new Mental Health Act, such that by 1959 its powers over the patients had become unqualified.

A benign form of psychiatry would try to help the patient to live a life he might reasonably wish for. This is a matter of professional estimation, however, and the official project is already an attempt to change the patient's mind - and generally to send him back to his old life, or into circumstances that psychiatric and social workers (but not necessarily the patient) think most suitable. The aesthetics, morality and politics of this enterprise are hidden behind the myths of mental illness and objective and efficacious medical care and treatment; and this is endorsed by the law. Whether in a GP's surgery or a psychiatric facility, the worse the apparent mental disorder the more likely it is viewed as definitely a medical matter, and the more likely the person is forced to submit to chemical or physical treatment; in other words, the worse the person's emotional, social or psychological problems, the less hopeful and helpful is the socially organised response.

A few patients may display violent or frightening behaviour, but most of those who end up under psychiatric management are likely to be passive, silent, fearful and withdrawn. Forty years ago there was concern that officials might be overestimating the potential for violence by psychiatric patients, and that they recommended secure hospitalisation and restraint too often.⁵¹ Nowadays, with the number of acute psychiatric beds cut beneath the bare minimum, families often feel let down by a system which routinely underestimates the risks to the individual and leaves him to struggle on, sometimes with disastrous consequences, in the very circumstances which caused him overwhelming stress, distress and confusion in the first place.

Psychiatry makes emotional distress and mental disorder chronic

Any mental disorder is a distressed and perplexed flight from a previous level of achieved identity and responsibility; in extreme cases the person regresses to infantile dependency. As a means of escape from his immediate predicament, the distracted individual may be willing to accept the idea that he 'has a mental illness': along with everyone else, he imagines that if what he experiences is the result of an illness, then medical care and treatment should be able to cure or at least help him. Or he may accept a medical diagnosis in order to avoid more explosive conflicts with others.

And yet the attribution of a mental illness always invalidates the person rather than addresses him as someone with particularly pressing material, social or psychological problems. Agents of the state (in the end, doctors) are likely to repudiate any and every uncomfortable thing said or done by the elective psychiatric patient. If by local consensus an individual 'becomes mentally ill', and is then officially defined (diagnosed) as indeed afflicted by a mental illness (rather than as someone who is panicked by urgent non-medical problems), the conflicts which precipitated the emotional distress and mental disorder tend to remain hidden or discounted, and the individual's distracted response to whatever or whoever oppresses him can only appear enigmatic and unaccountable - i.e., accountable only as randomly irrational behaviour and ideation, symptoms of the alleged illness. At the point of crisis, the individual is impaired by his distress and confusion, and this renders him vulnerable to the combined persuasive and coercive powers of his family, the community and agents of the state. Consequently, psychiatric officials are not forced to recognise, seriously take into account or try to discover any possibly stressful emotional, psychological or social triggers to the crisis. Instead, the individual is simply launched onto a career as a particular kind of invalid: 'psychiatric patient'.

Advocates of the medical model seem blissfully unaware that the diagnosis, in itself, is likely to have a deleterious effect on a person's sense of self, significance and well-being. When we discussed placebo (in Chapter 8, above) we noted that suggestibility works *throughout* the medical project. Perhaps he exaggerates, but Proust observes the effect of general medicine on self-perception:

51 See Ennis, B & Siegel, L (1973) *The Rights of Mental Patients*. New York: Discuss Books.

For one disorder that doctors cure with medicaments (as I am assured they do occasionally succeed in doing) they produce a dozen others in healthy subjects by inoculating them with that pathogenic agent a thousand times more virulent than all the microbes in the world, the idea that one is ill.⁵²

Predicated on the so-called medical model, psychiatric intervention glosses the psychological and interpersonal conflicts inherent to every psychological crisis, and consequently tends to ignore the likelihood that intimate others and witnesses are partisan. By implication, the official intervention denies that the crisis might have psychological and social or interactional causes, and this denial of the generally decisive role of human agency and responsibility (including that of the patient-elect), makes the individual into a kind of infant, while casting anyone else in the role of powerless onlooker. For his part, the distressed individual may welcome the role of patient as legitimization of a wish to give up the responsibility for having to conduct his oppressive life, and we might expect this abdication if his life seems to him to be dominated by an overwhelming and irresolvable problem (or probably a number of problems). By attributing an illness (a mental illness) to the most vulnerable and oppressed party in a crisis that will have developed out of social interaction, the difficulty is conveniently removed from the arena of interpersonal relations. A parent or a spouse, for example, does not have to consider their part in the crisis: 'common sense' confirms that they cannot possibly be responsible for the development of an illness.

Once diagnosed, it is very difficult for someone to escape from his new identity: 'mental patient'. The individual may also feel annihilated as a person; he may feel anger towards certain others, and he may experience his negation by them as persecution. In addition, the notion of 'an illness which runs a normal course' encourages psychiatric officials to dismiss *every* undesirable thing the patient says or does as 'only another symptom of the illness'. As soon as invalidation of the individual's undesirable ('bizarre') perceptions, beliefs and behaviour is ratified by a diagnosis, psychiatry actively discourages the individual's self-responsibility and may well make it harder for him to reasonably negotiate his life with others. For example, the consequences of the diagnosis may be that although his previous relationships continue, family members may say they will call down further psychiatric sanctions if the patient does not behave as they wish, while he may warn them that his illness will only cause him to become more difficult if he does not get his own way. This would be a feedback amplification of the crisis: the loss, abdication or forfeit of the person's responsibility for his own thoughts, feelings and behaviour leads to a mental illness diagnosis and, if he wishes it, this authorises the patient's abdication of his responsibility for his own thoughts, feelings and actions. In this manner, the person is hidden (or is able to hide) behind the mental illness diagnosis. Either he is *forced* by those who hold him in their power to play the role of a cipher - psychiatric patient - whose every undesirable word or deed has no effect since it is said to be irrational and only a symptom of his illness, or he can now *choose* to engage in that identity, as a strategy to lower the levels of conflict and stress he would encounter were he to act genuinely and be counted fully responsible. Either way, the result is injury to the individual's identity and autonomy.

In response to the negative feedback loop in self-image and self-esteem of someone undergoing a psychological crisis - enhanced by the pseudo-medical diagnosis, in and of itself - there is of course the treatment. This is also liable to trigger feedback amplification of the alleged illness, achieved by the administration of medicine which often causes deleterious and painful or frightening organic and mental effects. For example, a patient might resist the effects of being drugged or, after the experience of drugging, he might resist having a drug forced on him again; yet this is only likely to call down more potent drugging, which he may also try to resist. As we have seen, those who believe in the medical model - which is to say, nearly everyone - will probably interpret his resistance as 'the mental illness getting worse': in conflict with the Hippocratic Oath, 'Do no harm', but in accordance with the psychiatric medical model, a patient's opposition is interpreted as only a sign of the

52 Proust, M (1925/81) *Remembrance of Things Past* (Trans Scott-Moncrieff, CK & Kilmartin, T) New York: Random House. Vol 2, Ch 1: The Guermentes way.

irrationality caused by his illness, and this serves to justify more of the same treatment, or even worse ('more potent') treatment.⁵³

More than this, anyone who was ever said to have been mentally ill can quite easily make others feel uneasy without manifesting any current signs of a mental disorder - in fact, sufficiently uneasy for a psychiatrist to make (or confirm) a diagnosis and have him medicated.⁵⁴ This is presumably on the basis of a professional myth which is apparently widely believed, the self-fulfilling prophecy: 'Once diagnosed mentally ill, always likely to relapse'. The invalidation of anyone alleged to have a mental illness is achieved by a combination of labelling (diagnosis) and restraint (hospitalisation and drugging or electroshock). In this process, it seems to Joseph Berke that

[t]he rule-breaker becomes the recipient of other peoples' projections and the focus of their dissociated perversity and self-hatred.⁵⁵

At root, psychiatric labelling is a 'transpersonal defence against fear and guilt';⁵⁶ it is essentially a magical use of words to influence both the person who provokes anxiety in others - the rule-breaker, the person said to have a mental illness - and everyone around him. Mental health diagnosis is a micro-political act which allows interested parties to deny their actual feelings and behaviour, and by means of a pseudo-medical ritual, to attack, invalidate and deflect the individual who arouses their feelings of disgust, fear, anger or guilt. Labelling (diagnosis) recognises *only* the troublesome 'symptoms' (the psychodynamic defences) of the individual at the centre of the crisis; it turns psychological and interpersonal conflict and confusion into an event that is officially authorised *only* as an unfortunate deviant's 'illness' which, of course, is supposed to require 'proper medical treatment'. This allows the labellers to deal with those they stigmatise in whatever cruel and destructive manner they wish, but under a social justification and with a clear conscience.⁵⁷

Incapacity, injury and death from psychiatric medicine

Currently about 90% of all mental health cases are dealt with at the level of primary care, and the psychiatric process itself is often begun by calling in a local doctor (GP).

There is no regular record of the number of prescriptions of minor tranquillisers, but in 1986 there were 28.5 million for a UK population of 56million, and there are no signs of reduced use in the meantime. Research indicates that, at best, a minor tranquilliser (anxiolytic or benzodiazepine) controls symptoms for only about ten days; however, about one third of patients report no sedative effects at all. These drugs are also dangerously addictive: 30% experience withdrawal symptoms such as panic, insomnia, tremors, palpitations, sweats and muscle tension.⁵⁸ Most of these prescriptions are made by GPs for female patients - and most likely to silence the expression of anxieties triggered by commonplace but vital concerns such as financial difficulties, isolation, sexual or marital problems, exploitation or abuse.

By the early-1980s, the tricyclic anti-depressants (TCAs) played a part in 10% of all deaths by self-poisoning. TCAs are now mainly superseded by the serotonin reuptake inhibitors (SSRIs) which doctors hoped would be more effective and less toxic, although it has become clear that the drug companies often misrepresented or failed to publish evidence for just as common and just as significant ill-effects from the SSRIs as from the types of drugs they were to replace. In addition,

53 In Chapter 4, above, a psychiatrist and a nurse ignored a patient's complaints about the painful effects of the drugs they forced on him. This was celebrated as 'good practice'. Apparently, the Hippocratic Oath is now outmoded in the UK, and doctors are no longer required to swear it.

54 See text to footnote 13, Chapter 4. The research cited shows that *almost half* of all psychiatric treatment is continued in the absence of symptoms of mental disorder

55 Berke, J, op. cit. (n. 15, Ch 7), 24. This is not to deny that some of those subjected to the attentions of psychiatry are a danger to themselves or others. But there are questions concerning how to define and respond to someone in crisis, and about official disinterest in the motives of those who define and respond to the crisis.

56 Berke, J, op. cit. (n. 15, Ch 7), 24.

57 These ideas are expanded throughout Volume 2.

58 Pilgrim, D & Rogers, A, op. cit. (n. 35, Ch 1).

meta-analyses of the research disclose that the SSRIs are no better for combating depression than the previous generation of TCAs.⁵⁹

Until recently phenothiazines or 'major tranquillisers' were routinely used as anti-psychotics; their use was continued until the patient was thought to have recovered, or otherwise indefinitely. These drugs have a powerful effect on the brain and whole nervous system, both temporary and permanent. At best this was ambivalent for anyone undergoing a crisis: his life had taken a very disorientating turn and the medical response was likely to cause general sedation and warped sensations, and often alarming 'side-effects' such as perceptual distortions, lock-jaw, dizziness, spasms and shakes;⁶⁰ it was normal for a major tranquilliser to make the patient appear bizarre - they produce a dry mouth, involuntary working of the tongue, 'chewing' and difficulties with speaking. Under the authority of nurses who were supposed to be medically trained but were not likely to be very well-informed or particularly sensitive, the patient and his psychiatric managers would often construe the ill-effects of the drugs as further signs of the psychotic 'illness'. Combining drugs was never recommended yet nevertheless it was and remains common practice, and it seems to amplify the side-effects (ill-effects). The long-term, full-blown consequence of this type of drug is tardive dyskinesia (TD), an uncontrollable jerking of the whole body; in the meantime, dyskinesic effects were by no means necessarily tardive (later-developing).

One of the companies which caused the tardive dyskinesia epidemic is Roche. At the end of the 1980s, they estimated that 150 million people world-wide were on major tranquillisers, and that 3-6% of them (five to ten million) suffered from TD. However, by ignoring all the milder cases, and even those who develop TD after they stop using a major tranquilliser, independent research still put the proportion at more like 25%. This gives a global figure of *at least* 37 million suffering from serious TD. The dilemma for those who spent years on a major tranquilliser is that TD is masked when they are still on the drug but gets worse when they stop taking it. The drug companies admit that the effects are irreversible in 75% of cases: by 1990, this gave a conservative estimate of 25 million patients and ex-patients with moderate to severe permanent and irreversible neurological damage.⁶¹ One-third of those who stop taking a major tranquilliser report worse effects than when they were on the drug; this is because the drug raises neural activity in compensation, and anyone who stops taking it literally suffers from over-sensitive nerves. Added to which, anyone who stops using a major tranquilliser has to face all the problems which were previously somewhat 'blotted-out' of his mind. In accordance with the medical model, however, a patient's consequent levels of anxiety and 'over-reactions' confirm for any doctor who witnesses them that the person 'always was mentally ill' and that the drug 'must have been a remedy'. Evidence of TD began to accumulate in the mid-1960s, and yet the psychiatric profession and the drug companies both denied it for years.

The number of major tranquilliser prescriptions increased every year until the advent of the next generation of anti-psychotics (or neuroleptics), the group known as 'atypicals' - drugs such as clozapine (renamed: denzapine), olanzapine, risperidone and quetiapine. The original kinds of major tranquilliser are now mainly superseded, but the research has yet to catch-up with the full picture of the efficacy and long-term dangers of the latest drugs, although it is known that they are by no means without adverse ill-effects.⁶²

There is an expectation that mental health assistance will be technical, precisely measured, quick-acting and predictively accurate. This fantasy is satisfied well enough by equating drugging and shock treatment with 'real medicine'. Psychiatrists guarantee their prestige, power and well-compensated careers by associating themselves with general medicine; the pseudo-medicine of mental healthcare also permits doctors to process great numbers of patients fairly rapidly. Under a standard psychiatric regime, however, the person who is the patient is made invisible: in the face of

59 See text to footnotes 11-16 in Chapter 6, above.

60 When a doctor is called, the side-effects may be counteracted by an anti-muscarinic drug.

61 Breggin, PR, *op. cit.* (n. 107, Ch 1), 89-91.

62 See the section: Newer and better drugs? in Chapter 6, above.

the doctor's diagnosis, prognosis and judgement concerning the efficacy of a medical technique for managing the symptoms of the alleged illness, what the patient knows or feels is irrelevant. A significant consequence of identifying and treating imaginary illnesses (mental illnesses) rather than being attentive to persons is that doctors often ignore, deny or rationalise the harmful 'side-effects' of treatment. Were one to believe in the medical model, this might indicate a regrettable but necessary compromise with the patients' physical health for the sake of remedying their mental disorders. But since the so-called medical model has no scientific validity and the evidence indicates that psychiatric medicine does more harm than good, it rather signifies much less interest in patients' well-being than in keeping the social peace by almost any means.

Many patients resist psychiatric oppression. By 1985 it appeared that in the UK there was only 30-50% compliance with self-administered major tranquillisation.⁶³ Under regular surveillance, of course, this refusal by the patients is now sometimes authorised and institutionalised by more liberal psychiatric teams who say it is 'the patient managing his own drug administration according to his needs'. On the other hand, refusing treatment is viewed as a major problem by those who welcomed the community treatment orders (CTOs/SCTs) so as to compulsorily administer drugs. Peter Breggin points out that by the end of the 1960s psychiatrists were facing increased competition from social workers, clinical psychologists and counsellors, and generally from the social-psychodynamic perspective. This only seemed to increase the determination of those who made propaganda for the myth of the biological basis to mental illness.

For instance, it was well-known by the late-1980s that the major tranquillisers cause brain damage in at least half of all patients receiving long-term treatment. By then, however, the pharmaceutical companies had become one of the most powerful political lobbies on the planet, and they funded nearly all psychiatric research as well as every major psychiatric journal and convention. Consequently, '...the [American] Psychiatric Association is not beholden to the patients now, it is beholden to the drug companies.'⁶⁴ Things are not so different in Britain: the Royal College of Psychiatrists and the journals rely on funding from the drug companies, independent psychiatric research is rare, and one-third of the Members of Parliament declare income from a pharmaceuticals company. Are psychiatrists likely *not* to favour drugs, or researchers to discover that drugs *do not* work - or if they do discover information not in the drug companies' interests, is this likely to be widely advertised? Playing on everybody's amnesia and wishful thinking, new drugs are continually and quite fancifully marketed as 'better' and 'more selective', and concocted especially 'for those who fail to respond' to the established drugs.

The first psychiatric purpose is to impose social order on a crisis otherwise considered hopelessly chaotic. All the same, very often the intervention fails to relieve the anxiety of the person at the centre of the crisis, or even magnifies it. This is achieved through the alienation and stigmatisation which results from psychiatric labelling, prognosis and procedures, and by the distressing 'side-effects' of treatment. For example, a patient's perceptions are certainly likely to change when he is administered an anti-psychotic. To the extent that he is removed from the situation which originally caused him excessive anxiety (i.e., he is taken into care), and to the extent that, due to medical treatment, he undergoes organic changes which affect processes of thought or memory, the doctor does prove the efficacy of his method: *perhaps* the patient's original psychological or social problems might not trouble him so much. But new dilemmas follow immediately on the heels of the psychiatric response. Normally, the patient is denied effective emotional or cognitive help; instead, as soon as possible he is released back into the community, and therefore almost invariably he is faced with some or other emotional, psychological or material problem which drove him into the arms of psychiatry in the first place. But now he is likely to labour under the additional burden of medically-induced cognitive impairment, quite likely other ill-effects of medical treatment (the 'side-effects'), as well as the crushing stigma of an officially ratified mental deficit. These handicaps conspire to alienate him

63 Breggin, PR, op. cit. (n. 107, Ch 1), 89-91; and Pilgrim, D & Rogers, A, op. cit. (n. 35, Ch 1).

64 Breggin quoted by Weitz, D (1989) Exposing the myth of mental illness. *Asylum* 3 4 11.

further from possibilities for improving his psychological condition or social relations: the person's problems now include his new status as 'psychiatric patient' and the treatment itself. None of this would be so bad if everyone did not conceive of mental disorder as an *essential* deficiency rather than perhaps a transitory condition which might be alleviated by listening carefully to the individual, trying to understand his situation and offering practical help. As things stand, the attribution (diagnosis) of a mental illness is dehumanising: it degrades the person and incites fear and contempt amongst the public, thereby serving to justify callous treatment and actual harm.

As well as these difficulties, serious problems beset anyone trying to establish a life free from psychiatric medicine. Coming off drugs is a difficult pharmaco-organic and psychodynamic problem, and yet the myth of mental illness seems to prevent policy-makers from properly recognising and fully incorporating management of the ill-effects of treatment into standard routine. For example, it ought to be generally acknowledged that not only does withdrawing from a drug need to be gradual and monitored but it also requires a specific *extra commitment* of sympathetic help. Every official should know that the body compensates for a major tranquilliser by increasing its noradrenalin and dopamine activity and the firing rate of the serotonin receptors in the brain. As a result, when the neural system is no longer tranquillised it is unusually sensitised: when a patient comes off a neuroleptic it is almost inevitable that he will 'go high'. Of course, part of the 'high' (sensitivity and panic) consequent to drug-withdrawal is also due to the person now more vividly recalling the personal or social problems which caused him to be emotionally overwhelmed in the first place. Nonetheless, officials tend to neglect these problems, and read any signs of a patient's confusion or panic as 'proof of the need for him to continue taking the drug'; that is, they read the situation as the patient 'having a worse mental illness than was hoped' rather than his suffering psychologically as well as physiologically from drug-withdrawal. During treatment, as a matter of strict routine, full information about addictive and 'side effects' is not always adequately divulged to every patient. This makes withdrawing from a drug more critical than it need be.

Unfortunately, there are even greater dangers in drugging. Throughout the later-1980s and into the 1990s, apart from the regular number of the suicides in detention, there were frequent reports of the deaths of healthy young psychiatric patients (especially black men) due to forcible, authorised but excessive tranquillisation. There is no national audit, but in 1994 MIND reckoned that on average one patient every week was killed in this manner in a psychiatric unit somewhere in the UK.⁶⁵ There have been very few prosecutions and no convictions, and there is no reason to think that the situation has improved in the meantime. One case that did come to court is typical. To 'quieten him down', a young man of Indian origin was forcibly administered an excessive quantity of Droperidol. When that did not work, within one hour he was given *ten times* the maximum dosage *for six hours* (as advised in the *British National Formulary*). He died after a final intra-muscular injection of (at any time) twice the recommended maximum dose. The judge instructed the jury not to hand down a verdict of unlawful killing since the autopsy revealed that the victim had a minor heart condition. When the trial was over, an independent doctor informed the reporter that the man's heart condition was common and not in fact a serious health risk.⁶⁶

Staff in secure units, especially, work with the most disturbed and challenging patients, and undoubtedly many try their best to do a very difficult job under dangerous conditions. Be that as it may, no psychiatrist or psychiatric worker has ever been found guilty of causing death by restraint or forcible overmedication. In response to several major inquiries into abuses and deaths at Special or high security Hospitals in the last thirty years, practices in psychiatric facilities were modified so as to anticipate or cope better with flashpoints between staff and patients. Training in de-escalation and 'breakaway' techniques are now mandatory, as is regular training in control and restraint.

65 MIND Report on Deaths Caused by Neuroleptic Drugs, op. cit. (n. 75, Ch 6).

66 Virden, P (1993) Lawful killing of a mental patient. *Asylum* 7 4 12. This reported a case before York Crown Court.

Even so, there are not yet signs that the rate of deaths in detention or custody is falling. On the contrary, the numbers are probably increasing. Besides regular deaths by over-sedation in psychiatric facilities, the Independent Police Complaints Commission reported that 38 people with a diagnosed mental disorder died in police custody during the year to March 2004. A spokesperson for MIND reckoned that between 1998 and 2003 there had been 153 deaths in police custody, and that more than half involved individuals with prior indications of a mental health problem. The IPCC called on the NHS to provide more facilities for patients with acute symptoms. It stated that the police are not properly trained for the job but are left to 'pick up the pieces' when patients are not provided with proper support and when adequate information is not passed on. Ten years later the situation had not improved. The Equality and Human Rights Commission found that hundreds of deaths in the UK's psychiatric units, prisons and police cells were avoidable since they were caused by repeated 'basic errors' made by staff ignorant of mental-health risks. Between 2010 and 2013, deaths of detained individuals with known mental health problems ran at a rate of *nearly 4 per week*.⁶⁷

A form of domination

At its most advanced stage, domination functions as administration, and in the over-developed areas of mass consumption the administered life becomes the good life of the whole... This is the pure form of domination.⁶⁸

Capital takes no interest in the condition of souls - in misery and mental turmoil - unless there is profit or loss in it: the soul is neither a worker nor a consumer. Psychiatric texts elaborate an ideology which rationalises the administration of anyone overwhelmed by private woes as the management of a type of illness. The ruling ideology (the ideology of the ruling class) agrees with this, and the official response is advertised as an entirely benign sector of the health service. Yet once subjected to scrutiny, it is difficult to apprehend the official response to those incapacitated by emotional distress and irrationality except as integral to the general competitive and hierarchical organisation, i.e., as a form of domination. For, as we have seen throughout this first Volume, there is little evidence that the mental health service is much concerned with the autonomy, self-realisation or even the misery of someone who is distressed, confused and finally overwhelmed by psychological problems. The mental health industry is primarily engaged in the reinstatement of good behaviour.

More than this, as extra-judicial surveillance, coercion and the administration of harmful chemicals and electricity, the standard routines of psychiatry are an abuse of human rights. Although we might characterise the various psychiatric techniques as kinds of *latent abuse*, the public relations efforts of the medical profession are, of course, organised to celebrate those methods as indispensable forms of care and therapy; at the same time, the unrestricted powers delegated to the psychiatrists exposes every patient to the risk of emotional or mental cruelty, and physical and sexual harassment or assault, i.e., manifest abuse. No doubt many psychiatric workers - especially young, naïve and

67 *Deaths During or Following Police Contact: Statistics for England and Wales 2003/04* (2004) ipc.gov.uk/; *Deaths in police custody* (2005) *The Scotsman* 20 Jan; *Deaths in detention of hundreds of people with mental health conditions could have been avoided, new Inquiry finds* (2015) *The Equality and Human Rights Commission* website 23 Feb.

68 Marcuse, H (1964) *One-Dimensional Man*. Boston: Beacon, Ch 10. This observation continues in a manner reminiscent of the 'paranoid' perceptions of critics such as the diagnosed schizophrenic, Artaud, which call into question the assumptions underpinning the entire social order: '...Conversely, its negation appears to be the pure form of negation. All content seems reduced to the one abstract demand for the end of domination - the only truly revolutionary exigency, and the event that would validate the achievements of industrial civilization. In the face of its efficient denial by the established system, this negation appears in the politically impotent form of the "absolute refusal" - a refusal which seems the more unreasonable the more the established system develops its productivity and alleviates the burden of life. In the words of Maurice Blanchot: "What we refuse is not without value or importance. Precisely because of that, the refusal is necessary. There is a reason which we no longer accept, there is an appearance of wisdom which horrifies us, there is a plea for agreement and conciliation which we will no longer heed. A break has occurred. We have been reduced to that frankness which no longer tolerates complicity."'

idealistic recruits - are good-hearted, intelligent and interested in patients' problems. But novices soon find they have to struggle on their own against a system which demands that they do little more than medically process distressed persons for re-insertion into normal daily life as well-behaved workers and consumers. We do not suggest that this is by fully conscious design or intent, but rather a consequence of the overbearing weight of the culture, whereby in the delivery of the response to personal misery and irrationality, positive help for the suffering individual takes a back-seat to the demand for conformity and the social peace. A great many mental health workers may be well-meaning, but if any of them finds that what he is expected to do is distasteful, unhelpful or abusive, he soon finds that opposition is a lonely and unequal struggle against the institutional apparatus, the mental health ideology and medical power.

The evidence and argument in the preceding chapters indicates that rather than helping someone to identify the cause and find a solution to his bewilderment and distress, psychiatry tends to let him down. By defining every instance of worrying individual irrationality as undoubtedly the sign of an illness, i.e., by masquerading as healthcare while carrying out a kind of crypto-policing, psychiatry is able to serve the wishes of *everybody except the person in crisis*. Meanwhile, every health worker is nowadays required to abide by the Professional Duty of Care (PDoC).⁶⁹ This is meant to prevent cruelty and injustice, and ensure the safety and well-being of patients: in effect, the officials are required to perform their duties strictly 'by the book'. This might serve those with physical ailments very well, but not necessarily everyone diagnosed with a mental illness (functional mental disorder).

We have been at pains to emphasise that there is a categorical and irreducible difference between mental health and physical health. There is no doubt, of course, that every physical ailment (measles, diabetes, cancer, a broken leg) exists pre-discursively, i.e., prior to anyone recognising and talking about it. It is therefore managed or worked on without the practitioner having to *interpret* anything that the patient says or does (or anything relevant, except perhaps what the patient says about where it hurts or how long it was before he noticed the problem, etc.). In general medicine, doctors, nurses and other healthcare workers carry out their duties by reference to empirical knowledge of the objective processes of the body and invasive organisms. By definition, however, there are no organic markers for a functional mental disorder. No such malaise - such as depression (perhaps otherwise known as 'grief', 'despair' or 'a broken heart') or mania (panic, agitation, over-excitement, abandon) - exists beyond the limitations of discourse: every so-said mental illness is only determined by interpreting what the person says and does, and this interpretation is based solely on the 'properly-trained' and 'experienced' opinion of an official.

Accordingly, as opposed to a general medical diagnosis, and being no more than an interpretation and an attribution, every psychiatric diagnosis involves the legal exercise of a social power in which it is not up to the individual to decide whether or not he has a malaise, or what it might consist of, or whether he wishes for care and treatment. It is only the responsibility of a specialised functionary who is required by law to step in, make a diagnosis and initiate standard procedures.

As opposed to decisions about physical healthcare and treatment, which rely on organic signs (symptoms), mental health decisions are based only on *socially constructed representations of dysfunctional conditions of the mind*; these characterisations are accumulated by the psychiatric profession as elements in its agreed body of knowledge. In accordance with this, any individual believed to 'have a severe mental illness' - who behaves in ways considered particularly undesirable (including expressing undesirable ideas), and who is therefore 'at risk' - may be legally detained for the purposes of care and 'appropriate' treatment. And while most psychiatric patients are not formally detained, the threat of legal detention and treatment casts a shadow over the whole of the mental health project such that, despite the fine intentions of many doctors, psychiatrists, nurses and clinical psychologists, care and treatment is *very often* experienced as a kind of punishment.

69 See Scrivener, R et al (2011) Accountability and responsibility: Principle of Nursing Practice B. *Nursing Standard* 25 29, 35-36.

In contrast to general medicine (except for managing contagious diseases), the mental health duty of care operates insidiously as governance, i.e., as a component to a set of ‘techniques and procedures for directing human behaviour’;⁷⁰ it is a ‘political rationality’, a ‘program of government’.⁷¹

From this perspective, the PDoC appears less as a guarantee of the best care and treatment but more as a governmental regime - one that happens to be embodied within discourses of healthcare, ethics and consent.⁷²

The official discourse, in the terms of which mental health care and treatment is carried out, is distilled as authoritative inscriptions such as assessment procedures, clinical guidelines, codes of ethics and negligence laws. Together, these serve simultaneously both to articulate and to reify social relations in this realm of activity, so that a pre-ordained processing awaits each individual subjected to medical authority. In this manner, in the mental health system, the professional duty of care functions to suppress any apparent threats to the social order that might otherwise arise from emotional or mental disorder or any other apparently irrational kinds of deviance.

In which case, it is no surprise that vulnerable people, who are really distressed and really do need emotional support, are reluctant to seek help or even to speak out about their plight. Access to any official agency is intimidating enough without the added fear of a mental health diagnosis, stigma and incarceration.⁷³

Psychiatrists exercise a legal monopoly on the administration of worryingly irrational persons. If an individual receives an unfavourable diagnosis, he is forced to accept that he ‘has a mental illness’; if he disagrees or appeals against diagnosis or treatment, that is normally construed as ‘lack of insight’, delusional, and another symptom of his mental illness. In the first instance, someone diagnosed with a psychiatric illness is only permitted to appeal to another doctor. Only when he is already a psychiatric patient, and has already had to submit to supervision and treatment, is he able to appeal to a Mental Health Review Tribunal, which includes a solicitor and a lay-person.

Meanwhile, the attitudes of psychiatric officials are likely to be different according to whether a patient is perceived as compliant or resistant. So as to facilitate bureaucratic order, treatment, and everybody else’s peace of mind, each patient is identified as ‘good’ or ‘bad’, ‘gaining insight’ or ‘deluded’, ‘recovering’ or ‘remaining ill’. The medical model decrees that officials must first of all perform specific technical procedures: even if lip-service is paid to recognising a social dimension to care and treatment, this is seen as ancillary to the medical response. And yet the attitudes and actions of the officials are bound to affect the reintegration of a patient back into the wider community, or his further alienation from it, and hence assessments of his ‘progress’ or ‘cure’. Besides, it is difficult for a patient to become reintegrated mentally and socially - and then released from psychiatric control - except by appearing to keep to the career-path required of any patient, which is to say, by accepting everybody’s definition of the situation, including an identity decreed by psychiatric power.

In Volume 2 we will argue that what is recognised as functional mental disorder (mental illness) is the individual’s desperate attempt to comprehend and cope with intolerable events in his life, while overwhelmed by anxiety. It is only incidentally - if at all - that psychiatry gives much relief, asylum, compassion, rest, recuperation, moral support and material and cognitive help to those experiencing serious emotional distress and confusion: the psychiatric services are organised primarily as the elimination of emotional, mental and behavioural deviance, and hence as a surreptitious kind of administration rather than empathic remedy. In this project, the pseudo-medical rituals and rhetoric of psychiatry serve to legitimate official activity as no more and no less than the prudent exercise of morally neutral, scientific-objective techniques: in its conception of the psychiatric project, the so-

70 Foucault, M (1997) On the government of the living. In Rabinow, P (Ed) *Ethics: Essential Works of Michael Foucault 1954-84*. New York: The New Press, Vol 1, 82.

71 Rose, N & Miller, P (1992) Political power beyond the state: Problematics of government. *British Journal of Sociology* 43 2 173-204.

72 Connolly, M (2014) Psychiatry and the professional duty of (s)care. *Asylum* 21 2 7-8. Our discussion borrows from Connolly’s comments on the implications of the Professional Duty of Care.

73 Connolly, M, op. cit. (n. 72), 7.

called medical model absolutely separates the personal from the political in everyday life. Whereas we are each simultaneously the products and the producers of *history*, the medicalisation of every problem of living announces that those who suffer from crushing emotional distress and mental turmoil are *nothing but* the products of *nature* - i.e., *their own deficient natures*. By this deceit, the rituals and discourses of the medical model mystify everyday processes of human interaction, thinking and emotion, and covertly blame the vulnerable. Both in theory and in practice, psychiatry denies the experience of all those psychologically traumatised persons who are not only perceived as different, difficult and ill, but also as *incomprehensibly* irrational, and *undoubtedly due to an intrinsic defect and inferiority*. Along with any possible material causes of his misery (consequent to his socio-economic standing and discordances between him and his world), psychiatry ignores or regards every terror and confusion which the patient may experience as secondary or 'only a symptom'. The psychiatric medical model does not permit sickness (defect) to be attributed to the social relations or the behaviour of any other actors, but only to the suffering individual.

This individuation of every functional mental disorder as the unfortunate person's mythical illness (his mental illness) removes the crisis from the realm of moral or political activity and responsibility. This is a fraud which stigmatises the psychiatric subject and isolates him from the rest of humanity, i.e., 'normal people'. In daily practice, when biological psychiatry blithely attributes an 'inherent' or 'genetic' deficiency to anyone diagnosed with a serious mental disorder, this is only a whisper away from rationalising persecution. The psychiatric medical model is highly suggestive of the eugenic ideology, in which anybody who 'has a serious mental illness' is regarded as degenerate or sub-human. He may then be treated as such - i.e., like any other beast, he may be herded, corralled, gratuitously experimented on, and even killed, with little or no remorse.⁷⁴

Doctors insist on calling every mental disorder a 'mental illness'. This ignores the fact that there are no objective tests for any functional mental disorder, and that therefore none is actually an illness. Since there are no organic markers, when a psychiatrist is confronted with any particular patient it is never possible to be sure exactly which mythical mental illness he presents. If 'the illness' (i.e., the patient) is particularly recalcitrant, the only way to treat it (him) is to experiment on it (him) with a variety of drugs, or with shock treatment. The doctor does this in order to find out whether the illness (i.e., the patient) appears to respond to one particular treatment rather than others; when he thinks he has discovered the most appropriate treatment, he is then able to say more decisively which diagnosis fits. In this topsy-turvy arrangement, prescription amounts to wholesale ongoing experimentation on misinformed subjects, i.e., without their informed consent. And since resistance is considered a sign of the presence of the illness, psychiatric patients are unable to prevent this singular kind of medical experimentation, which is said to be carried out 'for their own good'.

As well as conducting off-the-cuff experiments with dangerous chemicals, electricity or behaviourist psychology, another bizarre aspect of psychiatric medicine (as distinct from general medicine) is that, so as to find a remedy or at least manage the alleged illness, each patient also runs the risk of being *blamed* for his condition. The social matrix is rarely called into question, but if sometimes evidence of social dysfunction can hardly be denied, it is not considered decisive for the individual's emotional and mental plight. And although he is supposed to be afflicted by an illness, everybody who is by consensus 'sane' expects the distressed and confused person to play a vital part in his recovery by reforming himself, i.e., he must recant his undesirable beliefs and stop acting deviantly. In Volume 2 we discuss the fact that in any social setting it is the most vulnerable party - for our interest, the psychiatric patient - who is likely to be made into a scapegoat for whatever frustrations others may experience;⁷⁵ and in this Volume we have demonstrated that the psychiatric

74 Aside from routinely 'trying out' different drugs on their patients, and the continuing practice of electroshock, even today not every psychiatrist feels that lobotomy and brain implants are beyond the pale (see Chapter 7, above). Sterilising patients was popular with many psychiatrists until World War 2, and during the war years Nazi psychiatrists enthusiastically carried out a cull of their patients (i.e., they deliberately killed them; see n. 94, Ch 1). Today, the eugenic project re-emerges in general medicine in the guise of genetic engineering.

75 See Chapter 20 (Volume 2).

medical model is hopelessly naïve and confused. As a result, mental healthcare's so-said medical-technical discourse - which includes reckless conjectures about constitutional or bio-chemical causes for the various kinds of mental disorder (i.e., blind guesses about causes) - always tends to morph into a moral judgement in which a patient may be blamed by officials if he fails to respond to their demands in the way that they wish. The patient is suspected of malingering or 'playing up', or he is accused of being *resistant to treatment* - he is bad not mad, or bad as well as mad; long-term or recidivist patients - who 'should be better by now' - are particularly suspected.

Before the days of Care in the Community, Goffman demonstrated that a person is initiated into the role of the psychiatric patient by coercive 'degradation ceremonies', and that the symptoms of an apparently chronic mental disorder may often be comprehended as responding to the demands of the institution.⁷⁶ Psychiatric patients now tend to spend less time inside facilities, and a combination of cost-consciousness, the radical critique and the demands of the 'psychiatric survivor' or 'user' movement seems to have forced policy-makers and managers to think more carefully about how care and treatment might *appear*. Nowadays it is publicly-stated policy to 'include clients' by keeping them informed and involving them in decision-making. To some extent this may be an authentic aspiration, yet with regard to the realities of the individual patient's isolation, distress and mental impairment in the face of a pre-existing, well-oiled and coercive organisation, it might also be viewed as public relations blather. It is true that nowadays, as a nod to political correctness, or even as a genuine attempt to include him in decisions about his psychiatric fate, the patient is always invited to his case reviews. Yet so are up to a dozen professionals - doctors, nurses, social workers, etc. - who have responsibility for the patient's case and are always able to over-rule him. These officials are most likely to believe in the medical model of mental illness, and to be dedicated first of all not to serving the whims of any individual patient but to the smooth-running of the psychiatric organisation, i.e., to carrying out official policy and the wishes of senior officials.

The medical model has important consequences for the motivation of any psychiatric patient: he is supposed to be ill, and medicine is supposed to be the most humane and appropriate response. But this invalidates the intelligibility of anything which the patient says or does which any official is disposed to consider undesirable and 'just another symptom of the illness'. It can call into question any lucidity the patient might display, and thereby discourage his own activity and self-knowledge. Given the medical definition of the situation, the psychiatrist accrues total power and his patient must become a passive, powerless and obedient recipient of treatments. 'Getting better' is reduced to the patient's compliance to the demands of the officials. Nothing in psychiatric practice has changed so fundamentally during the last half-century so as to obviate the critique posed by Goffman and others. It is still the case that what are recognised as 'the symptoms of the illness' are not only or necessarily dysfunctional responses to intra-psychic and inter-personal conflicts in the person's pre-psychiatric life: they are often the effects of medication and of a role and an identity every psychiatric patient is persuaded or forced to adopt, i.e., 'being mentally ill'.

Even though most psychiatric patients are not ill - in the normal and literal sense of the word - the medical model nevertheless insists that they 'have a mental illness'. The diagnosis of a serious mental disorder/illness immediately discounts the patient's autonomy and makes him dependent or infantile, whatever his current competence or however temporary his incapacity. The psychiatric patient is thereby generally subjected to an absurd expectation: he is supposed to be inflicted by an illness for which he cannot be held responsible (and neither can anybody else), and yet he must make an effort to recover. It is confusing to expect a patient to make a moral effort - to exert his willpower - when he is supposed to suffer from an illness which, apparently, he cannot help having. Besides, amongst other problems, he does often seem to suffer from an inability to manage his life.

Although the medical code of practice is supposedly based in technical needs, in practice it endorses paternalistic moralising. Really to allow negotiation and autonomy to the patients would be to deny the legal powers and expertise of the officials. Of course, we all hope that the doctors know

76 Goffman, E, op. cit. (n. 28, Ch 3).

best - we all defer to their greater knowledge. On the other hand, the doctors' alleged expertise with regard to the illness denies the autonomy of the patient, who is nevertheless supposed to make efforts to 'get better'. There is little room for the patient to find his way through this ideological morass. In practice, the way this conundrum is resolved is by the patient being permitted to recover only in a manner authorised by the officials: he is obliged to follow a certain approved path - a psychiatric career already mapped out for him, in which he must exhibit only an approved sequence of sentiments, ideas and behaviour, which together denote a steady improvement in his condition.

Not necessarily excluding the individual in crisis, in the meantime everybody is inclined to believe in psychiatric medicine since it offers the hope of relief from the malaise, and perhaps even a cure. Unfortunately, psychiatry soon appears to many patients not so much as a sympathetic and clarifying healing agency as a confusing and oppressive power which betrays them by engaging *only or mainly* in attempts to stop them from expressing how they feel, and tries to adjust them to oppressive 'realities'. Instead of assisting the person in the project of constructing a more reasonable and less miserable life, psychiatry tends to dehumanise, mystify, confuse and exploit him. As soon as he is the object of psychiatric attentions, the individual passes a point of no return. If he is not removed from his old life by expulsion to a place of seclusion, and segregated with others in similar conditions of distress and confusion, there is always that threat; and if the threat is carried out, he is methodically degraded, subjected to arbitrary rules and forced to submit and play the part of a deficient human being - someone who, not just at the moment of crisis, but constitutionally, is weak, unintelligent, misguided and irresponsible. Last but not least, he is administered potentially harmful medical treatments, often against his will.

The overall effect of the medical model is to further confuse the person in crisis, and to stigmatise him by saying that his 'having a mental illness' is an *essential* difference, which is to say that he is *essentially inferior* to normal people. And as long as the prevailing psychiatric ideology is enshrined in unquestioned beliefs and routine practices, no alternative perspective on individual irrationality is seriously considered by the officials or anyone else. Indeed, any other narrative is resisted by the professionals as irresponsible and dangerously heretic. Few psychiatric officials are able consciously, coherently or effectively to oppose the ill-conceived and oppressive medical model. Rather, every psychiatric worker is systematically encouraged to view those who suffer from overbearing emotional distress and mental turmoil in the same way as the doctors - as their being subjected to an illness or chemical imbalance which has a constitutional basis. This belief is said to be 'objective' and confirmed by medical science. And yet outside of psychiatric circles it is generally recognised by intelligent observers that the way to inspire people to act callously towards any class of 'outsiders' is to pejoratively name and identify them as abnormal or sub-human. Why should psychiatric officials be immune to this dynamic? If in their training they are thoroughly imbued with the medical ideology and scrupulously discouraged from exploring the ideas of developmental and social psychology, they are likely to be casually exploitative or oppressive without recognising it, even when they imagine that they carry out the most humane practices.⁷⁷ In this manner - by means of misguided theory, prejudice, stigmatisation, isolation, oppression, and motivated and confusing rationalisations - psychiatry routinely reproduces and amplifies the very emotional distress and mental disorder which everybody presumes it is organised to remedy.

As we saw in Chapter 10, Milgram's experiment showed that, in the name of science, and so long as someone who claims expert authority assures everybody that he knows what he is doing and will take responsibility, it is easy to take psychologically normal and well-intentioned people and get them to torture others.⁷⁸ In real life, it has recently been demonstrated that unquestioning trust in medical authority is the norm, and even in the face of what ought to be very worrying signs of malpractice the reflex of those in power is to fiercely resist complaints. This made it possible for a doctor to murder hundreds of patients before anyone began to notice anything was wrong. Harold Shipman worked as

⁷⁷ As depicted throughout Chapter 4, above.

⁷⁸ Milgram, S et al, op. cit. (n. 15, Ch 10).

a GP for decades, until some of his crimes were discovered in 1998; an enquiry established that 459 people died under his care, and at least 260 in suspicious circumstances.⁷⁹ Then, as revealed by the Mid Staffordshire NHS Foundation Trust Public Inquiry, between 2003 and 2005 many of the staff subjected patients at the general hospital to ‘appalling treatment’, and there were at least 400 but perhaps 1600 unnecessary deaths.⁸⁰ Later, it came to light that between 1988 and 2001, hospital GP Jane Barton had ‘presided over an institutionalised regime’ in Gosport that, in effect, and without any justification, involuntarily euthanized 456 elderly patients by means of powerful opioid painkillers; many records were missing, and there were probably another 200 victims. Despite their duty of care, nurses continued to carry out Barton’s instructions, although some had serious reservations but had failed to get management to accept there might be a problem. The death rate doubled during those years, yet rather than an investigation there were nearly thirty years of failures and cover-up by managers, consultants, the hospital pharmacist, the police, the coroner, the Crown Prosecution Service, the General Medical Council, the Nursing and Midwifery Council, and the local MP. It took years of campaigning by grieving relatives before there was a proper enquiry.⁸¹

Zimbardo’s experiment indicates that authorising someone to wield great power over a vulnerable population tends to encourage abuse - *whatever the prior disposition of the person exercising that power*.⁸² On the wider stage of history, we are all witness to the ease with which great numbers of hitherto normal people are able to turn on their neighbours with the mass murder of ‘ethnic cleansing’, so long as the perpetrators have been worked on ideologically and are exempted from personal responsibility by someone they accept as an authority.

We discussed this pathological social-psychological dynamic in Chapter 14,⁸³ and there is a clear parallel in medical training and practice. Recruits learn to treat patients according to the dictates of a doctor and irrespective of the manifest effects on the patients or of any complaints they might make - after all, nobody expects medical procedures always to be entirely painless or without discomfort. At the same time, recruits to mental healthcare are carefully *not informed* that there is no scientific basis to most of the standard practice, and that it is probable that any diagnosis is *purely arbitrary* and may be made in the absence of *any* evidence.⁸⁴ In which case, however well-intentioned they may have been when they began their careers, blind faith in the medical model combines with the concentration of power and responsibility in the hands of the doctors so as to systematically incite each psychiatric worker to become callous, irresponsible and punitive when he overrides any patient’s protests and carries out his duties, as instructed. (Obviously, a psychiatrist normally has much less contact with the patients than the nurses, care assistants and ancillary workers, and it is usually a nurse who administers treatments.) If many mental health workers are decent and humane, this is *in spite of* the bureaucratic processes and the demand to carry out allegedly objective medical techniques. As for the psychiatrists, it is normal for identity to form around status, and their tendency to believe in their own unquestionably superior powers of assessing mental illness and deciding an appropriate response is a reflection of their legal powers; this combines with a socially applauded ‘front’ by which they are able to deny any anxieties caused by perplexity or feelings of inadequacy in the face of serious mental disorder.

There are two facets to any psychiatric encounter: the publicly announced and allegedly medical practice, and then the unadvertised exhortation and everybody’s knowledge that coercion will be employed if all else fails. The notion of mental illness ascribes irrationality *only* to the individual who is overwhelmed and handicapped by anxiety, insists that this is only or decisively due to a kind of

79 The Shipman reports (2005) *BBC News* 27 Jan.

80 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, op. cit. (n. 87 Ch 14).

81 *Gosport War Memorial Hospital: Report of the Independent Panel*. www.gosportpanel.independent.gov.uk/; Evans, M, Taylor, R & Dixon, H (2108) ‘Blunders, failures and cover-ups’: Damning report verdict. *The Daily Telegraph* 21 June, 2-3.

82 See Zimbardo, PG, op. cit. (n. 16, Ch 10).

83 In the last half of the Chapter, beginning with the section: Alienated social practice.

84 See Rosenhan, DL, op. cit. (n. 41, Ch 5); and Summers, A & Kehoe, RF, op. cit. (n. 13, Ch 4).

disease, and that therefore there is a *paramount* need for medical treatment. Perhaps a person suffering from emotional distress and mental disorder does also feel ill. As we have seen, however, belief in an actual illness is based purely in the wish for a medical cure. Sedatives and stimulants do have their effects (although by no means always, or within safe limits) and patients are often persuaded by placebo, but there is no evidence for the greater efficacy of psychiatric medicine over placebo or a benign social-psychological response.⁸⁵

Belief in the medical model serves very well the wishes of a barely accountable social power. Categorising or naming is especially potent when someone is vulnerable and delivered to the total power of psychiatry. If he is not too deep in the throes of a psychotic episode, a psychiatric patient may well *collaborate* in taking the blame (accepting the diagnosis), at least initially. He may agree that he has a mental illness, and put up with the proposed remedy - loss of freedoms, the discomforts of drugging or shock treatment, etc. He may pin his hopes on a medical cure. In this way, the patient (and everyone else) turns his face from those unacknowledged psychological and social dynamics which lie behind disturbed and disturbing emotional and mental conditions. The medical model also provides a convenient alibi for those informal practices which accompany the so-said medicine, practices which constitute a politics of persuasion and coercion but which are *untheorised* - which are assigned no part in the so-called medical model - and are either undisclosed or denied. In the meantime, diagnosis and treatment is likely to render the patient more isolated, more alienated and less resourceful.

The medical model of mental illness mystifies processes of the psyche and the social relations. There is a question of the first interest of this pseudo-medicine: where a choice must be made, psychiatry operates for the sake of established power and against the vulnerable. How else is it possible that becoming or already being subjected to psychiatric attentions is just as strong 'evidence' for a mental illness as any apparent symptoms?⁸⁶ As soon as he is handed a psychiatric diagnosis, moreover, the patient is immediately subjected to a further prejudice: *anything whatsoever* that he says or does may be taken as further 'proof' of the presence of the mental illness. If he wishes to escape from psychiatry the patient must become docile and not refuse treatment; any other response will be taken as a sign of the continuing presence of the illness. In effect, unless the patient is able to get away, move away and begin a new life beyond medical surveillance, psychiatric stigmatisation is indefinite.

The usual response to institutionalisation, however, whether as in-patient or out-patient, is dependency marked by apathy and withdrawal, and intelligence dulled more than by the drugging or shock treatment. This is not necessarily an effect of the purported illness, i.e., of the 'natural' disposition of the individual, of 'how he would be, anyway': it is a social effect. In Chapter 12 we mentioned David Cooper's observation, that as soon as he is subjected to a psychiatric intervention, a person is faced with having to make one of three equally impossible responses to that social power which is legally permitted to hold him and do with him what it will: if he tells the truth, he will be 'destroyed by all the techniques available' for daring to express something unacceptable to psychiatric or other social powers; if he lies, he colludes with psychiatry and society, betrays his own experience and sense of reality, remains in conflict and distress, and will anyway most likely be taken by the psychiatrists and forced to submit to their technical processes; if he remains silent he will be called catatonic and paranoid, and in the end 'be forced to chatter acceptable nonsense'. Institutionalised and subjected to invasive treatment, when the patient is finally offered a little personal responsibility it is likely that he will shrink from it in fear.⁸⁷ Effectively, an individual under psychiatric management is transformed from someone who behaved in an alien manner into a kind of alien who was once a fully-fledged person.

85 See Chapters 6 to 8, above.

86 See Chapter 4, above, especially the text to footnote 13.

87 Cooper, D, op. cit. (n. 89, Ch 12), 148-149.

Meanwhile, the formularies indicate that for almost every psychiatric drug there is a good chance that it will cause the very symptoms it is intended to alleviate. The phenothiazines are supposed to ameliorate schizophrenia, yet it is known that they cause the ‘flattened affect’ of that condition, while every tranquilliser is known ‘paradoxically’ sometimes to increase patients’ anxiety and agitation. It is now clear that the feedback loop in which a patient’s continued resistance to sedation calls forth an increased dose and more frequent drugging often only ends in stupor or, with scandalous regularity, death. Apart from this, a normal dose of almost any psychiatric drug frequently has toxic effects - the so-called side-effects - as well as being addictive. Apart from dementia due to aging, psychiatric crises are not often medical events - i.e., there is seldom a demonstrable organic cause - but they are *always* social events. That is to say, there are always moral, political and ideological aspects to a predicament involving someone who seems very disturbed, others disturbed by him, and legally authorised takers, managers and healers. And although the standard psychiatric treatments may sometimes reduce a person’s immediate distress by way of active drug effects or placebo, it is dubious that on their own they offer him greater all round benefits than costs. However, it is certain that diagnostic labelling, constraint and medical treatments relieve the anxieties of those around the patient, including the officials: tranquillisers, sedatives and hypnotics are chemical strait-jackets which incapacitate the patient *and thereby tranquillise others*.

As we have demonstrated throughout this Volume, the standard psychiatric techniques are not based in sound medical science, i.e., developed from research findings derived from well-formulated and adequately tested hypotheses concerning organic-causal connections. Instead, they respond to naïve wishful thinking; they constitute an elaborate form of modern magic which aims to subdue the person or alter his mood in order to obviate ‘the symptoms’ of whatever ‘sick’ behaviour is deemed a problem - a problem, that is, not necessarily always to the patient so much as *always to others*, to psychiatric workers and other officials, or to the family or community. Psychiatric care and treatment might popularly be viewed as compassion in action, but in effect the so-called medical model is a licence for the officials (and, by their leave, everyone else) to release aggressive feelings on hapless victims. Joseph Berke’s perception bears repeating:

...[T]he force which motivates these outbursts of socially sanctioned violence [i.e., medical psychiatric treatments] is the wish to locate and destroy that which people find intolerable to perceive and accept as part of themselves: their envy, jealousy, greed, hatred, love and so forth... People who become psychosurgeons lend their technical expertise to the State for purposes of violent social control because the operation gives them the opportunity to annihilate in others (by means of projective identification and concrete action) psychological attributes which they cannot stand in themselves. The patient’s relatives collude with the operation for similar reasons. Ergo, the lobotomised patient is an interpersonal scapegoat on many levels.⁸⁸

Other kinds of experts may be able to commit abuses by hiding behind an esoteric mystique, but it is perhaps only with psychiatry that the expertise itself is systematically constructed full square on a blatant deceit: the medical model. Psychiatry is a type of emergency service. Very often the patient and those around him are desperate, and they are assured that help is at hand. Everyone supposes that whatever the experts suggest will be the most appropriate course of action, presumably selected from an accumulating repository of ever-improved scientific techniques. Doctors confirm this belief by making an apparently medical diagnosis and then prescribing exact quantities of impressive pseudo-medicines. If what is prescribed does not help, the patient is often told that this may be his fault - that the medicine failed due to his ‘resistance to treatment’. A patient might therefore imagine that he has to accept the harm being done to him, and ponder and somehow work on his own moral failure. From a psychoanalytic perspective, this silencing of the patient has the appearance of a systematic assault, rooted in ignorance and unconscious sadism, while a patient who welcomes this assault is deceived, or perhaps motivated by masochism or guilt.

88 Berke, JH, op. cit. (n. 15, Ch 7), 107 and 114.

The poor theory and confusion of motives in the ideology, research and practice of psychiatry cannot issue in objective scientific medicine but only in a confused and confusing kind of social control which *masquerades* as care and cure. Management in accordance with the dictates of the psychiatric medical model tends to be punitive, and we can only surmise that those who are entirely happy to practise it must be habituated to suppressing any compassion they may feel towards the patients. Their actions indicate that mental health officials tend to be motivated defensively to prevent patients from expressing themselves: to acknowledge what a patient has to say would disturb repressed memories of the official's own childhood pains and his own neurotic accommodation to established power.

It is true that lip-service is nowadays given to an interest in each patient's problematic life, but any normal psychiatric diagnosis remains *by definition* and *essentially* disinterested in the person and his context. This is strange, because Biology comprehends animal behaviour as response to an environment. Why would that not apply to humans experiencing emotional and psychological difficulties? In Volume 2 we demonstrate that however bizarre someone's ideas and behaviour, if only a sympathetic relationship is struck up with him they may turn out to be intelligible; that is, they may begin to make a kind of sense by reference to the circumstances of his life. Why does psychiatry refuse to acknowledge the best approach to the explanation of animal behaviour, and even some of its own research findings? Pseudo-medical notions regarding the aetiology of individual irrationality are hopeless fantasies, driven by unacknowledged emotional and political motives. In the field of mental health, the categorical system, the standard forms of practice and the organisation together amount to a gigantic rhetorical device constructed to deny both the actual processes that produce mental disorder and the possibility of adjusting the social relations as well as the individual psyche.

All the same, psychiatric ideology is no more than a particular crystallisation of a psychosis that characterises the general culture: the blind faith that everything which happens is only ever properly explained in terms of material causes. As we saw in Chapter 12, this belief is not supported by genuine science. The reductive proposition that we consist of matter is of course true, but it cannot generate useful propositions or hypotheses about human activity, and is no more than a banal *truism*: interesting propositions about human behaviour only arise from investigations of the meanings and intentions manifested in ideas and actions. Advocates of psychiatric medicine contend that they are 'being practical', but they fail to understand the limits of the application of the medical idea - they are simply possessed by the wish to control persons. Working from a misconception of the psyche which generates the notion of 'mental illness', and so as to legitimate their activities, psychiatrists are obsessed with discerning a tangible biological difference between those showing signs of a so-said mental illness and 'the normal population'. In the case of schizophrenia, as we have seen, even when the diagnostic category is such a lumping together of discrete reactions to overwhelming stress that it is hopeless to pursue a precise definition and a single material cause.

That uncritical psychiatric theory and research continues along the same old 'biological' path is perhaps a reflection of a more general social and intellectual pathology. Official culture subscribes to a version of reality which only changes in response to the interests of power, and there is instant collective amnesia about any such changes. It is not so long since madness was viewed as a moral failure, but nowadays any thoughts, feelings and behaviours which deviate from the generally agreed norm must be 'symptoms of an illness'. And yet the signs of almost every kind of so-said mental illness are at some time or place deemed acceptable or even significant. Psychiatry is a crucial component of the official culture; it is blind to the fact that its biological model is launched from a specific cultural platform. For example, there are beliefs and behaviours that constitute the signs of schizophrenia or depression in the UK which may be counted as entirely normal in (say) Italy or India.⁸⁹

89 Depression (grief) is expected after significant loss, and talking in tongues and bizarre ideas are encouraged by some churches; unmarried motherhood ('moral imbecility') was removed from the list of mental illnesses as recently as the 1950s, and homosexuality only after decriminalisation (in the UK in 1967; removed from *DSM* in

This ethnocentric bias prevents those working in the field from recognising that personal or inter-personal crisis is not illness, and no doubt it is intensified by psychiatry's function as arbiter of good mental health and normality, and hence guardian of society's mores. It is unfortunate for those who suffer from overwhelming emotional distress and mental disorder that these days the law consigns them to the authority, care and treatment of the medical profession. This sanctions a general blindness to the contradiction at the heart of psychiatric practice: that very few cases of mental disorder are the result of a real illness. An authentic medical diagnosis assesses an object (a person's brain) and not a subject (the person as a sensitive and conscious agent). Hence, any 'diagnosis' of someone undergoing a personal crisis which decides that he 'has a mental illness' is either deceitful or delusional; it engages with social, emotional and cognitive processes in a confused moral-political exercise of assortment which is absolutely different from discerning a physiological cause. Confusing mind with brain - reducing the subject to an object - is a moral and political exercise of motivated wish and practice that reflects the anxieties of the 'mentally normal' majority. Although the system of psychiatric beliefs is constructed and maintained by the doctors, they and every other relevant official are the agents of a consensus which gives its hearty approval.⁹⁰

Medical psychiatry assumes that mental deviance is essentially the result of a bio-chemical or genetic defect. It gives little or no weight to stress-driven and stress-causing organic features of the individual, even when these might be obvious to any dispassionate layman - factors such as insomnia and physical exhaustion. Instead, it assumes that these are consequences of the alleged mental illness. When a psychiatrist does acknowledge an environmental factor or stress itself - perhaps because it is so obvious that it cannot be entirely ignored - he refers to it as 'a precipitating factor' in an overriding disease process to which the subject was already 'predisposed'. Accordingly, the faulty brain is supposed to require a drug so as to 'manage the symptoms' (or at least to silence the patient). Between 1950 and 1990 - before information technology took-off - the most profitable global industry was pharmaceuticals. Naturally, drug companies promote the idea of individual illness rather than the inference that emotional and psychological distress is a product of personal, social, political or economic oppressions. The blanket and indiscriminate use of drugs is little more than another turn of the screw in those oppressions: by means of drugging or shock treatment, someone whose self and identity has collapsed into incoherent and apparently random distress and unsociability is further denied a voice and a life.

Whereas every psychiatric technique is supposed to be based in medical science, a psychodynamic perspective reveals the political nature of the enterprise. Individuals respond to the contexts or environments in which they find themselves. If someone gets very upset, or voices his dissent, or becomes confused and acts bizarrely, and does not or cannot easily explain himself, this is most likely to do with his becoming overwrought as a result of specific social interactions, whether local (concerning members of the family or other intimates) or more general (arising from the wider social arrangements). Any mental disorder needs to be investigated for a precipitating emotional trauma: it is likely to result from circumstances such as cruelty, exploitation or abuse, from emotional or physical insecurity, from the pressures of competition, from social isolation, or from some other failure of democracy, community and participation.⁹¹

Best known for his analysis of imperialism, Frantz Fanon was a psychiatrist who worked in Algeria during the war of independence. He saw parallels between rearing children under the social

1974.) As we have mentioned, new mental illnesses are also suddenly discovered, i.e., invented: e.g., schizophrenia and ADD/ADHD. And no-one seems surprised when the psychiatrists abruptly stop diagnosing and treating certain kinds of emotional or behavioural deviance as mental illnesses. In the same way, when an enemy state's ideology performs a flip-flop - such as aspects of the old Soviet propaganda - everyone is able to 'see through' what is going on very easily; but when an element of our own community's ideology suddenly reverses its perspective this is either ignored or comfortably rationalised.

⁹⁰ We detailed this argument in Chapters 12 and 13, above.

⁹¹ For example, it is well-documented that suicide rates rise and fall with levels of unemployment. See text to footnotes 33-34 in Chapter 1, above.

conditions of turmoil, insecurity and terror, and the imposition of psychiatric power. In both cases the subjects interiorise a form of domination by means of a kind of colonisation of the mind. Incapacitating emotional distress and mental disorder originate in social injustice and emotional trauma. But this is unacknowledged, and the normal rehabilitation of the psychiatric patient depends on the approval of his oppressor.

The colonised person is made to feel inferior to the coloniser and is only considered rehabilitated if he conforms to the cultural values of his oppressor. The self-esteem of the colonised person is therefore dependent upon the willingness of the coloniser to give him or her worth.⁹²

It is high time for the management of individual irrationality to move away from a position where it '...functions to exclude and repress those elements society wants excluded and repressed.'⁹³ At the moment, the psychiatric patient experiences exclusion, invalidation and coercion by an organisation of self-styled experts who insist that they know everything about his condition and how to remedy it, and that he (the person undergoing the experience) must keep quiet because he is only made confused by his illness and knows nothing at all of any possible use.

Revictimisation

It may have sometimes been compromised in practice, but 'moral management' of the insane was a beacon of humane reform during the first half of the 19th century. This was when there were still public hangings, unregulated mines and factories, no limits on working hours, child-labour, overcrowded and unsanitary living conditions for most people, and the average life expectancy for a working-class Londoner was twenty-two years. But by 1900, 'moral treatment' in calm and human-scaled environments had mostly been replaced by industrialised-bureaucratic management under medical control. There was still no plausible theory of the genesis of madness, or for its remedy, but the demand for 'efficient' administration of the insane had led to reliance on physical and chemical techniques applied to a relatively anonymous mass of bodies packed in big, barrack-like institutions.

By the end of the 20th century, most of the big old asylums were decommissioned. The way mental health patients are dealt with now appears much more humane. Standard treatment remains medication, and to a lesser extent, shock treatment: by means of chemical or electrical alteration of mood and functioning, internal restraint now largely replaces external restraint; this is an invisible and more convenient form of coercion. It is now routine to leave psychiatric patients 'in the community', or more quickly return them home after supervision and treatment in a specialised unit. This may seem progressive but, in itself, medical treatment does not help someone come to terms with his distress and confusion; which is to say, when he needs help to recognise, confront and overcome his problems, and thereby make a less miserable life for himself, it cannot be a long-term remedy. Research regularly shows that only a minority of psychiatric patients feel any benefit from medical treatment alone (i.e., drugs or ECT). And with little hope of ever escaping, they also tend to enter a stigmatised, demoralised and poverty-stricken underclass.

Antonin Artaud, the French actor, director and writer, was famously diagnosed and detained as a schizophrenic. In his view, a sick society invented psychiatry in order to defend itself against the investigations of certain visionaries whose faculties of divination disturb it.⁹⁴ This perception should not be dismissed out of hand. Thomas Szasz reported his experience of the normal response of fellow psychiatrists towards any diagnosed schizophrenic: 'Human garbage - get him out of my sight'.⁹⁵ All the same, for a variety of reasons of his condition and situation, coupled with the sheer weight of the consensus, a psychiatric patient may be willing to believe that medicine can help him, and often there

92 Fanon, quoted by Hopton, J (1994) Frantz Fanon revisited. *Asylum* 8 1 16-17.

93 Laing, RD (1985) *Wisdom, Madness and Folly*. London: MacMillan, 9.

94 See Artaud, A (1965) Van Gogh - the man suicided by society. In *An Artaud Anthology* (Ed Hirschman, J) San Francisco: City Lights.

95 Szasz, TS (1990) Interview with Bonnie Burstow & Don Weitz. *Toronto Globe & Mail* Jan.

is a placebo effect.⁹⁶ An unknown proportion of patients also experience a ‘spontaneous remission’ during their encounter with psychiatry - either by recovering emotional and mental equilibrium anyway, or by being frightened into saying that they have..⁹⁷

By contrast, patients who reflect on their experiences - and especially on the deleterious organic effects of drugging and electroshock - are often persuaded that the standard treatments are not helpful but counter-productive to both mental and physical wellbeing. Towards the end of the 20th century, one survey of service users (no doubt selective because it was canvassed through a magazine), found that 76% felt that they had not been cured or helped by psychiatric treatment (another 5% believed there was nothing to cure in the first place); only 10% felt that they had been cured. 38% wished for the abolition of psychiatry, but 46% wanted counselling and more funds put into community-based services..⁹⁸ A national survey by MIND, with a sample of 343 people who had recently been in-patients, found 25% reporting that the wards were therapeutic but 56% finding them positively anti-therapeutic. From the same survey, 27% reported a benefit but 47% felt the experience had made them feel worse; 45% found the wards depressing, and 30% found them unsafe and frightening; 16% reported sexual harassment, and three-quarters of those respondents said that the authorities had done nothing to stop it or prevent it happening again. 57% reported not enough contact with staff and, of this group, 82% reported typically 15 minutes or less contact with any member of staff in 24 hours. 60% found problems getting a quiet sleep at night; 45% reported inadequate access to food and - important in the context of the dry-mouth effects of some of the drugs - 31% reported insufficient access to drinking water..⁹⁹

As we saw in Chapter 14, above, there were no significant signs of improvement by 2015. A comprehensive survey by the Care Quality Commission recorded only 14% of a sample of patients saying that they had received ‘the right response which helped to resolve their mental health crisis’, while 40% said the response had been ‘entirely inappropriate and had not helped at all’; the CQC particularly found the behaviour of A&E mental health officials ‘quite shocking’..¹⁰⁰

As one ‘survivor’ has put it:

Oppression rather than recovery is the normal experience for those who enter the [psychiatric] system..¹⁰¹

In the experience of too many patients, psychiatry tries only to silence them and make them conform. It does this by a combination of persuasion and coercion, by disbelieving them, by the accusation (diagnosis) of their ‘having a mental illness’, by stigmatisation, and by invasive treatments. In this manner, and in accordance with the rationalisations of its medical model, psychiatric intervention re-victimises the patient: it adds to the oppressions which already caused the distress. The greater the individual’s apparent distress and confusion (or nuisance or danger), the more likely there is an immediately coercive and medical response, rather than genuinely inclusive discussions and offers of practical assistance. Added to this, there is substantial anecdotal evidence to support the suspicion that those functionaries who believe in the medical model - i.e., the great majority - are likely to disregard even well-documented histories of patients having been abused. Many patients and ex-patients have complained that, during diagnosis and treatment, officials readily convince themselves (and other authorities) that a patient is simply lying when she discloses information about abuse. This ‘lying’ is said to be calculated and motivated; it is known amongst psychiatric professionals as ‘attention-seeking’ or ‘manipulative behaviour’, and considered another

96 See the discussion in Chapter 8, above.

97 ‘Spontaneous remission’ simply means that the patient seems to recover but the doctors cannot imagine why. The phenomenon is officially recognised but neither regularly audited nor usefully researched.

98 Cresswell, J (1993) A users’ report on psychiatric services. *Asylum* 7 2 22-27.

99 The hospitals that make you sick: MIND & The Big Issue National Survey (2000) *The Big Issue* 412 10-12. All the respondents had been in-patients within the previous five years.

100 See text to footnote 79, Chapter 14.

101 Coleman, R, op. cit. (n. 97, Ch 6), 32.

symptom of the alleged mental illness.¹⁰² A sympathetic study of a sample of women diagnosed with borderline personality disorder (BPD) found that 88% reported sexual abuse, with 70% saying they had been sexually abused during early childhood. This made no difference to their receiving a mental illness diagnosis and no difference to their therapy, which remained only medical treatment.¹⁰³

Where the moral climate is authoritarian - as it is in many families and throughout most other institutions - any dependent individual who finds herself a victim of violence or emotional or sexual abuse soon learns to keep quiet about it. If she is terrorised into shutting up about it in one context (by the perpetrator, e.g., at home), she is most likely to be ignored or disbelieved, and even punished, if she dares speak about it in another (e.g., to a teacher, a doctor, a social worker, a psychiatric worker). In this way, and rather than afforded the sympathetic attention, comfort and justice they require in order to outface and outlive their terrors, confusions, sense of abandonment and sheer frustration, the silenced victims of childhood abuse regularly become emotionally distressed and mentally disturbed adults subjected to yet another intolerable accusation when, as a consequence of a particular crisis, they are diagnosed as 'having' this or that 'mental illness'. Once again they are made into victims - this time, by incredulous or indifferent mental health officials who would rather believe in the myth of mental illness.

Of course, significant business opportunities are generated by the profit-driven political-economy that is at the root of much emotional distress and psychological turmoil. The abiding 'problem of mental illness' conjures up a major sector of the pharmaceuticals industry to deliver psychoactive chemicals, and a sizable workforce to manage the casualties and administer the treatments. Drug companies profit by offering so-said medical remedies which often cause organic harm and are doubtfully more effective than placebo. GPs, psychiatrists, psychiatric workers and social workers confuse distressed individuals by defining their problems as undoubtedly medical (a biochemical or genetic abnormality); while providing a minimal level of care, they oversee every patient's life and enforce chemical or electrical treatments. Altogether, the mental health industry tends to restrict each patient within a tight circle of hopelessness. Never mind: the current dispensation guarantees an ever-expanding demand for the drugs (however ineffectual or harmful) and secure employment for an army of mental health officials (however ineffective they are as carers and healers). These are the effects of calling the problem by a false name: 'mental illness'.

This sorry parade of profitable delusion will continue until there is a radical shift in awareness and practice. Psychiatry is now fully integrated with the drugs industry. The myth of mental illness and medical remedy keeps every patient from discovering the cause of his malaise, and consequently a dependent invalid. And since psychodynamics is given no credence, every psychiatric official is likely to carry the load of his own unexplored emotional baggage, and work to a self-serving agenda rationalised by the medical model; since he acts only or primarily as a medical functionary, this is bound to inhibit reasonable and humane relations with the patients. The public imagines that psychiatry is applied medical science, and yet we can be sure from the weight of the evidence that it is a form of injustice and oppression.

The psychiatric establishment and the drug companies are always conspiring to extend their reach by inventing new mental illnesses.¹⁰⁴ There is a whiff of sadism to some diagnostic categories and treatments. Consider the major categories of schizophrenia, personality disorder (or BPD), dementia and ADHD. Most diagnosed schizophrenia onsets during adolescence, which is also when the label

102 See the special issue of *Asylum: Women at the Margins*. Especially: Anon (2004) Jo's story. *Asylum* 14 3 4-5; Anon (2004) Suzi's story. *Asylum* 14 3 11-13; Bressington, C (2004) Truly photographic memories. *Asylum* 14 3 14-15; Anon (2004) Sylvia hurts. *Asylum* 14 3 23. This is also affirmed by Lin Bigwood, a psychiatric nurse. Of course, this kind of malpractice also affects male patients. When a troubled son of the now infamous Phil Spector turned to mental health counselling, he was accused of lying about his connection to Spector, let alone the abuse he suffered as a child, and this 'lying' was said to be evidence for him having 'a mental health problem'. Phil Spector's Demons (2007) *Channel 4* 15 Oct. Testimony of Donte Spector.

103 Castillo, H (2000) User's views on Personality Disorder. *Mental Health Care* Oct.

104 See reference and text to footnotes 21 to 23 in Chapter 5, above.

'personality disorder' tends to be ascribed to troublesome individuals who do not happen to show signs of a psychosis. Both diagnoses are foisted on distressed and isolated young people who tend to be naïve and powerless to resist the determined attentions of a cohort of busy, authoritative-sounding and supposedly responsible officials and other 'normal' citizens. It is quite likely that aside from the complaints of the patient or the nuisance of the purported disorder, 'responsible people' (and not necessarily excluding psychiatric officials) are affronted by the energy, irresponsibility and possibilities of youth: the official response may be influenced by interested parties' negative feelings, such as disgust, indignation, frustration, anger, jealousy - or guilt. Similarly, dementia is a diagnosis easily foisted on a defenceless population, many of whom might suffer first of all from nothing more than aging: they are slow, they have problems with hearing or seeing, they suffer from bereavement and loneliness, etc. To any official who holds a little power but is yet to resolve his own Oedipal ambivalences, an old person may symbolise a parent: that is, unconsciously reconnected with powerful negative emotions from his own childhood, the official might resent the patient and act towards her aggressively or without compassion. Last in this list, an unpleasant recent 'discovery' is the condition first identified as attention deficit disorder (ADD) but soon 'refined' as attention deficit hyperactive disorder (ADHD): when they are a persistent nuisance, this diagnosis is applied to children as young as eighteen months, and diagnosis authorises subjecting the child to drugs with powerful affects on mood and mental functioning.¹⁰⁵

Most of the time, mental health practice is not a kind of technical expertise based in sound medical science; it is only a collection of handy ploys to contain certain kinds of deviance.¹⁰⁶ From a sociological perspective, the standard procedures appear as rituals and rationalisations employed to justify imposing sanctions on individuals whose emotional, behavioural or mental deviance is too upsetting - scandalous, a nuisance, frightening or dangerous; at the same time the medical pretence of the diagnosis directs everyone's attention away from the real cause of the individual's irrationality.

In which case, it is time to dispense with psychiatry's diagnostic system. The medical conceit makes moral and crypto-policing judgements appear scientific - and therefore indisputable. In reality, the long list of diagnostic distinctions does little more than serve an ideological purpose. A particular diagnosis may to some extent alert everyone to the sort of deviant behaviour the individual in question is likely to manifest, or the kinds of emotional and psychological problems which appear to afflict him, but almost every diagnostic category is by now hopelessly compromised by an overload of pseudo-scientific, essentialist and pejorative meaning. Since there is almost no belief or behaviour that does not cause anxiety to someone, psychiatry has reached the absurd position where there is a diagnosis for *anything* controversial that anyone might ever do or say. And just to make quite sure, in 1994 *DSM-IV* introduced a catchall category, Immature Personality Disorder; no diagnostic criteria are specified for this mental disorder, and the decision to assign the diagnosis is left entirely to the discretion of the interrogating psychiatrist.¹⁰⁷ Any mental illness diagnosis invalidates the person receiving the judgement. A psychiatric diagnosis goes much further: it strips him of his civil rights and is the individual's first step along a trail of stigmatisation, degradation, depersonalisation, discrimination and ostracism; pursuant to the requirements of 'care and treatment' (i.e., management), his space and body may be invaded at any time, his communications censored, his social relations forbidden, and he may be incarcerated and sent anywhere against his will; former patients find informal as well as legal difficulties in the fields of employment, insurance, travel and education.

Meanwhile, anyone who finds himself made into a psychiatric patient is urgently in need of sympathy, empathy and solidarity. Were less attention given to the niceties of attributing an exact diagnosis - supposedly in order to organise the appropriate care and treatment - the focus could shift

105 The whole of Chapter 12, above, examines and debunks the concept of schizophrenia. For a brief critique of ADD and ADHD, see text to footnotes 28-30 in Chapter 5, above.

106 See Chapters 5, 6 and 7, and 12, 13 and 14, above.

107 See text to footnote 23 in Chapter 5, above.

to listening to the person and investigating the stress-inducing circumstances of his life. It might then be possible to help him address his actual emotional, social, cognitive and material problems. In the name of 'objectivity', however, the medical model specifically mandates pseudo-technical forms of treatment in which every professional is supposed to 'keep his distance' from every patient. In Chapter 14 we argued that officials lose their fellow-feeling when they invest themselves in the role of technical-bureaucratic expert.¹⁰⁸ This identification positively discourages psychiatrists and other officials from collaborating with patients *as equals*, so as to help them address the real problems in their lives. Instead, the so-called medical model constrains every functionary to deny the significance of any patient's experiences, and of his manifest psychological, social and material problems; while 'maintaining detachment' and activating standard procedures, an official must only 'manage' the patient and 'treat' his alleged illness.

This imperative of the ideology and the social organisation is reinforced by the doctors who practice and control psychiatry being disproportionately recruited from privileged backgrounds and normally learning about 'professional ethics' at an early age. Recent research found that, compared to the general population, doctors are more than sixty-times as likely to have a parent who is a doctor, and while more than 54% of all types of doctor originate from Social Class 1, only 2% are recruited from the poorest 40% of the population. Until quite recently there seemed to be discrimination against entry into the psychiatric profession by women; this still seems to be the case for Afro-Caribbeans. The usual form of education for the children of the rich is a private boarding school (or a state school that mimics the private schools); the boarding system ejects children prematurely from the security they might have experienced in the home, and generally thrusts them into a consciously Spartan (somasochistic) organisation for producing an elite of 'objective-minded', emotionally-hardened and confident (or self-righteous) administrators. These tendencies are magnified by career-paths: the most influential positions in the medical hierarchy are unlikely to go to doctors recruited from social classes 4 or 5, and medical power is overwhelmingly white, conservative, male and, of course, wealthy and isolated by privilege from the experiences of 'the lower orders'. Psychiatrists are therefore unlikely to have a vivid and realistic comprehension of the plight of many of their patients. In fact, research shows that as they progress through training, young doctors move towards an ever-greater separation from the bulk of their clientele than they intended when they were raw students - they focus increasingly and above all else on clinical medicine and achieving power, prestige and a financially successful career; interest in patients' backgrounds and in social models of mental disorder declines steadily with each successive year of training.¹⁰⁹

We can guess that if doctors repress awareness of the psychologically traumatising circumstances of most of their patients with mental health problems, this is an expedient which seems necessary 'so as to be able to get through the case-load'. All the same, certain factors combine to make this repression especially strong within psychiatry itself. First of all, due to the over-riding legal power of the doctors, and whether or not they always agree, every other psychiatric worker is ultimately bound to execute upon the patients the dictates of the so-called medical model of mental illness. Secondly, there is a great social distance and hence a great difference in experience between most mental health patients and almost every doctor and probably most mental health professionals. Thirdly, since the medical model is far from proving an undoubted success in the field of mental health, and even if there is only subliminal awareness of the gap between the evidence and the official wisdom, doctors and other mental health officials seem to compensate for the cognitive dissonance that they must surely suffer by means of a *more fanatic medical belief*. Finally, and not least, since they are not adequately trained in social-psychodynamic theory and practice, and in fact are specifically instructed that it is mistaken, most mental health officials seem entirely happy to subscribe to the so-called medical model of cause, care and treatment.

108 See the sections: Alienated social practice, The fetishism of the office, and The fetishism of psychiatric medicine.

109 The research findings cited here are taken from Thomas, P, op. cit. (n. 11, Ch 6), 222-227.

In the meantime, epidemiological research continues to show that incidence of mental disorder associates most strongly with three social indicators: material deprivation, sex and ethnicity. The poor have always been exposed to greater risks of a mental health diagnosis than the rich;¹¹⁰ more females than males experience some kind of clinical mental disorder;¹¹¹ and in the UK, someone of Afro-Caribbean descent is twice as likely as the general population to be diagnosed with a mental illness, and five times as likely to be considered so seriously ill as to warrant hospitalisation for schizophrenia.¹¹²

Whatever the class, gender or ethnicity, an individual always takes a chance when presenting to a doctor or psychiatric official while showing signs of irrationality. Psychiatry's rationale is care and therapy but its first interest is the social peace - peace within the very contexts out of which very distressed and confused people emerge and present themselves. That the first interest of psychiatric officials is to control the patient's behaviour is not a matter of their social origins or attitudes: it reflects the overriding social function of psychiatry, which is not cure but effective *management* of individual irrationality. The generalised demand that psychiatry must only or mainly address itself to this end - rather than address itself to remedying distress and confusion - is to a large extent based in two fears: psychophobia, and the fear of disclosure of the real nature of the social relations.

When the powerless and the oppressed much more often fall victim to a serious mental disorder, when there is such a dichotomy between the class origins and the status and privilege of the doctors and most of those subjected to their authority, when the only aetiological hypothesis which anyone in authority will entertain is the dubious medical model, and when care and treatment is experienced by most patients as callous, unhelpful and dismissive of their reasonable concerns, it is difficult not to view psychiatry as *disguised class warfare*. (Of course, this is also a war against some of the abused, bemused, emotionally traumatised and dissident members of more privileged social strata.) A class-political perspective might help us to understand more clearly the bombastic fanaticism with which the officials champion their miserable, ill-conceived and unfounded medical model: psychiatry is that realm of social action in which specific agents of the ruling interests encounter and exert control over oppressed individuals who have succumbed emotionally and psychologically to the pressures of the social order, and who by their irrationality embarrass and threaten to disrupt it.

In most matters of emotional, psychological or spiritual well-being, the psychiatric establishment has displaced the Church in its alliance with the State. In the general consensus, an ideological conception of Science and Medicine outranks the rhetoric of Religion and Justice: repression in the name of Mental Health has replaced repression in the name of God or Justice. This was facilitated by the psychiatric profession developing its own elaborate and esoteric orthodoxy which, of course, involves proscribing every psychiatric heresy. Questions about the function of psychiatry, and its rationalisation, were settled by the early years of the 20th century. This was achieved by the administrative capacity of the new profession when it proved it could successfully run the big warehouse asylums or mental hospitals of the late-Victorian era, and by devising the pseudo-medical diagnostic categories of the various 'mental illnesses', attributed to emotionally distressed and disorientated members of the unemployed or the 'degenerate' poor (or to anyone else succumbing to overbearing oppression, such as certain disappointing members of the more privileged classes). Psychiatry has long since appeared as unquestionably an application of authentic medical science. Today, the self-assurance of the profession is facilitated by an ideology which has undergone a century of elaboration, and it is guaranteed by the consolidation of its organisation within the social fabric. Now, as they bandy about the terms of a contemporary scientificity, psychiatric officials are

110 Weich, S & Lewis, G (1998) Standard of living, social class and the prevalence of the common mental disorders in Great Britain. *Journal of Epidemiological Community Health* 52 1 8-14.

111 14% of all English men but 20% of all women, according to: Prescott-Clarke, P & Primatesta, P (Eds) (1996) *Health Survey for England, 1995: Findings*. London: The Stationery Office.

112 Mann, A et al (1998) British psychiatric morbidity. *British Journal of Psychiatry* 173 4-7; also Raleigh, VS & Almond, C, op. cit. (n. 53, Ch 5).

able to deploy an array of impressive, apparently medical techniques which they say are undoubtedly beneficial to the patients.

And so, in the modern management of incapacitating emotional distress and mental disorder, the condition of the suffering individual is defined as essentially a bio-chemical imbalance or an unfortunate genetic glitch; ostensibly palliative chemical or physical treatments are generally the first and last psychiatric response. But there is neither good evidence nor sound argument to support this belief and policy, and it is a scandal which blights tens of millions of lives. The ruling dogma, embodied in the diagnoses and prognoses, supplies a self-fulfilling prophecy in which the worst is expected of those who suffer the most. This devalues the person in crisis, and adds to his confusion and loss of confidence and self-esteem. Apart from this violence to the person and the truth, psychiatric routines do little to ameliorate chronic disability and much to encourage it. For more than a century, treatment has largely consisted in the containment or suppression of the individual's emotional, psychological and social problems by means of the containment and suppression of the person. And aside from thereby compounding emotional and psychological harm, there is an unpublicised epidemic of addiction and iatrogenic disease.

A psychiatric patient is not usually a fool. Although he is said to be ill, and is required to submit to treatment, each patient remains a person who experiences the degrading routines of bureaucratic and medical processing, the depersonalisation, disorientation, physical pain and harm, and the stigma and the isolation reinforced by the attentions of psychiatry. It therefore comes as no surprise that in a comprehensive non-directive UK survey of longer-term psychiatric patients, 45% reported that they felt they needed someone - generally anyone - with whom they could discuss their problems, and a further 27% wanted some other support, such as the help of a named person or simply company, understanding and reassurance. Such was the disenchantment with the services provided, however, that only 8% were happy with what was on offer, and only 6% thought that their medication had been helpful.¹¹³ Although that research was twenty years ago, so little has changed in the meantime that, as we mentioned, the recent Care Quality Commission survey found only 14% of its patient sample saying that the care they received had provided the right response and helped to resolve their mental health crisis, while 40% said the response was entirely inappropriate and had not helped at all.¹¹⁴

While illness (mental illness) is attributed to those experiencing incapacitating emotional and mental turmoil, they are also given the distinct impression that, all the same, they are somehow responsible for the malaise. In this manner, psychiatric oppression and stigmatisation institutionalises the paranoia engendered by the general social relations of a competitive and exploitative political-economy, or by specific traumatising relations. There is no evidence that an effective remedy for anyone's psychological problems is to call his distress and confusion 'a mental illness', and to insist on so-said medical treatment. At best, this only contains personal or social problems by means of a more rigorous control of the deviant. With the so-called medical model, every psychiatric diagnosis is a covert political act which functions to mystify mental and social processes, individualise the crisis, obscure social connections and responsibilities, and thereby defend an oppressive status quo. To make a patient of someone who is said to suffer from 'an illness called depression', for example, is to use motivated rhetoric and an overbearing social organisation with regard to what is *most likely* distressing emotional pain, disillusionment, alienation, isolation and confusion.

Anyone who suffers from a functional mental disorder is never simply a patient - only a case of an illness. Until he breaks down under the pressure of his emotional distress, the typical psychiatric patient has already had to negotiate problems in his life that apparently are unimaginable to most doctors. No-one has a right to say (to make the prognosis) that the person who is today agitated and irrational, or exhausted, depressed and dispirited, might not tomorrow recover his strength, revive his spirits and once again act as rationally and with as much autonomy as anyone else.

113 Faulkner, A, op. cit. (n. 2, Ch 6), 93. 13% wanted time to sleep, to relax or to be alone.

114 Public services must 'wake up'..., op. cit., and Campbell, D, op. cit. (n. 79, Ch 14).

The medical ideology: motives and consequence

What is it that makes psychiatric officials ignore or deny what patients feel? Why are they oblivious to the emotional, psychological and social dynamics of mental disorder? How can they regularly ignore everything known about the ill-effects of psychiatric treatment?

Apologists plead constraints of numbers and time. Having diagnosed his mental illness and inducted him into the system, a psychiatrist is only able to see a patient for perhaps a few minutes every couple of weeks. Even if he wanted to do so, he would not have time to explore every element to the circumstances in which the crisis arose. And yet the management of irrationality would not be organised under medical authority were that kind of overwhelming personal crisis not universally construed as a kind of illness. Without this misreading of events, the official response would not be delegated to hard-pressed functionaries employed *only* for their medical qualifications, and not at all for any psychological and sociological acumen they might be able to muster.

As it is, their medical training serves to legitimate the emotional imperative which drives each mental health professional to believe in the myth of mental illness. For the psychiatric medical model provides a superficially plausible defence against psychophobia¹¹⁵ - that anxiety inevitably aroused amongst uncomprehending witnesses to a distressed individual's acute or persistent irrationality. The most extreme anguish and distraction collects at the doors of psychiatry, and every face in the endless parade of the distressed and confused confronts each official with an immediate demand for help. More than this, the patients may be gross in the expression of their needs - they may appear frighteningly depressed or loud or manic, too bizarre, too chaotic. If he is unable to fathom or imagine social-psychodynamic causes, an official might find it hard to bear the high level of incessant demands - the distress and irrationality - without reassurance from the so-called medical model. The extreme behaviour of some psychiatric patients may be shocking, and perhaps (given the medical model) apparently hopeless; officials might find this intolerable without the emotional barrier and cognitive crutch provided by an organisation which by general consensus employs standard medical procedures to mend or manage faulty brains - rather than settle minds or persons by means of discussions focussed on psychological, interactional and other practical questions.

Within the apparently rational-medical organisation, a mental health official's responsibilities are precisely demarcated. Each professional may be thankful that he is expected only to perform a specific set of pre-ordained functions on a flow of objects - bodies with 'sick brains' - to which persons simply happen to be attached. After all, psychiatry is conceived as a branch of medicine like any other, and its medical model mandates disinterest in the material, emotional or psychological problems of the patients. More than this, psychiatric workers are admonished 'not to get too involved' with the patients, and they are regularly forbidden from discussing certain issues - matters which are taboo precisely because they *are* significant - for fear of 'upsetting the patient and making his illness worse'. This makes it legitimate for any official above the level of healthcare assistant to hide away in an office and shuffle paperwork, or to prioritise meetings with other members of staff - in which every official's 'medical' self-image is reaffirmed by the use of the latest jargon - and to emerge onto the ward only to issue directives and administer treatment.

Meantime, in normal daily life, emotional distress and irrationality immediately alerts any intelligent observer to likely emotional, psychological and social causes. If we allow that anxiety is most often a product of the vicissitudes of everyday life - and most often of the play of inter-personal power and dependence, scarcity and exploitation - we may immediately recognise the quasi-judicial and micro-political purposes of the mental health services. Were these openly acknowledged, however, everyone would also have to admit that the present system of care and remedy is thoroughly compromised since the medical model insists that every disturbed person's problems will only begin to find their solution when he is correctly diagnosed and suitably medicated.

115 Identified and discussed in Chapter 13 above, in the section: Psychophobia and the wish to view individual irrationality as illness.

Psychiatry's medical model performs three functions vital to the social and psychic economy of the established order - that status quo which is most often a leading cause of someone's anguish and mental turmoil. First, it rationalises the urge to hold at emotional and social distance anyone going through a personal crisis; second, the alibi of 'technical response' authorises the restraint and invasive treatment of that kind of troublesome deviant; and third, by refusing to view the problem in anything but medical terms, it exempts the social relations from criticism and analysis.

In the present set-up, it is inevitable that a psychiatric patient is depersonalised and stereotyped, ostensibly to remedy or manage his illness, but in effect so that he may be worked on discursively and coercively before being re-inserted into the routines of the wider social organisation. When emotional distress and mental disorder is viewed as *essentially* the contraction or development of an illness, this conveniently removes social, moral or political responsibility from everyone except the person in crisis. The principal responsibility of any psychiatric worker is then to placate the patient by carrying out the duties of a medical technician. As long as he performs his role, what more can he do? It is not his fault if treatment is not always very successful. Like every other medical professional, he can only await the development of improved techniques. It is by such evasions that psychiatry is defended, rationalised and organised as a form of *bad faith*.

As well as the forces of disruption and disorder without, we all fear the forces of disruption and disorder within. The psychiatric ideology defends against this fear by asserting an aloof, allegedly scientific-objective stance towards the relentlessly teeming misery which confronts the officials every working day, in which the object of treatment is to fix-up, tidy-up and send back into the community good enough role-players who will no longer be a nuisance to whoever might have an interest. The professionals like to perform this duty with a mixture of brisk pseudo-technical efficiency and bonhomie, whereby the patient's distress is downplayed, along with all the possible significations of his mental disorder and the full reality of his problem-plagued life. At the same time, whenever a doctor makes a mental illness diagnosis, everyone else is implicitly assured of their sanity. In this manner, the psychiatric medical model provides an alibi for the unspoken collective decision not to disturb the smooth surface of civility which conceals a multitude of unacknowledged oppressions. When an individual expresses his emotional and psychological disturbance by his irrationality the cause of his oppression is glossed by the myth of mental illness. Once, alienists or 'mad doctors' were fairly disreputable. Nowadays, by reference to the elaborate fictions of the medical model, psychiatrists are fully integrated into the fabric of the status quo as highly respected experts.

Together with the claim that medical treatment is appropriate and sufficient, deliberate neglect of the social causes of incapacitating irrationality is a ploy widely endorsed by the consensus. Few of us are sufficiently prepared emotionally, cognitively or practically to care for someone who succumbs to a personal crisis. By and large, out of sight out of mind. In Volume 2 we elaborate the suggestion that this is why so many people become so distressed and confused in the first place: in a competitive political-economy, exploitation is normal but time and compassion are in short supply. Furthermore, due to everyone's fragile sense of self there is a universal fear of contagion by the mad.

Unless they occur in wars or famines in distant and exotic countries, the consequences of living under emotional and psychological duress are generally denied any publicity - after all, according to the ruling ideology we live in the best of all possible worlds. It is therefore unsurprising that the psychodynamic perspective appears in psychiatric textbooks and training as no more than an afterthought to the ersatz medical model, and stress is counted only 'a precipitating factor' to mental illness. Each official views himself as a type of medical functionary who employs technical means to combat brain imbalances or deficits. Anecdotal evidence from patients, ex-patients and heretic officials suggests that very few psychiatric workers have any idea at all of the possible significations or causes of 'the symptoms' produced by the patients. And in the medical conception of things, a patient who continues to be irrational after treatment is not only disturbing to anyone puzzled by the meaning of his ideas and behaviour; he also provides worrying evidence for the failure of psychiatric medicine. Accordingly, to the extent that they are made anxious because they are able to comprehend neither the patients nor their problems, and to the extent that they are fully committed to the medical

model, psychiatric officials tend to be dismissive or hostile towards any patient who continues to display 'symptoms' after that period of time during which it is assumed that he ought to have been 'getting better', 'recovering' or at least 'stabilising'. As a paranoid defence, hostility also extends towards anyone who dares to suggest that it might be worth investigating and addressing the possible psychological and social reasons for each particular mental disorder.

This could account for a bizarre yet routine outcome of the conceptual error embodied in the assumptions of the psychiatric medical model: whereas a person is only consigned to care because he is worryingly irrational, officials are often surprised, perplexed and even offended when a patient displays signs of mental abnormality, and are forever anxious that he may do so. Since it maintains that every mental disorder is only the accidental development of a mysteriously elusive disease, the medical model cannot begin to account for the unique form of each patient's deviance. Consequently, officials who believe in the medical model and who also possess little native sympathy or empathy tend to overlook the patient's distress, and view his undesirable ideas and behaviour as a challenge to their authority and the smooth-running of the psychiatric organisation. In default of any other explanation, they resort to 'common sense' notions of rationality which they attribute to the patient: that he could very well not behave as he does but deliberately causes a nuisance by 'acting up', that he is 'manipulative' and 'attention-seeking'.

In addition, since the only permitted theory is the medical model, the psychiatric organisation cannot recognise any of its own informal or unconscious processes of group psychology. This gives free reign to the tendency for some functionaries to specifically select a patient as a scapegoat to receive particular blame, callous treatment or harassment: it allows those officials to voice and act out their frustrations on one or two convenient and powerless targets, and at the same time this demonstrates to every other patient the expectations, sanctions and rewards of the organisation. Even if more responsible officials regard such behaviour as regrettable, those 'natural' or unquestioned processes of human interaction - those routine abuses of psychiatric power - do nothing to produce a positive therapeutic atmosphere. Instead they serve to perpetuate everybody's distress and confusion, including that of the officials themselves.

Of course, patients often resist diagnosis and medical treatment, and this causes conflict with the authorities. 'Getting better' or 'recovery' is measured in terms of 'gaining insight', but according to the medical model this is primarily a question of whether or not the patient appears to acquiesce readily enough to his diagnosis and treatment. Consequently, many patients are unable to 'improve' or 'recover' without so far compromising what they actually know or feel that they run the risk of further stress and emotional trauma. The net effect is that those officials who believe in the medical model - i.e., most of them - rarely experience job-satisfaction, in terms of playing any significant part in alleviating patients' distress or helping them with their emotional and mental turmoil. In turn, this is frustrating and makes the officials feel unappreciated by their patients, and resentful towards them. Because the officials are not encouraged to be psychologically sensitive, this situation may also be read as the patients' fault. The 'ingratitude' and 'resistance' of the patients and the frustrations and resentments of the staff feed on each other in a negative spiral which leads to entrenched positions on either side: the patients tend to view the officials as dictatorial bullies, and the officials view the patients as stubborn and hostile.

Meanwhile, any official who rejects the medical model and enters this tense and untherapeutic milieu with enlightened psychotherapeutic intentions is most likely to be warmly welcomed by some patients but suspected and obstructed by colleagues and managers. If this member of staff seems to have more genuine rapport and success with those patients who are already defined as 'difficult' - since he is willing to freely discuss their problems with them, without dismissing what the patients say as 'only symptoms of the illness' - he risks accusations of 'insufficient objectivity' and 'maverick behaviour'. Too much is at stake, and this is never simply the matter of a friendly difference of professional opinion. Should the maverick openly question the medical model, that is seen as heresy, an appalling 'lack of insight', and a kind of mental illness in itself. The proper maintenance of therapeutic boundaries is vital, and colluding with a patient against the wishes of the psychiatric team

or managers would be deeply resented, and so any official who disbelieves the medical model must be forever on his guard - he is always open to accusations by jealous and fearful fellow workers and managers. And since those psychiatric officials who believe in the medical model are doomed to failure in their dealings with patients, and are likely to encounter more hostility from patients than any member of staff who takes a social-psychological perspective, the majority cannot imagine that a dissenting colleague's popularity or greater therapeutic success is due to anything other than unprofessional and treacherous behaviour.

In this manner, ideology, unexplored psychodynamics and the institutional structure combine to repudiate the full psychological and social significance of the psychiatric patient's malaise. Doctors are trained to distance themselves from the bodies they work on - or else they might find a paralysis of the will to manipulate, to drug and to shock. The greater his faith in the medical model, the less a doctor is fitted to interact beneficially with any patient so as to address his most significant emotional, psychological and social problems; nurse-training borrows the notion of 'clinical detachment'. Of course, a degree of emotional detachment is a prerequisite to professional efficiency. All the same, as an inflexible imperative in a pseudo-medical procedure, it is anti-therapeutic. However, the requirement for detachment or 'objectivity' is likely to sit well with the psychological needs of the officials since it authorises their habituation to the misery of the patients. They do not want to hear about it, and they shut their ears to whatever uncomfortable thing the patient says. If they do hear him, they will not believe him; and if they do happen to hear of them, they cannot believe that whatever events might have traumatised an individual can have had such significance for his emotional and mental well-being. Empathy is the ability to comprehend the importance or power of a personal event when it is the experience of another. Absence of empathy is mandated by the psychiatric medical model, and thereby institutionalised as the refusal to encounter the patient as a person rather than a case of an illness. Psychiatry is in denial of the trauma and terror which is the real basis to every patient's emotional distress and psychopathology.

Psychiatry acts as civilisation's bulwark against the chaos and unreason of emotional and mental turmoil; therefore, its first concern is with security, safety and order. The medical model rationalises the official refusal to indulge the 'nonsense' of the patient's irrationality - his fantasies, delusions or compulsions, etc. It is true that it is now fashionable to offer 'psychological therapies' to patients who are chronically neurotic rather than floridly psychotic. However, where mental health providers tentatively employ 'talking therapy', this is largely in its brisk, 'pragmatic' and 'motivational' form, whereby 'things are talked through' only so far as to encourage the patient to 'manage his anxiety' and to 'think positively about what he could do'. Cognitive behavioural therapy (CBT) is most favoured, and patients are generally discouraged from exploring the roots of their anxieties by means of free expression - and especially not the free expression of fantasy: the medical model insists that this only encourages the patient to indulge his mental illness.

Apart from these organisational and ideological imperatives, crucial biographic factors radically separate most psychiatric officials from most patients, as we already mentioned. In the nature of things, the greater the authority of a psychiatric official, the less likely is he to have suffered from the kinds of trauma, oppression, misery and stress typically experienced by the patients (or the more likely is he to have repressed any knowledge of it). It is unlikely that someone could achieve high professional standing if he is (or was) preoccupied by stress and emotional trauma. This means that senior members of the psychiatric or nursing professions are unlikely to have experienced great insecurity in their lives (or that they are able to repress their own painful memories). In which case, those who wield the most psychiatric power cannot easily comprehend the traumatic and stressful lives of those in their care, and might be reluctant to acknowledge the full impact of their patients' 'background' experiences.

The same can be said of GPs. Of course, since they are not social workers they can offer little to combat the psychologically traumatising circumstances of many of those who present. But neither is their medical training suited to helping people with emotional and psychological problems. We have already discussed the social, emotional and cognitive reasons: there is usually a social divide wide

enough to prevent most doctors from being genuinely aware of the experiences of patients who develop an incapacitating neurosis or a psychosis; most presenting patients are either much younger or much older than the doctor; they are also disproportionately female, disproportionately from an ethnic minority, and are mainly poor or dependent. Almost by definition, doctors are successful and affluent,¹¹⁶ and are largely from comfortable backgrounds. The majority are the children of doctors, and so they learned about the 'objective' medical attitude early in life; if they do not learn it as children, they do so at medical school. In addition, a high proportion of doctors are privately educated, and during their formative years this will have insulated them from the lives of most of the population. If they were boarders, it is likely they would have been traumatised by being taken from their mothers at an early age and plunged into a single-sex world in which they could survive only by 'steeling' themselves emotionally; as an essential element in their own defensive psychodynamic, this might incline them to deny the significance of the life of the emotions, and perhaps to find it difficult to empathise; it might also encourage them to act with unconscious sadism towards the relatively weak and defenceless. By contrast, those who suffer from emotional distress and mental disorder clearly lack the 'tough rationality' of the doctor, and appear before him as weak and ignorant. Added to this, when he is faced with a steady stream of presenting and continually re-presenting human misery, in his own mind a doctor has to deal with chronic cognitive dissonance: whereas general medicine is celebrated for its successes, no such claims can honestly be made for mental health treatments. The profession's characterisation of many patients - once mentally ill, always mentally ill - admits the failure of medicine in this field. It may occur to a GP or a psychiatrist that there is often only a choice between giving up altogether or, in spite of the evidence, forging ahead with an ever more resolute but blind faith in medicine.

A doctor ought to know that body and soul enter into positive and negative feedback cycles of health or ill-health, dilapidation or cure. Under the present dispensation, however - organised in terms of the ill-conceived, 'objective-scientific' psychiatric medical model - compulsive misunderstandings of the nature of functional mental disorder and the vital needs of the patients combine to undermine genuine sympathy, care and assistance for those who succumb to intolerable emotional and mental turmoil. These misconceptions are incorporated into the psychiatric enterprise by training that is exclusively medical. A few doctors, such as Harry Stack Sullivan, recognised this early in the development of modern psychiatry. For instance, it was clear to him that the schizophrenia diagnosis referred not to a disease but to processes of desperate human interaction, that a serious mental disorder is an extremely confused response to an overwhelming crisis in a relentlessly fraught life. In Volume 2 we discuss Sullivan's exasperation with the medical orientation of the training of nurses as well as psychiatrists. He found it a frustrating and nearly insurmountable barrier to any useful psychodynamic therapy.¹¹⁷ This is still the case today.

The bankruptcy of the medical model

Despite nearly two centuries of research, there is no evidence that any kind of functional mental disorder is caused by a disease or 'genetic propensity'. When doctors and other officials say that functional mental disorder is illness - that it is mental illness and there 'must be' organic pathology - this is unfounded, and only answers to a neurotic wish. In our second Volume we demonstrate that incapacitating irrationality develops in response to psychological trauma and being overwhelmed by stress; in this conception, the various typical dysfunctional responses to agonising emotional and mental turmoil - recognised by doctors as the diagnostic categories of mental disorder or mental illness - constitute a repertoire of psychological accommodations to emotional trauma caused by the

116 See Half of GPs earn over £100,000 (2007) news.bbc.co.uk/ 17 July. At that time, the average earnings for all UK workers was £25,000. The differential widened after the financial crisis of 2008, when average earnings fell more than that for doctors. See GPs take home £100,000 average salary despite pay fall (2012) *The Times* 27 Sept.

117 See text to footnote 49, Chapter 16 (Volume 2), quoting HS Sullivan.

private terrors which individuals are forced to endure. In short, we show that *functional mental disorder is always an unacknowledged kind of post-traumatic stress disorder*.

Apart from the dementia associated with aging, mental disorder is seldom due to brain pathology. Nonetheless, by insisting that mental disorder is illness - mental illness - doctors imply that the brain is somehow afflicted or intrinsically deficient. And so, in accordance with the ill-conceived medical model, the problem presented by the mental health patient is approached largely by ignoring the real causes of his unease and trying to control 'the symptoms' of an imaginary illness by administering pseudo-medical techniques based in haphazard guesswork. By saying the individual 'has a mental illness', and subjecting him to medical management and treatment, psychiatry not only stigmatises and re-victimises him for giving deviant expression to his perturbation, but throws everybody off the scent of the actual causes of his confusion and distress. For when he is obliged to submit to psychiatric power, and his imaginary disease is 'diagnosed', the individual is most likely to be preoccupied by a distressing and confusing phase of a personal crisis. Psychological vulnerability and an invidious legal position combine with the doctors' unrestricted powers to comprise a system of control which is both prejudicial to the remedy of mental disorder and wide open to the patient's exploitation or abuse.

In this Volume we have seen that there is no evidence to confirm the psychiatric medical model, and therefore no reasonable basis to the normal procedures of care and treatment. Despite this lack of proof, doctors continue to allege undiscovered aetiologies for the purported mental illnesses - such as constitutional defects, bio-chemical imbalance or a virus. The myth of mental illness has it that something must be wrong not with the person in his social context but with his brain; it follows that the person must become a patient - the passive recipient of an allegedly expert technical intervention. But not only is there no evidence of real diseases, defects or deficits causing functional mental disorders, neither is there proof of the efficacy of psychiatric medicine. And rather than remedy the patient's tribulation, there is much evidence that too often the psychiatric intervention compounds his oppression, confusion and misery.

Instead of the conventional approach, we propose the only plausible alternative - a social and psychodynamic perspective that posits emotional trauma as the original cause. Advocates for the medical model can be counted on to respond: All of us are subjected to stress, so how is it that most of us *do not* end up as psychiatric patients? We can all surely agree, however, that there are variations in types, degrees and duration of stress, and that some of us are able to call on more and better resources so as to mitigate or counteract it. For most of us, most of the time, life is a matter of habit. Under normal circumstances we do not spend much time thinking about what we do or why we do it. We tend to stop and think only when the pains outweigh the rewards of our activities, and we only question behaviour or beliefs when a problem becomes urgent. If we are lucky - and quite likely by talking things over with someone else - we are able to see a judicious solution to whatever the problem is, and we take it. If, on the contrary, someone is unfortunate, lacks the resources and can see no way out of his predicament, and there is no-one to respond sympathetically, intelligently and hopefully, he may find himself locked into a self-absorbed spiral of distress, anxiety and confused rumination. Especially if his overwrought condition results in behavioural disturbances and physical exhaustion, with consequent perceptual difficulties such as hallucinations, he may finally respond with panic and overtly irrational beliefs and behaviour.

This kind of impasse presents a person with a limited number of possible responses. Some individuals may become deviant: one path, if it seems available, is spontaneous or calculated but probably criminal relief, in which the subject tries to satisfy his desire or vent his frustration, for example, by means of theft or assault. Or he may sublimate, suppress or supersede his fears or desires by becoming or making himself oblivious to the self by resort to any of a variety of means ranging from socially approved religiosity or immersion in work, to drinking, substance abuse, self-harm or suicide. Or again, he may respond to a preoccupying impasse by constructing in his imagination a defence of his identity, and repudiating the conflict which causes him the unbearable anxiety; in this response, relief from anxiety is afforded by means of a compensatory but aberrant mental construct -

fantasy or delusion, or ritualised displacement behaviours - compulsions, hysteria, apathy or catatonia (any of which may respond to hallucinations); desire now finds an involuted part-satisfaction by way of beliefs and behaviours which make private sense to the individual but not to anyone else, and therefore further incapacitate and isolate him. In any case, the person cannot help but advertise his distress and confusion, and his anxiety might also cause him to feel strange or unwell (e.g., manic, insomniac or exhausted); doctors recognise this as 'mental illness'.

There is no science to support the notion that a person's irrational behaviour does not have its reasons simply because they are not immediately obvious to certain witnesses or endorsed by some or other consensus. Everyone understands emotion as a phase in a person's life which escapes rational self-control: it is an unbidden response to a particularly significant perception, and it consists in the body's complex hormonal and motor reaction to that perception, along with the experience of that reflex. Emotion arises in the context of the person's life amongst others - and of course this does not exclude unwanted feelings such as fear, anxiety, anger, depression, despair and panic. What psychiatry calls 'mental illness' is an acute or chronic state of emotional distress and cognitive and behavioural deviance. Someone diagnosed with a mental illness is neither ill nor peculiarly wilful: he is emotionally traumatised and psychologically disturbed.

Nowadays we may all wish every problem would be solved by science. Still, saying that acute or chronic irrationality is a kind of illness does not magically make it amenable to a medical fix. With regard to functional mental disorder (so-said mental illness), each diagnostic category simply discerns one type of irrationality amongst a recognised variety. As for treatment, chemical interventions and subjecting the brain to a powerful electric current are both brutal measures unsupported by science, or even evidence of greater benefits than costs to the patients. Using these methods to try to remedy functional mental disorder is like tinkering blindly inside a television set because a perfectly well delivered program is found upsetting or offensive.

Even though someone's behaviour may be deviant, bizarre, unfortunate, socially embarrassing or potentially dangerous, it does not make sense to try to assess it without seriously interrogating his beliefs and intentions. It is entirely possible - in fact, most likely - that what the person thinks, says and does may be some kind of a reasoned response to the world, *as he experiences and construes it*. In reality, of course, it is impossible to comprehend anyone's behaviour in isolation from context. The standard textbooks may mention 'environmental factors' in the genesis of mental disorder, but they neither go into details nor incorporate this concession into psychiatric theory, and the undisputed dominance of the medical model ensures that any reference is only in passing and no more than lip-service. Typically, doctors simply make a mental illness diagnosis and prescribe a medical treatment.

As a result, the pseudo-medical diagnoses and prognoses of psychiatry constitute a misguided attempt to obviate the subtle complexities of real life. In Volume 2 we will see that evidence from individual cases makes it clear enough that anyone who suffers from disabling emotional and mental turmoil is caught in a struggle with his sense of self and reality, and that invariably this is contingent on very difficult circumstances, the force of which is unacknowledged or denied by the person's most significant others. The medical model of the isolated individual who suffers from a peculiar kind of illness repudiates the patient's context: it is oppressive as well as untrue to assert that dysfunctional ideation and behaviour is due to some kind of undetectable bio-pathology. And even if an official takes an interest, out of his own private sympathy and concern, the medical model makes it hard for him ever to arrive at a clear understanding of a patient's behaviour and beliefs as perhaps an intelligible response to the circumstances of his life, as he experiences and struggles to cope with them; not only is every psychiatric worker shackled to a pseudo-medical routine and way of thinking, but the patient is no longer who he was in his usual environment, and whatever he says and does is not easily checked for any connections with his life before he became a patient. In line with the dogma of the medical model, the person is compelled to become just another patient who 'has a mental illness' - that is to say, an isolated locus of emotional and mental deficit, and a passive recipient of medical assistance.

Down the years, the ‘common sense’ perception of the nature of individual irrationality changed in response to wider social and technical fashions, and there is no evidence to support the modern belief that there is such a thing as mental illness. During most of the 19th century, since there was no proof of any real diseases causing mental deterioration, but often apparently successful remedy by means of ‘moral management’, it was reasonable to consider madness essentially a moral condition. It was only when medical science made great progress in the identification of physical diseases and treatments that the idea of mental *illness* became much more popular. Chemical medication (mainly sedation) was introduced in the latter part of the 19th century. This seemed to confirm that mental disorder is indeed an illness, and the identification of the bacterial cause and the effective treatment of syphilis (i.e., for general paralysis of the insane), after 1910, gave even greater impetus to the belief that there must be an organic cause for every kind of madness. In the half-century before World War II, the urge to eradicate ‘constitutional deficiency’ increased in popularity, encouraged by the pseudo-science of eugenics. The Nazi debacle brought eugenics into disrepute, but various forms of gross disruption of the brain remained popular: psychosurgery and insulin coma therapy were fashionable for another thirty years, and electroshock only began to fall from favour towards the end of the 20th century. New and apparently less dangerous drugs were introduced during the 1950s, and medication then seemed obviously the best way ‘to bring the faulty brain back into balance’.¹¹⁸

There was some criticism of the medical model between 1960 and 1980, but since then the psychiatrists and the pharmaceutical companies have experienced little opposition. As much as ever, people seem to believe that anyone who ‘has a mental illness’ (anyone burdened with that diagnosis) has a genetic kink, or has unfortunately developed ‘a chemical imbalance’ in his brain; sound-bites from biochemical and geneticist research papers supply the seemingly authentic scientific details. This belief is reinforced by every medical and psychiatric trainee being routinely misinformed that schizophrenia and bipolar disorder ‘have a genetic basis’, and that depression is ‘due to an abnormality in the neuro-transmitters’; anyone diagnosed schizophrenic or bipolar is expected to stay on an anti-psychotic medication indefinitely, and anyone who feels unduly anxious, depressed or in despair is told that she ‘lacks serotonin’ but an antidepressant SSRI (e.g., Prozac) will sort it out.

The glamour of the medical model is continuously worked on by the drug companies and the psychiatrists. We particularly mentioned Clozapine, a modern ‘atypical’ anti-psychotic, and a popular prescription for schizophrenia. Like lithium for bipolar disorder, it demands close monitoring for blood toxicity, thereby creating a need for special monitoring.¹¹⁹ In other words, so as to bring his deviance under control, the medication of choice deliberately jeopardises the patient’s physical health - and then he is monitored for the danger to his immune system. This technical response to the ill-effects of psychiatric drugging also performs an ideological function: the increased complexity makes care and treatment seem more like ‘real medicine’ and ‘real nursing’, thereby confirming that psychiatry is *indubitably medical*. At the same time, by interposing another medical routine between carer and patient, this drug of choice conveniently removes officials even further from that personal contact with the individual which so many avoid, but which is necessary if anyone is ever to discover and address the problems of living which so upset and overwhelm him.

None of this is to deny that emotional, psychological and interpersonal conflicts may sometimes, to an extent, be forestalled, stabilised or resolved by the assemblage of mental health incantations and rituals of diagnosis, management and treatment which all together *appear* impressively medical-scientific. Psychiatrists authorise what constitutes normal or abnormal behaviour and belief whenever they ratify what is good mental health and what is not; in the name of scientific medicine, they assign one or another mythical illness (mental illness) to anyone they judge mentally unwell. When ‘the problem’ of an individual’s aberrant feelings, ideas and behaviour is said to issue only from within

118 For details of these developments, see the section: A brief history of the management of madness, in Chapter 1, above.

119 For a brief account of the history of Clozapine, a currently fashionable chemical lobotomy for people with a schizophrenia diagnosis, see text to footnotes 56 and 57 in Chapter 6, above.

the distressed, disturbed and disturbing patient-elect, this assures every other interested party - those who make up the individual's usual environment - that they themselves are 'normal' and bear no responsibility for the emotional and psychological condition of the person in question. The diagnosis which identifies the alleged illness (mental illness) is accompanied by an assurance to each concerned party that 'the problem' - the patient with his allegedly sick brain - will be safely brought under control by the routine application of a reliable medical technique. By defining every psychiatric problem as definitely an illness and, expressly or by implication, not at all the result of psychological and interactional conflicts, it is sometimes possible to reduce anxiety, and thereby the conflicts, at least temporarily. This ploy works best if the distressed person at the centre of the crisis also feels *reassured* that he has a mental illness - after all, everyone around him says he has - and that it can be managed by means of medicine. At the expense of stigmatisation and the loss of his autonomy, and often at the expense of his physical health and further derogation of his emotional and mental well-being, a psychiatric patient might then be discharged to find a more tolerable re-insertion into normal daily life. Yet this is likely to be only as someone who remains at risk, and who forfeits certain rights in return for the offer of sympathy, care and being excused full responsibility for running his life.

In this manner, the standard psychiatric response denies the social and psychological dynamics to any mental disorder; this does little to reduce a disabling neurosis or psychosis but much to encourage its chronic and grumbling persistence. The confused ideas and unevidenced practice of the psychiatric medical model generate an enterprise which forever holds out the hope of cure and yet *does little or nothing* to identify and address the real sources of the patient's misery and mental turmoil - i.e., particular psychological, social and material problems. Psychiatry does not cure patients. On the contrary, it holds out false hopes for a medical solution to their personal and interpersonal problems. It insists on the stigmatising medical model which, in practice, depletes patients' resources by means of toxic chemicals and other harmful treatments, and the various constraints forced upon them; it invalidates and considers irrelevant every thought, belief and activity which it views as inconvenient or simply signs of the alleged mental illnesses; it tends to obstruct any steps patients may take towards coping with their psychological and social conflicts by identifying and facing up to them; in general, by making them into a uniquely constrained and stigmatised kind of patient, it isolates, confuses, blames and demoralises people in crisis.

The medical model of mental illness is ill-conceived and unhelpful to anyone in the throes of a personal crisis. It is not as if the current system is even cost-effective: when officials fail to address patients' psychological, social or material problems, but insist on medication or shock treatment, this is a false economy which too often results in long-term disability and welfare dependency. Nonetheless, there is general indifference or even hostility to the psychodynamic idea, and the medical model continues to find unquestioned support despite the lack of evidence for its utility to *the patients*. Never mind the efficient use of resources, apparently the public is happy with an ideological and bureaucratic apparatus which wilfully denies uncomfortable evidence of psychological trauma, social conflict and injustice, and is organised first of all not to help the suffering individual but to manage his worrying deviance. In short, the medical model fails mental health patients since it mandates largely unhelpful practice, but it does serve very well as an alibi for oppressive social relations in general and quasi-totalitarian psychiatric power in particular.¹²⁰

Of course, we do not suggest that medicine should not be used for genuine brain pathology, nor that medication can never benefit someone so overwhelmed by anxiety that he becomes disturbingly irrational. However, most cases of so-said mental illness are not real illnesses: there is no brain or neurological dysfunction; they are functional mental disorders - neither more nor less than worryingly irrational emotional states, beliefs and behaviours. Mental illness is a myth. Like phlogiston in 18th century chemistry and aether in 19th century physics, it is a hypothesis that turned out to be wrong. The psychiatric diagnostic system discriminates a multitude of disorders, and in Volume 2 we

120 Legally, psychiatry acts *in loco parentis*; in practice, and 'as a matter of course', officials very often work with parents. This working with parents (or other carers) can easily become collusion *against* the patient.

acknowledge that when he suffers from a preoccupying psychological trauma and finds himself under intolerable stress, a person may respond to his overbearing anxiety with any of a variety of typical dysfunctional, manifestly distraught and aberrant emotions, behaviours and irrational perceptions. But it is misleading to say, for example, that a person *has depression* or *has a depressive illness*, rather than that he *is* depressed. Neither does anyone ever *contract* or *have* any kind of mental illness; instead, he may *become* or *remain* distressed, preoccupied, worryingly irrational, etc. Mental disorder is not something anyone catches or ‘has’. The disorder is not, in the normal sense of the word, a disease. There are no organic signs for functional mental disorder (mental illness); it is recognised *only* by the person’s distress and irrationality, and it is a product of extreme *unease*.

Nevertheless, at the beginning of the 20th century the victory of the medical model over moral or social understandings and styles of management led inexorably to the medicalisation of all those problems of living in which a person in the throes of a psychological crisis becomes isolated and irrational to the point of intolerable nuisance or danger. Apart from the current diagnostic categories, various other kinds of mental or behavioural deviance have at some time or another been defined as mental disorders and subjected to psychiatric management. These include alcoholism and other addictions or obsessions, such as gambling and eating; also vandalism, petty theft (but seldom grand theft), homosexuality (but not lesbianism), bearing a child out of wedlock (but not fathering the child), dangerous driving, excessive shopping, and having unorthodox political views.¹²¹ In the name of care, doctors are permitted to label and administer whatever forms of irrationality arguably fall within their remit. This labelling, coercion and treatment is said to be scientific medicine, yet the science is seriously wanting and there is no clear evidence for the efficacy of the medicine. Diagnosis is always a judgement on present and probable future behaviour (the prognosis); it is left to the psychiatrists to define mental ill-health, and there is no appeal from their decisions to any outside authority. Once a psychiatric official is involved, the individual in crisis (or at the centre of the interpersonal crisis) is forced to accept whatever stigmatising label he is assigned: disagreeing with a psychiatric judgement is likely to be interpreted as another symptom of the purported mental illness. This denies not only the psychological but also the social, moral or political implications of emotional, cognitive or motivational deviance: social relations of power and dependency, which determine vulnerabilities and chances for exploitation or abuse, lie unquestioned behind the cloak of apparent medical-scientific objectivity. Unless the person in crisis is quickly able to resolve his immediate problems, or evade the authorities, once taken up by psychiatric power he is embarked on a career as a unique type of patient who has no choice but to submit to certain constraints and to dubious and hazardous treatments; and this career is defined by the formal and informal structures, procedures and prejudices of the psychiatric organisation and its officials, as much as by the individual’s pre-existing psychodynamic.¹²²

A parody of the germ theory of disease developed during the 19th century, the medical model of mental illness is a formidable myth based in everyone’s fear of madness and blind faith in Science and Medicine. With the rise of effective medicine at last based in scientific evidence of organic causes and effects, there emerged a tendency to view any persistently undesirable personal behaviour as the symptom of a disease. ‘Disease’ soon became synonymous with ‘unnatural’: illness was seen as a kind of imbalance, and vice versa, any kind of imbalance was viewed as illness. Within living memory, even the slightest illnesses could regularly become life-threatening, and doctors took to employing military and imperialistic metaphors: bacteria were said to ‘invade’, ‘infiltrate’ and ‘colonise’ the body, and the illness or pathogen was not ‘treated’ or ‘managed’ so much as ‘attacked’; in 1910, Ehrlich’s cure for syphilis was celebrated as Medicine’s first ‘magic bullet’. All this seemed

121 Under current UK legislation, ‘promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs’ do not, on their own, constitute grounds for psychiatric action. See *The Mental Health Act (2007)*, op. cit. (n. 70, Ch 1), Part 1, S. 1(3).

122 This was first systematically detailed in the empirical studies of Goffman, E, op. cit. (n. 28, Ch 3) and Becker, HS, op. cit. (n. 15).

to endorse psychiatry taking the same muscular stance towards every kind of emotional or mental disorder as any other medical specialism did towards physical illness.

The more mysterious and incapacitating the malaise, and the less certain any remedy, the greater everyone's anxiety and the more desperate the wish for a cure. Since interrogating psychological and social causes is generally under a taboo, mental disorder does appear to fall into this category of illness. Before there was a cure for syphilis, perhaps one-third of all psychiatric patients suffered from general paralysis of the insane (GPI). It is therefore not surprising that since it was discovered that syphilis is the organic cause of that type of mental disorder, and that the disease may be remedied, generations have embraced the naïve and unfounded psychiatric belief that every other mental disorder *must have* an organic cause for which there *will be* found a medical remedy. Despite a century of research which has failed to replicate the success with GPI, the psychiatrists still seem to hope for a new and indisputable 'magic bullet' for another major so-said mental illness. In the meantime, they are licensed to try to remedy or 'manage' every patient's deviance by intruding on his cerebral processes with whatever plausible chemical or mechanical means fall to hand.

In this Volume we have argued that far from benefiting distressed individuals, the psychiatric medical model is an administrative ideology which inhibits recovery by blocking other possibilities for managing personal crises: saying that someone 'has a mental illness' simply sidesteps personal, inter-personal or wider social issues, leaving them unrecognised, unaddressed and therefore unresolved. A mental health diagnosis temporarily removes the patient's responsibility for running his life. But after a while - after some time in treatment - he is expected to begin to take up again his responsibilities. First of all, he is expected to conform to the routines of the psychiatric organisation; and then, when it is felt that treatment 'ought to be taking effect', the patient is also expected to 'make an effort' to get better/recover. According to the consensus, there is no doubt that psychiatric medicine is beneficial, and so non-compliance with an official expectation is interpreted as further evidence for a patient's irrationality/illness. Meanwhile, the medical model removes responsibility for the crisis from every other person, and deflects criticism of the social relations: if the crisis is an illness, it cannot be caused by anything anyone ever did, nor remedied by much that they might now do. Consequently, the medical model, which converts the person into a patient - someone who is sick - is generally unhelpful, confusing and often (by the treatments employed) harmful to the individual in crisis.

Towards the end of the 19th century, doctors increased their influence in the management of the insane, and by the middle of the 20th century very few people disputed psychiatric authority. Medical monopoly of the management of mental disorder was facilitated by the apparently unqualified successes of the new psychiatric drugs: the UK's 1959 Mental Health Act permitted doctors to define every kind of worrying individual irrationality in medical terms, and to take full control of its management. Nowadays, when somebody is so upset and confused as to engage in worryingly irrational behaviour and ideation (and in the absence of any organic cause), this is not interpreted as possibly a temporary condition which might find a negotiated solution by way of careful conversation and practical help (such as reducing the stresses to which the person is subjected). Instead, it is seen as undoubtedly the sign of a mental *illness*. Even when there is some official recognition of an individual's problems of living, if his emotional, mental or behavioural deviance is judged excessive, almost invariably he is said to have a mental illness of a type conforming to one or more of the long list of diagnostic categories, each with a specific prognosis. Personal, psychological, interactional or social problems are ignored or repudiated as mere side issues. Manifest problems of living are said to be due to misperceptions and misbehaviour caused by the mental illness, rather than the contrary - that the person's distress and irrationality results from apparently intractable problems of living. There is no genuine offer of sympathetic comfort and aid to everyone involved, so that together they may better address *their* problems. Instead, the particular distressed and confused individual is elected '*the problem*' and compelled to submit to a kind of control and treatment which is represented as care and remedy (or 'management') for his so-said illness: the individual who shows signs of excessive irrationality is forced to become a dependent patient. All-powerful doctors then proceed to

employ any of a variety of purportedly scientific techniques so as to interfere with the supposedly deficient part of his organism, i.e., his brain. If the patient then regains sufficient mental and emotional equilibrium, and the doctors think that this is the work of the medicine, they say that he is cured, or that his illness is now adequately managed.

Since he is supposed to have succumbed to an illness upon which only medical experts are deemed competent to act, whatever the mental health patient says, thinks or feels is technically a matter of little or no importance: except as a symptom, the very essence of the patient's malaise - his aberrant emotional or mental condition - is uninteresting and irrelevant to his would-be therapists. And since, by definition, the significant effects of his affliction are irrationality and incompetence, according to the medical model it is obviously absurd to try genuinely to include the patient in decisions concerning his own therapy. More than this, by insisting on the *intrinsic* irrationality of every psychiatric patient, the medical model positively encourages officials to disregard or act callously towards them. For example, why waste time trying to impart information to patients who, by definition, lack the power of reason and decision? In 1996, by which year it was legally incumbent on officials to give every patient such information, a UK survey of psychiatric patients reported that 87% did not feel that they had received enough information about their medication, and 86% reported receiving no warnings about possible adverse effects.¹²³

The effect of the medical model is to re-victimise the psychiatric captive.¹²⁴ This is achieved by defining the problem as essentially located only 'in' that individual, by stigmatising him with a pseudo-medical diagnosis, by generally making a fatalistic prognosis for his mythical illness, and overall by forcing him to become a patient, thereby permitting officials to subject him to invasive pseudo-medical techniques known to be hazardous. Despite supposing that he cannot help having contracted or developed an illness, everyone unites in demanding that the patient must somehow sooner or later begin to exercise his dilapidated moral muscle *so as to help himself*. Since this expectation is precluded by the normal sense of the word 'illness', this blunt belief in the necessity for the patient to make an effort of will if he is to get better is illogical and confusing.

Doctors are normally viewed as healers who invite the confidences of their patients. The psychiatric patient is only subjected to medical power because he has no sympathetic others who are able to help him, and he may be disposed to hope that this substitute friend - an expert - knows best. And yet the medical model is a confusion of wishful thinking and disguised moralising, and it is unsurprising that the various psychiatric recipes only ever cook-up an indigestible porridge of care and treatment which tends to leave patients isolated with their anxiety and confusion. Anyone given a psychiatric diagnosis finds that anything he feels or believes which does not accord with the views of his managers is viewed as an irrational symptom of his illness, and is most likely disbelieved and prohibited. This means that when an official denies whatever a patient might know well enough - albeit perhaps mixed in amongst a number of aberrant ideas - this serves only to magnify and perpetuate the patient's frustration and confusion. Besides, forcing medical treatment on anyone may well add to any perceptual confusions he might already experience; it is also likely to cause him the problem of alarming, painful and disabling organic 'side-effects'. Along with the medical definition of his malaise, all of these official attentions are only likely to distract the patient (and everyone else) from ever becoming aware of the real causes of his distress and confusion.

Meanwhile, the members of any group tend to identify themselves positively in comparison with a negative which consists of anyone recognised as different or 'other'. This discrimination is often rationalised by accusations of the deviant's *intrinsic* deficiency and inferiority, or *wilful* difference. This tendency to derogate the intentions and full humanity of whoever appears different is magnified to the extent that the variance triggers the perceiver's anxieties concerning his own fragile constructions of reality and self. Bearing this in mind, we repeat that with respect to the functional mental disorders there is no evidence for the claim that psychiatric diagnosis is an act of scientific-

123 Cobb, A, op. cit. (n. 3, Ch 6).

124 See the discussion in the section: Revictimisation, in this chapter.

medical discovery. Rather, it is no more than the perception of an undesirable emotional or mental condition, the unfounded attribution of an illness, and an act of labelling convenient to the immediate interests of certain functionaries (GPs and psychiatrists) who are expected to ensure the safety of the individual and the public. It is also unavoidable that every psychiatric diagnosis is simultaneously an act of social exclusion performed on that kind of deviant; by the same token, a mental illness diagnosis automatically defines as sane and included in the community of 'normal' people everyone who has *not so far* attracted the attentions of a doctor as suffering from an abnormal emotional or mental condition. Stigmatisation is inevitable with the medical model: each diagnosis proclaims the *essential difference* of every mental health patient from the sane and normal majority. This is untrue and not conducive to compassionate care and therapy.

While there is no evidence that those who suffer from a functional mental disorder have succumbed to an illness, in most cases there is likely to be information that they suffer from a particularly troublesome life - if only the responsible officials would admit it (or engage in a little detective work). It is therefore not true that those who are emotionally distressed and disorientated 'have a mental illness', and insisting that they do is confusing and unhelpful. Apart from which, nearly every aspect of the official processes which follow from this unfounded belief gives rise to scandalous issues of prejudice, discrimination and the abuse of human rights. Of course, unlike racism, sexism or ageism, official culture does not recognise psychiatric oppression for what it really is. On the contrary, policy-makers and administrators generally congratulate themselves on delivering a mental health service which, given funding limitations, incorporates all the latest humane and progressive techniques and procedures. However, the evidence belies this complacency. Instead, it seems that due to the allegedly medical-objective (prejudiced, detached and uninterested) attitude taken towards each distressed and disorientated person, psychiatry routinely amplifies and makes chronic the very problems it is ostensibly organised to resolve.¹²⁵ This is confirmed by most psychiatric patients who are surveyed, and now even by the government's own regulatory agency, the Care Quality Commission.¹²⁶

Contrary to what is claimed or implied, diagnosis and treatment are not based in scientific evidence of causes and remedies, and the authority and prestige of Medicine is used to legitimise threats and compulsion: rather than a service to ailing persons, psychiatry is first of all a type of social control rationalised as purely medical assistance. Doctors falsely attribute illnesses to certain kinds of emotional, mental and behavioural deviants, and are permitted to enforce chemical, electrical and behavioural interventions. And as long as critically worrying emotional distress and irrationality is conceived as primarily and undoubtedly an illness that requires a medical response, everybody's attention is distracted from the problems of living which lie behind the personal crisis. The psychiatric medical model leaves distressed individuals stranded with their unresolved problems. Failing to acknowledge the social and psychological dynamic to a mood, behavioural or mental disorder (or actively denying it) is the most significant factor prolonging distress and confusion.

Beyond this, routines of management (e.g., restraint) and treatment with dubious and potentially dangerous techniques (drugging and shock treatment) impinge on a person's integrity and physical health. In the field of mental health, as we saw earlier in this book (especially in Chapters 6-8), there is little unambiguous evidence of benefit but much that the so-said therapies add to patients' problems rather than help them to recognise, confront and overcome the difficulties that cause their distress. The standard treatments - medication and electroshock - are not endorsed by research evidence; as remedies, they are not more effective than counselling or psychotherapy, placebo or no treatment at all, they often have terrifying effects, and they put patients at risk of actual harm and addiction. What is more, when they assert the presence of a mental illness, doctors affirm an *essential* difference between the ideas and behaviour of the person in crisis and the gamut of 'normal' beliefs

125 This is demonstrated in Chapters 4 to 7, above.

126 See text to footnote 79 in Chapter 14, and to notes 96-98, 111 and 112 in this chapter. See also the section: Patients' experiences of psychiatric drugs, in Chapter 6, above.

and behaviour; this is untrue, and makes psychiatry profoundly degrading, stigmatising, socially isolating, and often psychologically harmful.

There is no question that most people who find themselves subjected to psychiatric authority do so as a result of being overwhelmed by emotional distress and confusion, to which they respond with all manner of upsetting and incapacitating ideation and behaviour. Yet psychiatry refuses to acknowledge that almost all the emotional, mental and behavioural deviance consigned to its management is to some extent - and often to a great extent - not only a cause but also a result of imputations made during the exercise of social power. As we saw when we discussed labelling theory, at the top of this chapter, it is not necessary for deviance to inhere in an act but rather that the act be *defined* as deviant, and that influential others *respond* to it as behaviour which demands sanction. Labelling often *produces, amplifies* and *perpetuates* deviance. This especially happens if, for pressing reasons of his own, someone mired in a distressing personal crisis accepts the medical definition of the situation and becomes firmly committed to the role and identity of a particular kind of deviant: if he accepts that he 'has a mental illness', 'has schizophrenia', 'has bi-polar', or 'has a personality disorder', etc.

The psychiatric medical model insists that a contingent emotional and mental condition is an essential attribute of a kind of sub-person. Psychiatric diagnosis is an act of labelling which always has a number of unintended, unanticipated and seldom acknowledged but significant and negative consequences - not only for the behaviour of the person marked out by the diagnosis but also for everyone around him. Consequent to the routines which isolate, stigmatise, ostracise and constrain him, and perhaps by being persuaded that he is ill, the psychiatric patient is likely to have his options severely restricted, including access to roles and activities previously open to him. Often he is *forced* to submit to psychiatric power; certainly, the threat of coercion is omnipresent. He is also likely to assume the identity of 'being mentally ill'. In the present conception of the psychiatric project, the individual is expected to play the role of a certain type of incompetent (a mental patient) who will only be able to give credible signs of recovering his wits after 'appropriate' medical treatment. The individual risks more serious sanctions if he cannot or will not play the part ascribed to him. No matter how apposite or plausible it may be, there is nothing he can say or do which will count for anything without ratification from his official managers. If he protests what is done to him - and whether it is the pseudo-medical treatment, the routine processes of institutional oppression or even outright abuse - he calls attention to himself as a troublesome patient whose sickness now manifests as 'lack of insight', and whatever he says may be discounted as 'only another symptom of the illness'; in this set-up, the patient is unable to resist more intensive treatment, which is likely to be employed so as to better remedy or 'manage' his 'persistent illness'.

In mental health, the medical model is a licence to ignore the needs of a whole category of vulnerable persons. If a psychiatric patient makes a genuine complaint about the painful effects of medication, or suffers from a real illness, or reports troubling events in his life which might have a crucial bearing on his present condition, or reports neglect or abuse, this may easily be dismissed as 'only another symptom', and serve as the pretext for more intense treatment (greater punishment). The medical model is not merely approved by the authorities - it is *enforced*. It therefore serves as the perfect rationalisation or alibi for any manner of irresponsible actions taken by officials, or by those with whom they are complicit: it amounts to an almost impregnable Abusers' Charter.¹²⁷

Medical psychiatry tends to amplify and prolong the patient's emotional distress and confusion or mental turmoil by invalidating, stereotyping and stigmatising him, by drugging him or subjecting him to electroshock, and generally by isolating him and obstructing his access to possible avenues of help and self-help. The attribution of a mental illness is not at all the first step in curing or assisting the afflicted individual. Instead, diagnosis is too often the first step in a process of his remaining seriously oppressed and incapacitated. By some fancied genetic or other mysterious cause, fate is supposed to have dealt the patient the poor hand of a mental illness; now, having to cope not only

127 See the section: Dereliction of duty and the abuse of patients, in Chapter 14, above.

with his original social and psychological problems but also with new problems posed by the diagnosis, prognosis and treatment, he is likely to enter on a career as 'a chronic case'.

The urgent need for a psychodynamic approach

Until 1959, disputes about the sanity of individuals could go to civil law in the UK, and the onus was on psychiatric authority to argue the dangerously irrational nature of the individual. Since then, the boundary between madness and sanity has been left entirely to the decisions of psychiatrists.

The diagnostic system summarises the general consensus of the profession, but the fact that it changes over the years indicates that the border between mental dysfunction and mental health is never entirely clear or undisputed, unlike the identification of physical illness. For example, should doctors be concerned with addictions or attempted suicide? Suicide was decriminalised and moved to the category of irrationality more than fifty years ago, but for at least as long it has been argued that addiction is a mental health problem, and that any addict who commits a crime should be treated as having a mental health problem rather than put through the justice system. When they wish to widen the psychiatric net so as to catch and 'treat' or 'help' a greater range of emotional, mental or moral deviants, liberals find themselves agreeing with enthusiasts of the medical model. On the other hand, conservatives who advocate 'personal responsibility' and those on the left concerned about 'individual freedom' both oppose the tendency towards a psychiatrised society in which ever more categories of behaviour are defined as mental illnesses: one side opposes psychiatry since it seems to wish to remove the righteous assortment of guilt and retribution, and the other fears the urge to catch every kind of eccentric in a web of totalitarian control in which targeted individuals are managed and medicated for the rest of their lives. Even so, few would argue with the idea that anyone who falls into a state of incapacitating emotional distress or mental disorder does require some kind of organised help.¹²⁸

However, it does not follow that assistance must conform to the dictates of the ill-theorised, unproven and fundamentally unhelpful medical model. Diagnosis presumes that the presenting individual is incapacitated by an illness; although the bare outlines of some such data is always recorded, a mental health official is *essentially* and *technically* disinterested in most aspects of the person's life, whether they are his main concerns and relationships or any other social, cultural, political or economic circumstances which impinge on him. Moreover, every attribution (diagnosis) of a mental illness at the same time implies the rationality, normality and non-culpability of the social relations and everybody else around the patient - and that may be misleading.

It is now a hundred years since a bad idea about functional mental disorder filled the gap left by the absence of an incontrovertibly superior theory. The medical model has no greater theoretical or practical value than any other panicked and wishful response to psychological or inter-personal crisis. Psychiatry is able to sustain a degree of limited, stop-gap utility due to the legal powers of restraint,

128 Psychiatrist Thomas Szasz advocated total personal responsibility. See both citations for Szasz, TS (n. 18, Ch 1). Szasz seems to have stood on the libertarian right. He argued that *any* free help necessarily encourages a person to sink further into irresponsible dependency by identifying himself first and foremost as a patient who is ill and therefore cannot help himself. This possibility is certainly very often realised as a result of the normal paternalist or authoritarian routines of orthodox psychiatry.

Although he rejected pseudo-medical diagnosis and used to offer psychotherapy for 'problems of living', unfortunately Szasz often seemed to suggest a crude 'malingering' theory of emotional distress and mental disorder. His idea that everyone should choose and pay for help ignores the constraints of reality. First, there is the individual's overwhelming irrationality at the moment of crisis, then the problems of income distribution (i.e., poverty), and then the great vulnerability of anyone in the throes of a psychological crisis. Not only is the individual in crisis very often incapable of many rational choices *until he begins to recover* but his suffering is most often a sign of the emotional damage wreaked by social or economic disadvantage and exploitation: because a person is vulnerable and cannot always help himself by his own individual efforts is exactly why some form of organised help is needed. And if a person cannot or will not exercise his autonomy, that in itself is a sign of pathological apathy (i.e., emotional distress) which any humane society ought to address.

coupled with the ability to inflict on its captives certain gross, inhibiting and often harmful organic effects. This practice is rationalised by the persuasive power of its apparently scientific rhetoric and the medical appearance of its technical apparatus and organisation.

Throughout this Volume we have seen that the organisation of mental health care and treatment is hopelessly compromised by its arbitrary and political nature. As soon as psychiatry is brought to bear on him, anyone undergoing an emotional or mental crisis loses his full humanity: the myth of mental illness rationalises extracting him from his social context by threats or main force, making him a peculiar type of prisoner-patient, and working on him with ersatz medicine. More than half a century ago, Thomas Szasz pointed out that just because someone is in psychological crisis and may appear peculiarly deviant and express bizarre ideas, that does not mean he is ill - that he has a mental illness. There is no evidence for the existence of mental illness: it is a fiction. Szasz also recognised that when someone is forced to become a *patient* in a *medical* process this removes from him the responsibility for his actions - at least until the officials decide that his so-said mental illness is remedied, sufficiently managed or 'in remission'. Besides, the normal processing of the psychiatric patient is an infringement of his liberty and a form of cruelty:¹²⁹ medication and electroshock are both harmful and very often *experienced* as torture.

Someone in crisis may perhaps welcome the intervention of a doctor, but by the time he gets to be interviewed by a psychiatrist, distress, panic and vulnerability are likely to prevent him from conducting a very useful conversation about his problems; and since it is routine for doctors to deal with individual irrationality by means of medication, he may also be experiencing unsettling drug effects. Neither does it help a person recover his composure by telling him that his ideas and behaviour are *nothing but* the symptoms of a kind of illness, especially since he often knows differently. Again, once someone is taken by psychiatry it is difficult for him to resist the consensus that he will only get worse if he fails to submit to medical treatment - which will perhaps be needed for years or even the rest of his life. In the medical model, after all, 'a particularly serious case' (e.g., someone who 'has' schizophrenia or bi-polar disorder) may 'go into remission', but according to most authorities the person will never be rid of his essentially schizophrenic or bi-polar nature.

The conventional psychiatric project has always been managerial and adjustive - the attempt to quieten down or liven-up the patient, to make him stop being deviant and voicing his undesirable ideas, to get him to cope again 'like a normal person'. Hopes were raised with the introduction of each new technique - bromide, electroshock, psychosurgery and insulin therapy each had their day. Sixty years ago, when the modern psychiatric drugs were introduced, there were great hopes for a cure for every type of emotional and mental disorder. However, it soon became clear that the drugs were at best ameliorative, that they were often addictive, that many were harmful, and some had caused an iatrogenic pandemic of irreversible neural damage (TD). In the meantime, nearly two hundred years of research into the structure and function of the brain has failed to discern any causal relation between neurology and psychopathology.¹³⁰

At the beginning of the 20th century - at the very moment when the psychiatric profession was congratulating itself on 'discovering' the disease of *dementia praecox*/schizophrenia - a new idea was introduced: psychodynamic theory. In the wake of the Freudian revolution, psychological and sociological evidence and argument nowadays persuades many of us that mind is a self-production conditioned by the environment; that is to say, a person's feelings, beliefs, attitudes and behaviours are crucially influenced by his relations to others. The unsubstantiated psychiatric medical model simply confuses the issue by encouraging a wild goose chase of motivated wishing and futile casting-about for non-existent illnesses and miracle cures. For almost two hundred years the partisans of positivist psychiatry have unsuccessfully laboured to make the terms of their discourse rigorous and

129 This view is articulated throughout his writings but first drew notoriety in Szasz, TS, op. cit. (n. 12, Ch 3), and was explored exhaustively in Szasz, TS (1963), op. cit. (n. 18, Ch 1). Deriving from the Latin: *pati*, suffer, a patient is defined as someone who passively suffers pain or provocation.

130 Although the first successful electrical stimulation of a part of the brain to elicit a muscular response was made in 1870. See Kraepelin, E (1917/62) *One Hundred Years of Psychiatry*. London: Peter Owen, 127.

operational in a properly scientific manner: in order to carry out research, psychiatry continually tries and fails to make a scientifically predictable, precisely quantified object out of the person or parts or processes of his body (especially, of course, the brain). This is a naïve conceptual blunder - recognised in philosophy as 'misplaced concreteness' - which misconstrues the genesis of emotion, cognition and volition: these events only ever arise within the dynamic of an individual's life with others. A person's life is so much more than his medical condition, it contains a profusion of significations and possibilities which may only be disentangled and comprehended by carefully interrogating the individual and crucial witnesses. Since 'personal life' or 'the life of the mind' exists only in the imaginative constructs of the individual, 'a biological cause for mental illness' could only ever be an overweening pseudo-scientific conceit. Likewise remedy: always looking in the wrong direction - to neurology rather than psychology and significant events in the person's life - psychiatrists only ever deliver ersatz medicine which proves no more beneficial than placebo or no treatment at all.

In the light of the evidence and arguments, it seems best to admit that the concepts and diagnostic categories of the orthodox psychiatric project are hopelessly subjective and arbitrary. The psychiatric medical model is based in a wish and a delusion. It is therefore futile to attempt to locate a specific mental illness which a person 'has' - which he suddenly contracts or which emerges after mysteriously incubating within him. Psychiatric diagnosis is notorious for depending on accidents of mood and whim - of the doctors as much as of the patients. For example, it has always been difficult to get two psychiatrists to agree about whether any one patient suffers from schizophrenia or bi-polar disorder or exactly what else, or whether a patient suffers from endogenous or reactive depression, etc., etc. When diagnosis depends so much on situational contingencies - such as whether the assessor is an optimistic liberal or a pessimistic authoritarian, or whether he got out of bed in a good or a bad mood - this is not medical science but only an ideological masquerade: *the appearance of scientific medicine*. For many years there was controversy within the psychiatric profession as to whether recovered schizophrenics 'ever really had schizophrenia in the first place'. Fanatics of the medical model dismissed every report of a recovery resulting from sympathetic care and sociability with the assertion that in those cases there must originally have been a wrong diagnosis. Heads I win, tails you lose. This was dogma, not medical science.

Psychiatrist David Cooper rejected the medical model. He advocated a permissive environment for patients, and was optimistic about recovery. Perhaps he had a greater toleration for eccentricity than most, but in his experience few diagnosed schizophrenics display full-blown, persistent psychosis: they simply do not manifest a sufficient number of symptoms. Strictly speaking, this means they do not suffer from that particular mental disorder. Rather, they are *labelled* schizophrenic, and often for quite minor transgressions of norms governing the expression of emotion, perception or volition.¹³¹

What kind of medical science is it that makes different judgements about health, or the kind of illness, depending on the doctor's degree of toleration for a person's abnormal emotional state, his eccentric ideas or his behaviour? In fact, of course, no science at all: only, for devious and covert purposes, a play on everyone's blind faith by means of a monstrously audacious professional rhetoric. The best that may be said for psychiatry's diagnostic categories is that they are sometimes convenient tags for directing the resources for care towards generally similar kinds of habitual response to personal crisis. It is time to remove the 'medical' blinkers and at last allow the possibility that an extraordinary and disturbing emotional or psychological condition is the response of a brain-healthy person to extraordinarily disturbing, traumatic or stressful events.

As we saw in Chapter 5, above, the mental health diagnostic categories are a medical hoax. If someone is beset by emotional distress, confused and irrational, it does not follow that it is reasonable

131 Cooper, D, op. cit. (n. 89, Ch 12), 39. The reader is again referred to the research of Summers, A & Kehoe, R, op. cit. (n. 13, Ch 4), which shows that it is likely that decisions about medication for schizophrenia are made in the absence of symptoms.

to attribute to him, without evidence, a constitutional or contracted disease - a mental illness. Unusual EEG readings or CAT scans, or the registration of hormonal abnormalities do not prove the presence of illness. In themselves, any such measurements say nothing about cause - they may simply be physiological correlates to the emotional and mental state of the person at the time. It is not legitimate to announce the presence of an illness where there is no evidence of organic pathology. Rather, we should recognise that it is characteristic of persons to enter incapacitating emotional and mental states under conditions of great stress; that under baneful circumstances someone may not be able to extricate himself from a highly-charged and dysfunctional emotional and mental condition; and that these circumstances often include the uncomprehending, insistent and irresistible attentions of psychiatrists and their assistants, all blinkered by the medical model. A so-said mental illness is nothing more than a person's apparently typical or habitual pattern of maladaptive beliefs and behaviour, tagged with a pseudo-medical label; this pseudo-diagnosis is accompanied by a pseudo-prognosis for the likely progress of the disorder. Thereby, psychiatry legislates an inappropriate response to the person's most pressing problems, and subjects him to the onerous and debilitating social expectations of a self-fulfilling prophecy.

It might finally be objected that although the medical model or theory may be inconsistent or is not yet fully worked-out, *at least the medicine sometimes works*. This depends on what is meant by 'work', and for whom. Is the objective to bring deviance under control, whatever the human costs, or to liberate the patient from misery and confusion? Leaving this question aside for the moment, even on its own terms the efficacy of psychiatric medicine is far from certain. Against the use of neuroleptics, for example, and apart from the harm they cause to the neurological system and other organs, it is now clear that there is no evidence that the medications help diagnosed schizophrenics get better; in other words, they cure nothing and only sometimes have an effect on symptoms. Even so, a significant proportion of patients report no benefits, while treatment makes others feel worse. It is also clear that when patients relapse after coming-off a neuroleptic - a regular occurrence - this is largely a super-sensitivity withdrawal response to an addictive drug, heightened by the normal lack of sufficient care or support.¹³² A similar case can be made against the antidepressants. On top of which, meta-studies indicate that no kind of psychiatric medication is superior to psychotherapy, placebo or no treatment at all.¹³³

It is true that psychiatric intervention may sometimes offer respite, particularly by removing the individual from the situation in which his mental disorder developed, and perhaps by the judicious, short-term use of a drug. Patients may sometimes seem to benefit from the medical approach, but only limited successes with symptoms can be claimed for medication and shock treatment, and since the medical model offers no substantial or practical theory of causality, there is no coherent remedial method. At the same time, everyone - including the patient himself - is encouraged to invoke the medical model so as to ignore or explain away as the workings of the so-said illness anything untoward that the individual might feel or not feel, think or not think, do or not do. As a consequence, any nuanced explication of the individual's psychological and social circumstances is forestalled, thereby impeding any possible progress with identifying and addressing the issues most significant to the individual, and hence the potential recovery of his emotional and mental balance. We have seen that the medical model permits officials to invalidate as a symptom of his mental illness anything whatsoever that any patient says which is administratively or personally inconvenient - including complaints of physical discomfort, pain or harm. A psychiatric diagnosis always degrades and stigmatises the patient and leaves him facing discrimination; coupled with the often debilitating effects of treatment, a negative prognosis easily becomes a self-fulfilling prophecy. Meanwhile, the

132 Kane, JM & Freeman, HL (1994) Towards more effective anti-psychotic treatment. *British Journal of Psychiatry* 165 (supp. 25) 22-31. After a wide survey of the research to that date, Kane & Freeman find that there is no clearly proven benefit from any neuroleptic medication. See also the discussion in Thomas, P, op. cit. (n. 11 Ch 6), 104-127; their conclusions were confirmed in 2009 by Tyrer, P & Kendall, T, op. cit. (n. 58, Ch 6).

133 See text to footnotes 28, 57, 58, 61 and 70 in Chapter 6, above.

medical model mandates medication as the appropriate response to any patient deemed a particular nuisance, and this regularly leads to deaths by over-sedation.¹³⁴

We conclude that the medical model is inappropriate for the alleviation of functional mental disorder, and that its first purpose is crypto-policing. It is an ideological device which misleadingly defines the nature of certain kinds of problematic situations and the persons embroiled in them; it is employed so as to systematically ignore or deny crucial aspects of personal life - which is to say, emotional, psychological and social life - and to justify the use of coercion against a certain kind of troublesome deviant. Some patients may enjoy the respite from personal and inter-personal conflict sometimes afforded by psychiatric hospitalisation or drugging, but the medical model is first of all convenient to the psychiatric profession and other interests, e.g., pharmaceutical companies and relatives or others troubled or discomforted by the person in crisis.

When he investigated the history of scientific discoveries, it became clear to Thomas Kuhn that at any one time each scientific community works with one specific set of interconnected concepts and assumptions. Kuhn calls this the community's current 'paradigm'. This all seems reasonable enough since, on the face of it, at the time the preferred paradigm seems best to account for all the phenomena within the particular scientific field. Consequently, almost every experiment and theoretical idea within the field is informed *only* by that set of ideas, and framed within it - and any evidence which does not fit the paradigm is either ignored or subverted. But when the number of counter-instances or anomalies increases, and they cannot be denied or sabotaged any longer, the paradigm goes into crisis. Sooner or later, this triggers a fresh approach with a radically different way of looking at things: a paradigm shift - a fundamental change in the underlying assumptions and approach of the discipline.¹³⁵ In the history of science there have been many such paradigm shifts. Perhaps the most famous was, for the very big and the very small, the substitution of Einstein's relativity physics for Newton's 'model'.

Psychiatric textbooks mean the same thing as 'paradigm' when they refer to their own set of assumptions, ideas and methods as 'a model' (the medical model). In this Volume we have seen that orthodox psychiatry, which works from the assumptions of the so-called medical model, suffers from an extraordinary lack of confirming evidence, which is to say, a surfeit of counter-instances or anomalies. Furthermore, no official attempts are made to address this problem, and any criticism of the ruling model or its concepts and methods is fiercely resisted. Decades ago it became clear that what passes for psychiatric theory is more akin to theological dogma than science, and the medical model is mandated as a catechism rather offered as a set of ideas open to criticism, testing and possible refutation. And yet, all along, there was a competing 'model', and one which might at last be gaining some momentum, even within official research and thinking: the psychodynamic hypothesis. However, we should not underestimate the deep-seated emotional, cognitive, material and institutional interests that stand in the way of a much needed change in the mental health paradigm.

In Volume 2 we propose an alternative to the medical model of mental illness, care and treatment: the psychodynamic perspective. For, no matter how fine the intentions of all or most of the officials, we cannot avoid concluding that *psychiatry wears the mask of medicine so as to work the levers of an oppressive social power*. By providing a quasi-police force and a superficially plausible ideology for the management of all those emotional and psychological deviants who embarrass or seem to threaten the social order, psychiatry functions first of all as an integral component of the spectacular society: the standard mental health response gives *the illusion* of employing the most up-to-date, precisely measured medical-scientific techniques so as to supply the most compassionate and efficacious assistance to each suffering individual. However,

[m]ental illness does not exist. It is a convenient category for collecting and keeping on one side accidents of identification. Those whom power can no longer govern or kill, it accuses of madness. It is there that we find the extremists and monomaniacs of the role -

134 See text to footnotes 65-67, above.

135 Kuhn, TS (1962) *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

and also those who laugh at roles or refuse them. [While t]heir isolation is the criterion that condemns them... it is not just isolation that creates madness, but [absolute] identification as well...

Paranoiacs, schizophrenics and sadistic killers whose role is not recognised as a public utility (that is not distributed under the label of power, like that of the policeman, the ruler or the soldier) are of use in special locations - asylums, prisons, museums of a sort - from which the state reaps a double profit: eliminating in them dangerous rivals and enriching the spectacle with negative stereotypes. Bad examples and their exemplary punishment give some point to the spectacle, and protect it.¹³⁶

136 Vaneigem, R, op. cit. (n. 87, Ch 13), 132-133. Situationist theory identifies 'the spectacle' as the dominant social relation: that of *competitive exchange*, which is today sustained largely by false images. 'The spectacle in general, as the concrete inversion of life, is the autonomous movement of the non-living.' Debord, G, op. cit. (n. 74, Ch 14), para 2.

Appendix to Chapter 12: NEUROBIOLOGICAL & GENETIC SCHIZOPHRENIA RESEARCH¹

By the nature of the research we can guess what kind of discovery the researcher can make. Knowing this we can suspect that this discovery is what the researcher secretly and unconsciously wants. Gregory Bateson²

This Appendix summarises and updates research evidence presented by Professor Alec Jenner et al, in the book Schizophrenia: A disease or some ways of being human?

Neurobiological Research

The latest discoveries regarding brain biochemical processes and also the obvious effects of psychopharmacological agents (such as the neuroleptic drugs) are used by researchers and clinicians as, they imagine, strong arguments in favour of the neurobiological origin of schizophrenia. But things are much more complex than might appear at first glance, and medical research has yet to provide *any* convincing evidence for the physiological nature and cause of schizophrenia.

In biology the complexity of interactions between phenomena, and between the forms of auto-regulation and replication, make us question the inappropriate use of the classical concepts of natural law and lineal causality adopted from Newtonian physics but applied outside the domain of everyday physics itself. Relativity physics and the other natural sciences have long since replaced such notions with those of interdependent elements within systems, structures and processes. The living brain is a system consisting of trillions of dynamic neurone interconnections. The idea that a person's mental condition (whether 'good' or 'bad') is to be explained in terms of one or a few easily identifiable, determinative lines of neurobiological cause and effect is wildly implausible.

It is important to remember that people undergoing emotional crises may well register certain thought disorders, and perhaps 'untypical' brain processes - as measured chemically, by electroencephalograph (EEG) or by scanning - but that *when thinking about non-sensitised topics both an emotionally disturbed person and the psychiatric patient may well show no confusion and no aberrations*. This suggests that there is no brain disease.

If we regard psychotic behaviour and speech as self-defeating and undesirable kinds of life-style and interpersonal (mis-)communication³ in a context of emotional distress and heightened concern with the self, it is by no means surprising to find in very disturbed individuals: (1) neurobiological anomalies, probably qualitatively similar to those presented by normal people undergoing painful emotional experiences; (2) a positive therapeutic response to drugs whose main function consists in chemically damping-down patients' states of high arousal; (3) a pattern of psychophysiological reactions also suggesting a high level of central nervous system activation or arousal. This became clear to even-handed mainstream psychiatric researchers many years ago.

...A possibility arises...that the metabolic disorders associated with schizophrenia, or at any rate some of them, may not be uniquely associated with clinical schizophrenia in any qualitative sense. They may occur in a lesser form in the metabolism of schizoid people, or in the metabolism of normal people undergoing complex and painful ego-damaging

1 This appendix conflates and somewhat updates Chapters 6 and 7 of Jenner, FA et al, op. cit. (n. 3, Ch 12). Editing here is to avoid repetition of points made elsewhere in the body of the present book.

2 Bateson, G (1972) *Steps to an Ecology of Mind*. New York: Ballantine.

3 As proposed by Haley, J (1963) *Strategies of Psychotherapy*. New York: Grunne & Stratton.

emotions, or even in the symptom-free relatives of schizophrenics. The chemical distinction between these groups may only be quantitative or regional. In the non-schizophrenics the aberrant metabolic processes may never reach the pitch required to 'break bounds' and invade the whole cerebral mechanism of perception, thinking, emotional and motor control, as they seem to do in schizophrenia.⁴

Obviously, this quotation does not radically question the essence of schizophrenia, yet it does recognise that metabolic disorders similar to those that may perhaps appear in someone diagnosed with schizophrenia may also occur in any normal person who undergoes ego-damaging emotions.

Nothing in the research negates this argument. The latest neurobiological studies employ strategies which are supposed to be evermore sophisticated. But, for instance, the alterations in platelet monoamine-oxidase activity found in diagnosed schizophrenics - and previously thought to be related to possible 'basic aetiopathogenic mechanisms' - are now known to depend on many types of variables which have little to do with the so-called 'schizophrenic disease process': such variables as the drugs received by the patient, nutritional states, phase of the menstrual cycle, or the personality and gender of the patient.⁵ Interestingly, however, platelet monoamine-oxidase activity does relate to levels of anxiety and arousal displayed by the patient.

The most important finding of [our] study is the significant decrease in platelet MAO activity after relaxation therapy... Evidence from other sources also supports an association between anxiety and MAO activity. It has been demonstrated that stress increases MAO activity in animals. Similarly, an association has been demonstrated between stress-related hormones such as ACTH and adrenalin and enzyme activity. It has been demonstrated that injections of adrenaline increase platelet MAO activity in humans.⁶

At present it is generally conceded that low platelet levels of MAO occur only in some, not all, chronic schizophrenic patients. The various levels do not correspond with any particular type of schizophrenia... Some normal persons have levels that are even lower than those found in chronically schizophrenic patients... This conclusion - that the depressed levels are genetic markers - has been questioned.⁷ If this conclusion is correct, why should acutely schizophrenic patients have normal levels? And why do bipolar depressed patients also have low platelet levels?⁸

Interesting findings have also emerged in other fields of research. In psycho-endocrinology, for instance, there was an elegant demonstration of the existence of relationships between psychotic (and schizophrenic) intense emotional crises and massive and dramatic adrenocortical responses.

4 Smythies, JR (1963) *Schizophrenia: Chemistry, Metabolism and Treatment*. Springfield: Thomas.

5 Gattaz, WF & Beckman, H (1981) Platelet MAO activity and personality characteristics. *Acta Psychiatrica Scandinavica* 64 79; Gattaz, WF et al (1981) Low platelet MAO activity and schizophrenia: Sex differences. *Acta Psychiatrica Scandinavica* 64 67.

6 Mathew, RJ et al (1981) Catecholamines and monoamine oxidase activity in anxiety. *Acta Psychiatrica Scandinavica* 63 245; this refers to Bujatti, J & Reiderer, P (1976) Serotonin, noradrenalin and dopamine metabolites in Transcendental Meditation techniques. *Neural Transmission* 39 257. Also see Mathew, RJ et al (1981) Anxiety and platelet MAO levels after relaxation training. *American Journal of Psychiatry* 138 371-373.

7 Dominic, EF & Gahagan, S (1977) In vitro half-life of ¹⁴C-Tryptamine in whole blood of drug-free chronic schizophrenic patients. *American Journal of Psychiatry* 134 1280.

8 Weiner, W (1983) Schizophrenia: Etiology. In Kaplan, HI et al (Eds) *Comprehensive Textbook of Psychiatry: III*. London: Williams & Wilkins. Weiner refers to Bourdillon, RE & Ridges, AP (1971) Catecholamines and schizophrenia. In Himwich, HE (Ed) *Biochemistry, Schizophrenias and Affective Illness*. Baltimore: Williams & Wilkins, 123; Carlsson, A (1978) Antipsychotic drugs, neurotransmitters and schizophrenia. *American Journal of Psychiatry* 135 165; Heller, B et al (1970) N-Dimethylated Indoleamines in blood of acute schizophrenics. *Experientia* 26 503; Hoffer, A (1967) Biochemistry of nicotine acid and nicotinamide. *Psychosomatics* 8 95; Horrobin, DF (1977) The roles of prostaglandins and prolactin in depression, mania and schizophrenia. *Postgraduate Medical Journal* 53 160; and Horrobin, DF (1980) A singular solution for schizophrenia. *New Scientist* 28 642.

In this respect, the fixed delusion of the schizophrenic might be seen as a pathological coping mechanism or defence, helping him to minimise anxiety in the same way that the profound religious faith of some of our women awaiting breast surgery helped them to maintain tranquillity. Indeed, as the schizophrenic patient in therapy gives up his delusions and faces painful reality again, he often re-experiences emotional distress and adrenal activation before he makes a full recovery... Certainly the diagnosis of schizophrenia alone will not tell us whether the adrenal cortex is activated or not. In these patients it is necessary to isolate specifically the clinical dimensions of emotional arousal and disorganisation of the ego's buffering mechanism.⁹

Again, it has been pointed out that

[m]ost research is directed to a study of the biochemistry of the schizophrenic subjects themselves. Brain samples are rarely obtainable except post-mortem, and so more readily accessible body materials - urine, blood or cerebrospinal fluid - from certified schizophrenics are compared with those from control normal people...

When such approaches were first adopted, several decades ago, they soon began to show up large differences in the biochemistry of hospitalised schizophrenic patients from those matched for sex, age, and so forth. But these differences turned out to be artefactual. Non-schizophrenic hospitalised patients showed similar differences from the normal. The differences were eventually traced to the effects of long periods of eating poor hospital diets, or to the chemical-breakdown products of drugs that had been administered to the patients, or even to excessive coffee-drinking by hospitalised patients...

It would be wearisome and unnecessary to recount in detail the history of research into the biochemistry of schizophrenia [in the thirty years to 1984]. Almost every biochemical substance known to be present in the brain has, within two or three years of its introduction into the bio-chemical dictionary, been studied for possible involvement in schizophrenia by clinical scientists with the hope of a breakthrough in their hearts and with grant money (often from drug companies) burning holes in their pockets...

Rarely have results obtained by one group of researchers been confirmed by another group of researchers in a different group of patients. Rarely has any resolution of conflicting claims been attempted. Rarely has any concern been expressed by the enthusiastic clinical researchers that schizophrenia might be associated with many different biochemical effects, or indeed that many different types of biochemical change might lead to or be generated by the same behavioural outcomes.¹⁰

Attempts to discover a biochemical basis for schizophrenia have not always been very well executed. For example, some research seems to reveal that patients have high serum copper levels. This is shown by the Akerfeld test which confirmed that ceruloplasmin levels are also augmented in such patients. However, several methodological mistakes were made in the investigations (for example, the necessity for excluding situations in which high levels of ceruloplasmin occur, such as in pregnancy and in several diseases), and also obvious sources of technical errors, since the test utilised is affected by serum levels of ascorbic acid.¹¹ Hence, the findings are related to other factors such as patients' diets. Furthermore, other investigations asserting a low level of neuraminic acid in

9 Sachar, EJ (1970) Psychological factors relating to activation and inhibition of the adrenocortical stress response in man: A review. *Progress in Brain Research* 32 319-320.

10 Rose, S, Kamin, LJ & Lewontin, RC (1984) *Not In Our Genes: Biology, ideology and human nature*. Harmondsworth: Penguin.

11 Weiner, H, op. cit. (n. 8).

the CSF of schizophrenics¹² may have suffered from influences hidden to the author, since it has not proved possible to repeat them.¹³

A line of research on abnormal levels of serum constituents was directed at proteins, especially of enzymes. For example, work was done on a protein fraction of the serum taraxein.¹⁴ This was identified as a circulating immunoglobulin, that is, an antibody able to interact by ligation to the nucleus of oligodendrocyte of the septal area of the cerebrum. It was thought to be produced by an inborn error of metabolism. But so far the findings have not been confirmed.¹⁵

Research has been carried out on the levels of immunoglobulins of schizophrenics. Elevations of IgG in one of several studies of various sub-groups of immunoglobulins (A-D-G-M) were reported.¹⁶ This has not been confirmed by other studies. It now seems that elevated levels relate to the administration of psychotropic drugs.

An abnormal antigen was found in the serum of schizophrenic patients.¹⁷ Subsequent work identified a rheumatoid factor in the serum of these patients.¹⁸ Yet this did not correlate with a diagnosis of schizophrenia, rather than with depressed mood; and none of this was later confirmed.¹⁹

Schizophrenia has been proposed as a type of auto-immune disease.²⁰ But even if there definitely was a rheumatoid factor as an autoimmune phenomenon in which IgG acquires antigenic properties, (this property possibly resulting from a genetic mutation in immuno-competent cells), which by themselves develop antibodies, it would also be true that the presence of these antibodies would not necessarily give them a pathogenic role in any disease. They can occur in normal individuals. Some projects that caused less of a stir reported other immunological reactions; none produced conclusive findings.²¹

Research on altered levels of enzymes in the blood of acute psychotic patients has been directed at several categories of substances. The most widely studied have been creatinine-phosphokinase (CPK), aldolase and the monoaminooxidases (MAOS). The elevation of the serum transaminase glutamine oxaloacetic acid oxidase (TGO) once found²² has not been confirmed by other investigations.

12 Bogoch, S (1960) Studies on neurochemistry of schizophrenia and affective disorders. *American Journal of Psychiatry* 116 743.

13 Jenner, FA et al (1962) Bial's Reaction for neuraminic acid in cerebrospinal fluid from schizophrenics. *Journal of Medical Science* 108 822-824.

14 Heath, R & Krupp, IM (1968) Schizophrenia as a specific biologic disease. *American Journal of Psychiatry* 124 1019.

15 Boehme, DH et al (1973) Fluorescent antibody studies of immunoglobulin binding by brain tissues: Demonstration of cytoplasmic fluorescence by direct and indirect testing in schizophrenic and non-schizophrenic subjects. *Archives of General Psychiatry* 28 202; Logan, DG & Deodhar, SD (1970) Schizophrenia: An immunological disorder? *Journal of the American Medical Association* 212 1703-1704; Whittingham, S et al (1968) Absence of brain antibodies in patients with schizophrenia. *British Medical Journal* 1 347.

16 Solomon, GF et al (1969) Immunoglobulins in psychiatric patients. *Archives of General Psychiatry* 20 272.

17 Haddon, RK & Rabe, A (1963) An antigenic abnormality in the serum of chronically ill schizophrenic patients. In Heath, RG (Ed) *Serological Fractions in Schizophrenia*. New York: Harper & Row, 151.

18 Rosenblatt, S et al (1968) The relationship between antigamm-globulin activity and depression. *American Journal of Psychiatry* 124 1640; Solomon, GF et al, op. cit. (n. 16).

19 Mellso, GS et al (1973) Schizophrenia and autoimmune serological reactions. *Archives of General Psychiatry* 28 194.

20 Burch, PRJ et al (1968) Schizophrenia: Autoimmune or autoaggressive? *British Medical Journal* 2 50.

21 Pulkinnen, E (1977) Immunoglobulins, psychopathology and prognosis in schizophrenia. *Acta Psychiatrica Scandinavica* 56 173; Stabenau, JR et al (1968) Serum macroglobin (S19) in families of mz twins discordant for schizophrenia. *American Journal of Psychiatry* 125 309; Turner, WJ & Chips, HE (1966) A heterophil menolysin in human blood: Distribution in schizophrenics and non-schizophrenics. *Archives of General Psychiatry* 15 373.

22 Schweid, DE et al (1972) Creatine phosphokinase and psychosis. *Archives of General Psychiatry* 26 263.

Elevated levels of CPK in about 40% of patients with a wide spectrum of acute psychoses have been confirmed.²³ But in most of the cases levels returned to normal some days or weeks following the onset of the episode. Furthermore, it has been found that enzyme alterations depend on such factors as race, sex and intra-muscular injections.²⁴ Significantly, the iso-enzyme of CPK, which is elevated in acute psychosis, is of muscle origin and not cerebral,²⁵ and the same is so for aldolase. The elevated serum levels of CPK and aldolase, found mainly in the initial phase of the mental disorders, are not specific for schizophrenia and we cannot discern what, if anything, that means for an aetiological theory of schizophrenia. Rather, when other variables are controlled, the serum enzyme levels reflect an increase in motor activity, not the psychotic condition itself.²⁶

Another line of research is based on the view that the pathogenesis of schizophrenia is provoked by abnormal metabolites with psychotomimetic properties, but resulting from normal body constituents. Perhaps 3,4-dimethoxyphenylethylamine originates from endogenous dopamine, or exogenous diet;²⁷ but a correlation between its levels and the diagnosis of schizophrenia has not been clearly shown.²⁸ For a long time the correct gas chromatographic mass spectrographic identification in urine was also in question. Dimethyltryptamine originating via a hypothesised abnormal pathway has also been investigated, but it has not been shown specific for schizophrenia.

Work on transmethylation disorders producing psychomimetic substances²⁹ became entangled with 'the pink spot' story: pink spots on paper chromatograms treated with particular reagents (ninhydrin followed by Ehrlich's reagent) seemed to be specific for schizophrenia.³⁰ Some researchers took this very seriously, and seemed unaware of the tendentious nature of the category of schizophrenia and the problems of chemical studies in the field.³¹ They took the genetic theories as facts and intended to use the spot as a marker. Forty-six positive findings were reported from 73 schizophrenics, and none from 16 non-schizophrenics. This seemed to confirm a more limited earlier report³² and the theorising of a decade earlier;³³ the fact that a similarly reacting spot is produced by a methylated product of dopamine (3,4-dimethoxyphenyl-ethylamine) seemed to fit all these facts together into a great story. Similar spots can be produced by many substances, though. Once more, these apparently convincing results turned out to be artefacts resulting from enthusiasm instead of careful and accurate science.

An early scientific howler was the work which 'demonstrated' the existence of the peculiar smell of the sweat of a great number of schizophrenic patients. It was stated that laboratory mice could be conditioned to discriminate it.³⁴ Many psychiatrists were seduced by the usefulness of that particular scent as a diagnostic criterion for schizophrenia - before it was pointed out that the material

23 Coffey, JW, Heath, RG & Guschwan, AF (1970) Serum creatine kinase, aldolase, and copper in acute and chronic schizophrenics. *Biological Psychiatry* 2 4 331-339; Meltzer, HY (1976) Neuromuscular dysfunction in schizophrenia. *Schizophrenia Bulletin* 2 106.

24 Meltzer, HY (1969) Muscle enzyme release in the acute psychoses. *Archives of General Psychiatry* 21 102; Meltzer, HY & Moline, R (1970) Muscle abnormalities in acute psychosis. *Archives of General Psychiatry* 23 481.

25 Meltzer, HY, op. cit. (n. 24); Meltzer, HY & Moline, R (1970) Plasma enzymatic activity after exercise: A study of psychiatric patients and their relatives. *Archives of General Psychiatry* 22 390.

26 Harding, T (1974) Serum creatine kinase in acute psychosis. *British Journal of Psychiatry* 125 280.

27 Friedhoff, AF & Van Winkle, E (1962) Isolation and characterisation of a compound from the urine of schizophrenic patients. *Nature* 194 879-898.

28 Mendolson, J (1964) Discussion of Dr Friedhoff's paper: Biological O-methylation and schizophrenia. *Psychiatric Research Reports of the American Psychiatric Association* 19 154.

29 Osmond, HJ et al (1952) Schizophrenia: A new approach. *Journal of Mental Science* 93 309.

30 Friedhoff, AF & Van Winkle, E (1962) The characteristics of an amine found in the urine of schizophrenic patients. *Journal of Nervous and Mental Diseases* 135 550.

31 Bourdillon, RE et al (1965) Pink spot in the urine of schizophrenics. *Nature* 208 253-271.

32 Friedhoff, AF & Van Winkle, E, op. cit. (n. 30).

33 Osmond, HJ et al., op. cit. (n. 29).

34 Smith, K & Sines, JO (1960) Demonstration of a peculiar odour in the sweat of schizophrenic patients. *Archives of General Psychiatry* 20 272.

conditions and the institutional diet had not been taken into account. This is an interesting case since, from classical times and up until the 17th century, some educated people (and, of course, especially the Inquisitors) thought they could detect ‘the peculiarly fetid smell of the Jew’. Some authorities used to maintain that the smell left a Jew as soon as he baptised to Christianity but returned immediately if he relapsed back to Judaism!

Presently there is no confirmation of theories depending upon tryptamine,³⁵ methionine³⁶ and tryptophan, nor of alterations of nitrogen metabolism.³⁷

Besides all this, though, a very important question is whether the published biochemical anomalies described could be the *cause* of schizophrenia or just co-variants of the psychological and behavioural states of schizophrenic patients.

One cannot help wondering how the finding of a specific biochemical substance, for instance, would enhance the understanding of the cause of schizophrenia. Presumably, such a substance could be important as a validating criterion of diagnosis, in the manner that changed levels of the thyroid hormone serve as a validating diagnostic criterion of thyroid diseases. But such a finding would have little aetiological significance in itself, because the causes of the diseases of the thyroid gland are largely unknown and go far beyond changes in the levels of the thyroid hormones. Furthermore, changes in a substance or substances may be co-variants of some behavioural manifestation...

Logic dictates that a pathophysiological finding is not necessarily pathogenic, despite the traditional attempts in medicine to attempt to infer causes and pathogenesis from pathophysiology and pathological anatomy after the start of an illness. Knowledge of the causes and pathogenesis of an illness is limited and will be advanced only by predictive and longitudinal studies of persons at risk for a particular illness and its sub-forms.³⁸

It is true that the advances of psychopharmacological research have been significant. They attest to a certain success of one approach to the problems of mental and emotional suffering. Yet such an approach should not preclude all others. For there are also intrinsic drawbacks: unwanted secondary effects (‘side effects’), a naive and over-confident use of psychopharmacotherapy, a tendency to discount the *really* problematic contexts to mental disorder. Therapeutic potentials may be blunted by the apparent successes of the drug approach. For the

[a]nti-psychotic drugs exert beneficial effects in virtually all classes of psychotic illness and, contrary to a common misperception, are not selective for schizophrenia... Thus the hopes of the 1950s and 1960s for the discovery of clearly defined, genetically determined inborn errors of the metabolism to explain psychiatric disease have not been realised.

Moreover, there is a growing realisation that there may be an over-simplification in the attempt to formulate hypotheses about the causes of mental illness from the tenets of psychopharmacology. Thus it was commonly hoped that knowledge of the mechanisms of action of anti-psychotic or anti-depressant drugs would point the way to the discovery of underlying pathophysiological changes in schizophrenia or manic-depressive illness that are functionally opposite to the effects of the drugs. This has not proved to be the case.

The anti-psychotic, anti-manic and anti-depressant drugs have effects on cortical, limbic, hypothalamic and brain-stem mechanisms that are of fundamental importance for the regulation of arousal, consciousness, affect and autonomous functions. It is entirely possible that physiological and pharmacological modification of these brain regions might have important behavioural consequences and useful clinical effects regardless of the fundamental nature or cause of the mental disorder in question. Moreover, the relatively

35 Dominic, EF & Gahagan, S, op. cit. (n. 7).

36 Pollin, W et al (1961) Effects of amino acids feedings in schizophrenic patients treated with Iproniazid. *Science* 133 104.

37 Gjessing, R (1947) Biological investigations in endogenous psychoses. *Acta Psychiatrica et Neurologica Scandinavica* 47 93.

38 Weiner, H, op. cit. (n. 8), pp. 1147-1149.

poor temporal correlations between the known effects of most psychotropic drugs, which for the most part occur rapidly, and their clinical effects, suggest that secondary or even more indirect changes brought about by the drugs may mediate their clinical actions.³⁹

In the case of schizophrenia, there is an average latency interval of about three weeks between the start of treatment and the appearance of any therapeutic results. Since delusions, hallucinations and formal thought disorders are probably a result of states of increased arousal and emotional turmoil, they will only begin to fade away after patients' anxieties have been 'damped down' by the drugs to a reasonably low level (although, of course, the damping down might well be the effect of rest and respite or placebo).⁴⁰

The dopaminergic theory of the aetiology of schizophrenia proposes an abnormally high level of dopamine or an increased post-synaptic sensitivity to dopamine. The hypothesis arose in part from an extrapolation of the mode of action of the neuroleptic drugs proposed, in 1962.⁴¹ At that time an experiment showed that in the brains of mice neuroleptics increased the levels of the metabolites of dopamine, suggesting therefore that the dopaminergic receptors had been blocked. These suggestions have been impressively confirmed by subsequent and more sophisticated techniques. However, [f]rom the known actions of the drugs a hypothesis is constructed about the cause and the pathogenesis of schizophrenia. But is this a logical approach to its cause and pathogenesis? The pharmacological action of a drug like digitalis in congestive heart failure does not tell us about the multivarious reasons why the heart failed.

Many drugs with a variety of pharmacological actions on different systems are used for the treatment of essential hypertension, whose cause and pathogenesis are quite unknown. At best the action of a drug may indicate something about the pathophysiology of a disease but not about its predisposition or inception. In fact, it may even be dangerous to extrapolate from the action of a drug to the pathophysiology of a disease.⁴²

Drugs that alleviate symptoms, like the use of aspirin for toothache, may be worth developing even if they tell us nothing about the causes of the disorder. The multiplicity of drugs (and formulations of drugs) is an aspect of the way the pharmaceutical companies work in a field where knowledge of patent law is as important as clinical skills. The problem is that of confounding the effect of a drug with the offer of an explanation, the alleviation of suffering with a cure for the disease.⁴³

Recognition of the therapeutic efficacy of a drug allows us to draw no conclusions about the aetiopathogenesis of a disease: e.g., paracetamol remedies pain, but cannot indicate the root cause. Besides, it is extremely difficult to determine physiological states before and after the onsets of pathologies. This limits any ability to produce a conclusive aetiopathology.

These obstacles to causal investigations of schizophrenia led to the use of research strategies based upon the experimental induction of model psychoses, by the so-called psychotomimetic drugs like amphetamine, mescaline and LSD 25. This is worth comment.

Such problems have made yet another approach more attractive to reductionist thinking; to observe the effects of pharmacological agents - drugs - on human behaviour. If a drug induces schizophrenia-like behaviour - for example auditory hallucinations - then attempts will be made to conclude that the drug interferes with a biochemical process in the normal person which is damaged in the schizophrenic. Hence, for example, there was a period in

39 Baldessarini, RJ (1985) Drugs and the treatment of psychiatric disorders. In Goodman, LS & Gilman, A (Eds) *The Pharmacological Basis of Therapeutic*. New York: Macmillan 387-388.

40 Klein, DF (1981) Low dose maintenance of schizophrenia. *Annual Meeting*. London: Royal College of Psychiatrists; May, PRA (1971) Cost efficiency of treatments for the schizophrenic patient. *American Journal of Psychiatry* 127 1382-1385; May, PRA (1973) Rational treatment for an irrational disorder: What does the schizophrenic patient need? *American Journal of Psychiatry* 133 1008-1012.

41 Carlsson, A, op. cit. (n. 8), 165.

42 Weiner, H, op. cit. (n. 8), 1147.

43 Rose, S, Kamin, LJ & Lewontin, RC, op. cit. (n. 10), p. 218.

the 1960s in which attempts were made to find links between LSD and schizophrenia on the grounds that users of LSD experienced hallucinations that might be seen as analogous to those of the schizophrenic. This logic, which argues backwards from the effect of the drug to the cause of a disease is plainly risky, both for the logician and the patient. As we have emphasised in the case of L-dopa, no drug has a single site of action. Foreign chemicals introduced into the body are not magic bullets. Yet such thinking has dominated more than thirty years [now more than sixty years] of research on the biochemistry of schizophrenia, generated endless research papers, made scientific and medical reputations, and brought substantial profit to the big drug firms.

The history of thinking among biochemists about schizophrenia over the period is inextricably intertwined with that of the pharmaceutical industry, for which psychotropic drugs have been one of the biggest money-spinners.⁴⁴

In 1981 'the death of the dopamine hypothesis' was proclaimed by one researcher, after he summarised his painstaking research into the biochemical mechanisms of schizophrenia. He implied that we should now begin to search elsewhere for the causes of schizophrenia since his findings - so far as dopamine was concerned - did not confirm the role of this amine as an aetiological factor in schizophrenia.⁴⁵ As a biochemist, he might well continue his search for other possible biochemical explanations, although we think we are also entitled to approach this problem from a completely different perspective, i.e., social-psychology.

Even before the appearance of neuroleptics, some researchers, including the eminent Portuguese neurologist Egaz Moniz in 1935, had identified the organic basis for thought in the synapses. He tried to deduce from the therapeutic effects of pre-frontal lobotomy that certain psychoses, including schizophrenia, were caused by abnormal brain function. (In 1949 he won the Nobel Prize for inventing lobotomy.) Thomas Szasz comments⁴⁶ that Moniz recognised that his objective in applying lobotomy to human beings was less to find a cure for psychoses than to lay the cornerstone for the edifice of organic psychiatry. This was meant to establish a firm basis for an *organic* theory of the *functional* psychoses. This was not like traditional medical research. In order to try to establish the organic nature of *dementia paralytica*, researchers studied post mortem brains, and established the histopathological nature of the condition. They did not mutilate living people in attempts to prove that General Paralysis of the Insane is an organic disease, nor did they draw conclusions about the nature of the disease from the mode of therapeutic intervention. Nevertheless, the reasoning behind Moniz's method is widely accepted today. For instance, it is generally believed that because the major tranquillisers seem to affect behaviour in ways that many feel is desirable, this *proves* that the patients have a disease with an organic basis.

With regard to psychophysiological studies applied to schizophrenia, much of what is presented as a discovery is misleading since suitable control groups were not included in the research.

Practically all the positive findings in schizophrenics have also been described in anxiety states, whenever direct comparisons have been made. It is not defeatism but realism to suggest that no psychophysiological property of schizophrenics has been unequivocally demonstrated. Until patients with anxiety states are routinely included as an additional control in studies of schizophrenic patients, no real scientifically sound conclusions can be drawn. Thus, the raised autonomic and endocrine variables, the lack of reactivity, the slowness to adapt and habituate, the poor stimulus discrimination and the generally impaired performance of the schizophrenic are found in greater or lesser extent in the morbidly anxious patient, and can often be induced by stressful procedures in the calm normal.⁴⁷

44 Rose, S, Kamin, LJ & Lewontin, RC, op. cit. (n. 10), 217.

45 Iversen, L (1981) Lecture to the annual meeting of the Royal College of Psychiatrists. London: Royal College of Psychiatrists.

46 Szasz, TS (1977) *Schizophrenia: The sacred symbol of psychiatry*. New York: Basic Books.

47 Lader, MH (1975) *The Psychophysiology of Mental Illness*. London: Routledge & Kegan Paul.

In the field of neurophysiological research, workers obtained findings on neurotics - supposedly non-psychotic, understandable patients - which showed significant differences in evoked potentials between obsessional patients and matched normal controls.⁴⁸ Others have proved the existence of hemispheric quantitative EEG changes in neurotic patients showing symptoms of tension, anxiety and/or depression. These EEG changes seem responsive to certain kinds of psychotherapeutic intervention, mainly in the case of patients rated 'very anxious' during psychotherapy. It was suggested that the EEG changes in this 'high intensity group', found following a therapy session, reflected a general deactivation of the brain and a functional improvement of the right hemisphere. The hypothesis was also offered that the release of blocked feelings in a primal therapy session is followed by an overall increase in both EEG amplitude and amplitude variance in the temporal areas, indicating a more relaxed (less activated) brain.⁴⁹

Risk factor seems to be associated with abnormal oculomotor tracking.⁵⁰ This was confirmed by other studies, and used as a genetic marker for schizophrenia.⁵¹ However, this is subject to similar objections to those we have already raised.

The abnormality is present in non-schizophrenic persons, and in the relatives of schizophrenic patients... It may be premature to ask the meaning of such abnormalities... Does it reflect some central neural state that impairs attention or the sampling of the appearance of the external world? But why should an impairment lead to schizophrenia in some but not in others? And why does the disorder persist in remitted schizophrenic patients? Brain disease can produce the same dysfunction. It is seen in cerebral arteriosclerosis, Parkinson's disease, lesions of the brain stem and cerebral hemispheres, and psychotically depressed patients.⁵²

Much work has been devoted to the neurobiochemistry of schizophrenia.

Among the claims for causative factors in schizophrenia made since the 1950s we may point to: abnormal substances excreted in the sweat of schizophrenics; injection of the serum of schizophrenics into other normal subjects inducing abnormal behaviour; the presence of abnormal enzymes in red blood cells and blood proteins. Between 1955 and [1984], conflicting research reports have claimed that schizophrenia is caused by disorders in serotonin metabolism (1955); noradrenaline metabolism (1971); dopamine metabolism (1972); acetyl-chlorine metabolism (1973); endorphin metabolism (1976); and prostaglandin metabolism (1977). Some molecules, such as the amino acids glutamate and gamma-amino-butyric acid, came into fashion in the late 1950s, but fell into neglect, and now, in the 1980s, have come back into fashion once more.⁵³

Without being exhaustive, we could also include studies of histamine, reduced susceptibility to infections, the alterations of glucose metabolism, and relations to other diseases - e.g. tuberculosis, hereditary disorders, and to neurological disorders such as porphyria, homocystinuria, Huntington's Chorea, Wilson's disease, etc.

What all these studies appear to indicate is that finding more or less conspicuous neuro-biological, psychophysiological, psychoendocrinological, or neurophysiological anomalies does not necessarily imply the existence of any kind of disease process which could therefore be the only thing capable of producing the anomalies. Hence, even the eventual discovery of an enzyme defect in schizophrenia

48 Ciesielski, KT et al (1981) Some electro-physiological observations in obsessional states. *British Journal of Psychiatry* 136 413-420.

49 Hoffmann, E & Goldstein, L (1981) Hemispheric quantitative changes following emotional reactions in neurotic patients. *Acta Psychiatrica Scandinavica* 63 157.

50 Holzman, PS et al (1973) Eyetracking patterns in schizophrenia. *Science* 181 179.

51 Shagass, CM et al (1974) Eyetracking performance in psychiatric patients. *Biological Psychiatry* 9 245; Shagass, CM et al (1976) Eyetracking performance and engagement of attention. *Archives of General Psychiatry* 33 12.

52 Weiner, H, op. cit. (n. 8), 1130.

53 Rose, S, Kamin, LJ & Lewontin, RC, op. cit. (n. 10), 218.

would not necessarily imply that this is genetically determined, nor that it has a specific causal relation to schizophrenia.

At an earlier time psychiatrists and neurologists chose to distinguish between organic and functional nervous disorders... But such a distinction is unacceptable to the dominant, full-blooded materialism of contemporary psychiatry. If there is a disordered mind, there must be associated with it some type of disordered molecule or cellular event in the brain. Further, the reductionist argument insists that there must be a direct causal chain running from the molecular events in particular brain regions to the most full-blown manifestations of existential despair suffered by the individual.

Even when proper care is taken to circumvent this problem by ensuring that the subjects studied have been kept off drugs for a period, that they have the same diet as their matched controls, and so forth, there remains a general methodological problem that cannot be avoided. Even if an abnormal chemical is found in the body fluids of a diagnosed schizophrenic compared with the best-matched of controls, one cannot infer that the observed substance is the cause of the schizophrenia; it might instead be a consequence. The causal argument assumes that the substance is present, and, as a result, the disorder begins. A consequential argument says that first the disorder occurs and then, as a result, the substance accumulates. If an individual suffers an infection from a flu virus there is a considerable increase in the antibodies present in the blood and mucus of the nose - they are the body's defences against the virus. The antibodies and the mucus haven't caused the infection, and one cannot readily deduce the actual causes simply by observing such consequences...

The ideology of biological determinism is linked to an insistence that biological events are ontologically prior to and cause behavioural or existential events, and hence to a claim that if brain chemistry is altered in schizophrenia, then this altered biochemistry must be some type of genetic predisposition to the disorder.⁵⁴

As we have seen, these same anomalies can be found in neurotic patients and stressed normals. Besides, no data so far obtained for psychotic patients in any way discounts explanations by the psychodynamic model - those which take into account the motives and purposes of the patient, and which try not to forget the possible meanings of their symptoms. Thomas Szasz points out that after decades of intense research there are 'mountains of facts about neurochemistry and psychopharmacology, but...none about schizophrenia'.⁵⁵

And, as another critic comments,

The information reviewed, however, points up another common fallacy in schizophrenia research - the role of fashion in dictating research hypothesis construction... Why should nature have chosen to inflict the 'schizophrenic abnormality' upon whatever specific chemical the experimentalist happens to be best equipped to measure?⁵⁶

We have reviewed the neurobiological research because it now has a long history and yet, after decades, no significant correlations have been found between any mental health diagnosis and a brain-chemistry anomaly. Apart from the glamour of the constantly improving and impressive-looking new technology, it is likely that the latest fashion for brain-scanning rather than biochemistry is a response to this 'lack of success'.

Nonetheless, in terms of science rather than gratification of researchers' wishes to discover a cause and secure fame and a career, the research has actually proved very useful. For by eliminating possible causes 'in the person's brain', failure to confirm the various hypotheses goes a long way towards establishing the real cause: it is now clear that individuals with a psychiatric diagnosis *do not suffer from intrinsically abnormal brain chemistry*.

54 Rose, S, Kamin, LJ & Lewontin, RC, op. cit. (n. 10), 212.

55 Szasz, TS, op. cit. (n. 46).

56 Weiner, H, op. cit. (n. 8), 1147.

Genetic Research

Researchers and clinicians often refer to the findings of psychiatric genetics as ostensible proof for the hereditary basis of schizophrenia, and to show the reasonable nature of theories which ascribe to mental disorders the status of specific and discrete nosological entities which most probably have an organic basis.

First of all, though - and as we have said, this applies to neurobiological research, as well - *the lack of reliable external criteria for the validation of the clinical diagnosis of schizophrenia* puts researchers in the strange position of having to investigate the genetic basis for a disease without being at all certain about what they mean when they speak about that disease. It is true that there is *some* agreement with regard to the definition of schizophrenia, but the conventional categories are usually taken for granted as real or objective in themselves rather than only more or less convenient 'handles' on a very complex and dynamic reality.⁵⁷ This is misleading, and it is bound to distort the genuine statistical significance and the interpretation of research data.

Despite this, researchers have pressed on, and through the years several strategies have been used to identify the role of the transmission of genetic factors in schizophrenia.⁵⁸ These have included family trees, consanguinity, twin and adoption studies, and linkage studies.

Family studies only confirm that schizophrenia tends to run in families with a history of mental disorder. As well as genetic information, families habitually share a life-style and ways of conceiving and misconceiving reality, and attitudes towards the world. Many psychological traits run in families - everything from dietary and consumption habits to television-viewing, world-views, voting preferences, and all manner of healthy and unhealthy behaviours - without anyone suggesting that they are genetically determined. Since different aspects of the acquisition of behaviour imply *either* genetic or cultural transmission, the results of consanguinity studies cannot be conclusive proofs of tendencies to the genetic inheritance of a mental disorder.⁵⁹

It is now clear that the striking results obtained by pioneer research in the field were contaminated by serious methodological mistakes. For example, the studies of families and twins in the 1930s are consistently contradicted by more recent and more sophisticated research.⁶⁰ Current ideas about genetic transmission are far less straightforward and naive. One commentator writes that

Kallmann's first major work, published after his arrival in the USA, was a family study of schizophrenia in 13,851 relatives of 1,087 patients admitted to a Berlin hospital in a ten year period, in which he estimated the prevalence of the different forms of schizophrenia in relatives of patients compared to the general population. The population expectancy of 0.85% was much smaller than the expectancy of relatives of 16.4% for children and 11.5% for siblings. This implied the hereditary nature of schizophrenia, although cultural transmission was not ruled out until the Danish-American studies of a generation later.⁶¹

Although methodologically superior, neither do the Danish-American studies⁶² provide conclusive evidence in favour of clear-cut genetic factors in the aetiology of schizophrenia. For instance, the study of adopted-away offspring of schizophrenics (as compared to the control group of those of normal biological parents) gives a statistical significance with regard to the incidence of schizophrenia only when included in the 76 adopted-away subjects is a sub-group of 24 whose biological parents were diagnosed *not* as schizophrenic but manic-depressive, or as having other

57 For example, as does *The International Pilot Study of Schizophrenia* (1973) Geneva: World Health Organisation.

58 Fonseca, A & Fernández, DA (1965) *Heranca de Personalidade: A Genetica em Psiquiatria*. Porto: Porto.

59 Kinney, DK (1983) Schizophrenia and major affective disorders (manic-depressive illness). In Emery, AEH & Rimoin, DL (Eds) *Principles and Practice of Medical Genetics*. London: Churchill-Livingstone.

60 Kallmann, FJ (1938) *The Genetics of Schizophrenia*. New York: Augustin.

61 Gershon, ES (1984) The historical context of Franz Kallmann and psychiatric genetics. *Archiv der Psychiatrie Nervenkranken* 229 273-276.

62 See Kety, SS et al (1971) Mental illness in the biological and adoptive families of adopted schizophrenics. *American Journal of Psychiatry* 128 302-306; also see Rosenthal, D et al (1971) The adopted-away offspring of schizophrenic parents. *American Journal of Psychiatry* 128 307-311.

psychiatric disorders. If that sub-group is excluded from the findings, the difference between those born to schizophrenics and those born to normals is nowhere near statistical significance.⁶³

This study also failed to replicate earlier findings⁶⁴ which had been widely accepted as strong evidence in favour of the hypothesis that schizophrenia is essentially a genetic disorder, and which suggested a so-called common-core diathesis for schizophrenia and sociopathy. In the study, 47 offspring who had been permanently separated from their hospitalised schizophrenic mothers in the first few months of life were compared with the offspring of 50 non-schizophrenic mothers, who had also been separated from their mothers at a very early age. Five of the children of schizophrenic mothers went on to become schizophrenic, as compared to none of the controls. In this study the index - the group from the schizophrenic mothers - also contained 9 sociopaths (as against 2 in the control group), 13 neurotics (as against 7), and 4 mentally defective⁶⁵ subjects (as against 0).

All the same, the fact that the index group were the offspring of hospitalised schizophrenics may well have blocked favourable adoption conditions. In fact, several of the subjects had been raised in institutions. The conditions of birth and adoption (or not) could undoubtedly be influential to the children's later adaptations to their social worlds, for a variety of physiological, psychological and sociological reasons that have nothing to do with any hypothesised genes of schizophrenia. The fact that the index group tended to develop with significantly greater psycho-social problems could as well lead to a hypothesis ascribing the interesting differences rather to less favourable conditions than the postulate of a hypothetical common-core diathesis for schizophrenia and sociopathy. For instance, the mental deficiency that was found is well-known to correlate with such intra-uterine insufficiencies as might well pertain when a mother-to-be is a diagnosed schizophrenic.⁶⁶ As well as a tainted pedigree, the child of a schizophrenic mother is significantly more likely to enter the world (and meet its substitute parents) with an under-weight and tinier body, and this has developmental effects.⁶⁷ Long before his onset of schizophrenia, one of the five schizophrenic offspring in the 1960s study was diagnosed as mentally defective, with an IQ of 62.

As reported in a psychiatric journal, the following practice seemed to be standard by 1980, and we cannot believe it would have been unusual in earlier decades:

I was recently involved in the adoption of the baby of a sixteen-year-old schizophrenic whose own mother had also suffered from schizophrenia. The social workers explained that the adopting parents were entitled to the background information about the baby's origins, and I agreed to meet them. Questions were asked about the heritability of schizophrenia and even what signs to look out for in adolescence in the unfortunate event that the daughter should develop the illness. I realised that the child entered its family trailing a background of schizophrenia and would be watched closely all its life to see if the hereditary taint would show itself in abnormality. What is the bearing of this upon the adoption research from Oregon and Denmark, which I had thought represented cast-iron evidence for schizophrenia being to a substantial extent truly inherited by genetic mechanisms? If there was some transmission of background information to the adopting parents, as can occur in this country, did it invalidate the aim of the research to separate genetic and environmental influences on the children studied?⁶⁸

Scandinavian studies show that, corrected for age, the incidence rate of schizophrenia in the offspring of each monozygotic (mz) twin of a pair discordant for the mental disorder is identical, at

63 See Lidz, T et al (1981) A critique of the Danish-American studies of the adopted-away offspring of schizophrenic parents. *American Journal of Psychiatry* 138 1066.

64 Heston, L (1966) Psychiatric disorders in foster home reared children of schizophrenic mothers. *British Journal of Psychiatry* 112 812-825.

65 Nowadays known as 'learning disabilities'.

66 See Wolkind, S (Ed) (1979) *Medical Aspects of Adoption and Foster Care*. London: Heinemann.

67 Humphrey, M (1980) Book review. *British Journal of Psychiatry* 136 297.

68 Smith, A (1980) Adoption research in schizophrenia. *British Journal of Psychiatry* 136 352.

10%. This leads to the conclusion that genetic transmission alone is not adequate to explain the origin of the cases of schizophrenia in these offspring.⁶⁹

The authors of the second Danish-American study claimed to have proved beyond doubt the genetic basis for schizophrenia.⁷⁰ But this has been successfully challenged by various other researchers. For example,

[i]n the study there was a highly significant difference between the index and the control groups in the half-sibling category, and there were no clear differences in the full-sibling or parent categories. This finding is peculiar and contradictory. It shows, in effect, that the less consanguinity the greater the genetic effect. Differences should be weakest, not strongest, in the half-sibling category.⁷¹

In the same paper, the author points out an interesting question about the methodological issues brought about by the comparison of index and control groups in psychiatric genetics:

Although the interpretative assumptions of the authors [of the second Danish-American study] was that differences were associated with poor (destructive, defective, illness-inducing) genes in the index group, it is equally possible that observed differences could also be associated with good (constructive, superior) genes in the control group. For example, those who think of schizophrenia as a maladaptive social solution to problems in living might argue that the control adoptees without any psychiatric history had more genetically determined social assets, such as better physical appearance, intelligence, athletic ability and/or other talents that can facilitate optimal social adjustment in Western culture... Since the study failed to match the biological families of index and control groups for genetically based social assets, it could be that control adoptees tended to come from middle and upper class persons with favourable genetic heritage who were giving up infants for adoption because of illegitimate teenage pregnancies, whereas index adoptees tended to have been put up for adoption because of more chaotic social situations characteristic of persons with less genetic and environmental advantage in social adaptation. However, this formulation, like the genetic interpretation, falters because of the failure to find differences between index and control groups. Thus the argument remains at a stalemate.⁷²

The same stalemate pertains with regard to twin studies. Both theoretical critiques and empirical studies have clearly demonstrated that the earlier twin studies produced results greatly over-estimating the role of genetic factors in schizophrenia. More recent studies try to avoid the pitfalls of unrepresentative sampling and uncertain zygosity diagnosis; and they find much lower concordance rates for mz twins with respect to schizophrenia.

Although the higher concordance for schizophrenia of mz twins is not an artefact, its significance is complex. Concordance levels of 50% do not disprove the effect of the environment.⁷³ The environment of mz twins is peculiar.⁷⁴ They are often dressed identically, mistaken in their identification, treated as a unit - 'the twins' - and share much experience.⁷⁵ Also, of course, pre-natal and post-natal experiences are very similar. Where mz twins are discordant for schizophrenia, obstetric difficulties are commoner for the psychotic twin.⁷⁶ Studies not involving twins also show

69 Fischer, M (1973) Genetic and environmental factors in schizophrenia. *Acta Psychiatrica Scandinavica* 2381.

70 Kety, SS et al, op. cit. (n. 62).

71 Benjamin, LS (1976) Reconsideration of the Kety and associates' study of genetic factors in the transmission of schizophrenia. *American Journal of Psychiatry* 133 1131.

72 Benjamin, LS, op. cit. (n. 71) 1132.

73 Kinney, DK, op. cit. (n. 59).

74 Jackson, DD (1960) A critique of the literature on the genetics of schizophrenia. In Jackson, DD (Ed) *The Etiology of Schizophrenia*. New York: Basic Books.

75 Hoch, HL (1966) *Twins and Twin Relations*. Chicago: University of Chicago Press.

76 McNeil, TF & Kaij, L (1978) Obstetric factors in the development of schizophrenia: Complications in the births of pre-schizophrenics and in reproduction by schizophrenic parents. In Wynne, L, Cromwell, R & Mathysse, S (Eds) *The Nature of Schizophrenia*. New York: Wiley 401-402; Pollin, W & Stabenau, JR (1968)

higher levels of obstetric complications for psychiatric patients than for controls - which include normal brothers.⁷⁷ and adopted children.⁷⁸ As opposed to dizygotic (dz) twins, mz twins show lower birth-weight as well as other developmental differences, such as retarded intra-uterine development and elevated levels of perinatal and early mortality.⁷⁹

In twin studies there are several sources of error making comparisons between mz and dz twins impossibly problematic. For example, the genetic repertoire of each mz twin differs in the way in which the environment induces the activation of genes, as well as in the timing of the activation of those inductions during the critical periods of development. Hence mz and dz twins do not present us with perfect natural experiments.

The second Danish-American Study⁸⁰ tried to avoid the limitations already discussed. In this study, most of the sons of schizophrenic parents had been adopted before the psychotic episode of the parents - thus hopefully eliminating pre- and post-natal environmental factors which followed the onset of the parents' mental disorders. Yet the study produced the contradictory results discussed above.

Linkage between schizophrenia and a hypothetical genetic marker could favour a genetic theory. Various studies so far do not elucidate whether such markers are of discrete alleles predisposing to schizophrenia⁸¹ or pleotropic effects.⁸² There have also been studies of linkage between schizophrenic spectrum disorders and the genes responsible for the HLA antigens for histocompatibility.⁸³

Investigations of linkage and biological indicators of schizophrenia have led to speculations about the precipitating role of the altered enzymatic levels. However, these notions are immediately undermined by the fact that the enzymes are not exclusively controlled by the genes. It seems that enzyme levels in the brain and general organism are influenced by earlier social experiences.⁸⁴ A metabolic error (like that of phenylketonuria) is only demonstrable if phenylalanine is present in the diet. So the enzymatic defect in schizophrenia might not necessarily mean that such a defect or deviation is genetically determined or has a simple causal relation to schizophrenia. This suggests that even if the predisposition is genetically transmitted, the mental disorder might not be.

Most authors agree that there is no simple genetic transmission of schizophrenia,⁸⁵ but there is no agreement at all about the hypothetical model of genetic transmission of the condition. Several

Biological, psychological and historical differences in a series of mz twins discordant for schizophrenia. In Rosenthal, D & Kety, SS (Eds) *The Transmission of Schizophrenia*. Oxford: Pergamon.

77 McNeil, TF & Kaij, L, op. cit. (n. 76).

78 Jacobson, B & Kinney, DK (1980) Perinatal complications in adopted and non-adopted schizophrenics and their controls: Preliminary results. *Acta Psychiatrica Scandinavica* 62 337-347.

79 Campion, L & Tucker, G (1973) A note on twin studies, schizophrenia and neurological impairment. *Archives of General Psychiatry* 29 460-464.

80 Kety, SS et al., op. cit. (n. 62).

81 Asarnow, RE (1978) Residual performance deficit in clinically remitted schizophrenics: A marker for schizophrenia? *Journal of Abnormal Psychology* 87 597-608; Demisch, L et al (1977) Substrate-typic changes in platelet monoamine oxidase activity in subtypes of schizophrenia. *Archiv fur Psychiatrie und Nervenkrankheiten* 224 319; Holzman, PS et al (1980) Deviant eye tracking in twins discordant for psychosis. *Archives of General Psychiatry* 37 627; Turner, WG (1979) Genetic markers for schizophrenia. *Biological Psychiatry* 14 177; Wyatt, RJ et al (1975) Low platelet monoamine oxidase and vulnerability to schizophrenia. In Mendlewic, EJ (Ed) *Modern Problems of Psychopharmacology: Genetics and psychopharmacology*. Basle: Karger.

82 Kety, SS & Kinney, DK (1981) Biological risk factors in schizophrenia. In Regier, D & Allen, G (Eds) *Risk Factor Research in the Major Mental Disorders*. Washington DC: ADM; Kinney, DK, op. cit. (n. 59).

83 Turner, WG, op. cit. (n. 81).

84 Henry, JP et al (1971) Effect of psychosocial stimulation on the enzymes involved in the biosynthesis and metabolism of noradrenalin and adrenaline. *Psychosomatic Medicine* 33 227; Stone, EA et al (1976) Survival and development of maternally deprived rats: Role of body temperature. *Psychosomatic Medicine* 38 242.

85 Stone, EA et al, op. cit. (n. 84); Kidd, KK & Cavalli-Storza, LL (1973) An analysis of the genetics of schizophrenia. *Social Biology* 20 254-265; Matthyssi, SW & Kidd, KK (1976) Estimating the genetic contribution to schizophrenia. *American Journal of Psychiatry* 133:2 185; Shields, J et al (1975) Schizophrenia

models are proposed. (1) Monogenetic or monofactorial theories which propose either (a) a recessive gene, modified or not in its action on other genes, and with heterozygotes presenting as schizoid,⁸⁶ (b) a dominant gene, or (c) a gene of intermediate nature.⁸⁷ (2) A bi-factorial theory involving two loci.⁸⁸ (3) Polygenic or multifactorial:⁸⁹ these theories either (a) do not see schizophrenia as a disease but see the person as being susceptible for various reasons and hence incapable of adapting or being very sensitive to certain stresses, or (b) conceive of schizophrenia as a psychosomatic state.⁹⁰ Both (a) and (b) deny that schizophrenia can be explained in terms of Mendelian genetics, in which m/z twins would be 100% concordant. (4) Genetic heterogeneity: this conceives of schizophrenia as a heterogeneous collection of entities originating from different and independent genetic errors.⁹¹

In recent times people became overawed by the potentialities of genetic research. In 1988 there was the sensational announcement throughout the media (and including the supposedly more responsible press) of the triumphant discovery of 'The Schizophrenia Gene'. At last no-one need take the blame for schizophrenia, and the disease might even be genetically-engineered out of existence. The trumpeted findings were quickly reported in the scientific journal, *Nature*.⁹² At the same time, however, and also published in *Nature*, there were two other studies which disconfirmed that research.⁹³ There was no media coverage for the disconfirming reports. This left the public with the idea that schizophrenia is now a scientifically proven genetic imperfection - a curse carried by schizophrenics and passed down certain degenerate family lines. This is a notion that many people already wished to believe - rather than the idea that a person undergoing a certain kind of psychotic experience might have succumbed to relentless and extreme social and psychological pressures due to having to live through dire social circumstances.⁹⁴

Just prior to this sensational news event, and itself creating rather less but still considerable excitement, was another report about investigations into manic-depressive psychosis amongst the Amish, a particularly isolated and inbred population in the USA. Attempts were made to study a locus on chromosome 11,⁹⁵ and wild premature claims were made by some of the research team. But replication studies did not confirm their suggestions.⁹⁶

Towards the end of 1999 there were front-page news reports of the great advances being made with the human genome project, and the 'quality' press reported senior scientists involved in the project who stated, as a matter of no doubt, that the fast-approaching full mapping of the short gene Number 22 will definitely identify the genetic locus of many physical diseases, and 'including schizophrenia'. This kind of claim is now regularly heard from researchers promoting their own particular medical-genetic research projects.

A heretic might ask: What if one day 'the genetic cause' of schizophrenia really should be discovered? Transmission of the colour of hair, eyes and skin is also genetic. Should we already be

and the schizoid: The problem for genetic analysis. In Fieve, RR, Rosenthal, D & Brill, H (Eds) *Genetic Research in Psychiatry*. Baltimore: John Hopkins University Press; Slater, E & Cowie, VA (1971) *The Genetics of Mental Disorder*. Oxford: Oxford University Press.

86 Heston, L, op. cit. (n. 64); Kallmann, FJ, op. cit. (n. 60).

87 Kidd, KK & Cavalli-Storza, LL, op. cit. (n. 85).

88 Karlsson, JL (1966) *The Biological Basis of Schizophrenia*. Springfield: Thomas; Matthyssi, SW & Kidd, KK, op. cit. (n. 85).

89 Kidd, KK & Cavalli-Storza, LL, op. cit. (n. 85).

90 Weiner, H, op. cit. (n. 8).

91 Erlenmyer-Kimling, L & Miller, NE (Eds) (1986) *Life-Span Research on the Prediction of Psychopathology*. Hillsdale, NJ: Erlbaum; Weiner, H, op. cit. (n. 8).

92 Sherrington, R et al, op. cit. (n. 40, Ch 12).

93 Kennedy, JL et al, op. cit. (n. 40, Ch 12); Claire, DS et al, op. cit. (n. 40, Ch 12).

94 As we argue fully in Volume 2 of this book.

95 Engeland, JA et al (1987) Bipolar affective disorders linked to DNA markers on Chromosome 11. *Nature* 325 783-787.

96 Kelsoe, JR et al (1989) Re-evaluation of the linkage relationship between Chromosome 11p Loci and the gene for bi-polar affective disorders in the Old Order Amish. *Nature* 392 238-243.

talking about 'blue-eye disease' or 'brown-hair' disease - or 'black-skin disease'? Geneticist ideology is silly and pernicious. We agree with Francois Jacob, Nobel Laureate for Medicine and Physiology:

It makes no sense to bestow a fraction of the total organism upon hereditariness and the remainder on ambience. This is the same thing as asking if Romeo and Juliet's love has a genetic or a cultural origin.⁹⁷

A genetically sufficient explanation for schizophrenia is really most unlikely, and so there is something highly projective or political about all the wishes and efforts put into looking for a genetic cause as distinct from other possible factors. 'Genetics and schizophrenia' is a perennially appealing fantasy. The whole attempt to find a genetic cause for mental disorder is just an exercise in tautology: everything in biology of course depends upon laws of susceptibility. That kind of research is popular and exciting because it performs an important *ideological* function, not a scientific one. A false interpretation of heredity can lead those suffering from emotional and mental distress towards fatalism and despair. All the over-simplified notions about the mechanics of genetics, disease and psychiatric disorders immediately also give rise to simplistic ideas about diagnosis, prognosis and therapy. This has very serious consequences for the patients, their families and even - in terms of the cost of chronicity, if nothing else - for society as a whole.

Simplifying the difference between innate and acquired behaviour (genetic vs. environmental determination) gives rise to a number of errors. For example, in the literature the transmission of 'predispositions' or 'tendencies' to schizophrenia is termed 'vulnerabilities', i.e., deficiencies. There are a number of theories of vulnerability, such as the concept of 'schizophrenic fragility'.⁹⁸ Each theory carries implicit pejorative connotations of undesirability and moral stigma. It would be more appropriate to employ the term 'diathesis', which implies wider possibilities, including a favourable hereditary predisposition. 'Diathesis' intends a capacity - taking into view the history of the person, and his aptitude, the possibility of presenting specific behaviours in certain circumstances; it is the substrate of 'capacity', and depending on the degree of maturation or involution, it includes education - the individual's learning and experience.⁹⁹ 'Capacity' is also a word free of pejorative connotations; it does not imply an increased risk or vulnerability to schizophrenia but only a probability (i.e., a specific predisposition) to present certain symptoms which are used in the diagnosis of schizophrenia. The genetically transmitted trait might not be abnormal or directly pathogenic; it only represents a normal (Gaussian) variant. In this conception, and depending on the influences of the environment, the multi-potential traits may lead either to a good or a bad adaptation.

It is interesting that a study of the relationship between schizophrenia and creativity found that, as compared to the wider population, people recognised as 'creative' have more first-degree relatives diagnosed with schizophrenia, and also that diagnosed schizophrenics have more first-degree relatives recognised as creative.¹⁰⁰ Of course, members of families are bound to share cultural histories. However, most people hold many equivocal ideas about heredity: they confuse heritable and congenital diseases, they accept a simple genetic basis for resemblances between parent and child, and they believe uncritically in the heredity of acquired characteristics, including the full gamut of behaviours and personality traits which necessarily develop in social settings. The prevailing belief is that nothing much can be done about medical conditions with a hereditary predisposition. And yet the inherited diseases are not at all necessarily inevitable or incurable: some can be prevented and others respond well to treatment - which is to say to the modification of the environment, such as diet, exercise and education.

97 Jacob, F (1970) *La Logique Du Vivant*. Paris : Gallimard.

98 Zubin, J & Spring, B (1977) Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychiatry* 86 103-126.

99 Pieron, H (1968) *Vocabulaire De La Psychologie*. Paris: Presses Universitaires de France.

100 Karlsson, JL (1970) Genetic association of giftedness and creativity with schizophrenia. *Hereditas* 66 177.

It is profoundly mistaken to imagine that heredity equals chronic or incurable. It was on this dangerous and paralysing sophism that pre-Mendelian notions of 'degeneration'¹⁰¹ and 'stigma'¹⁰² developed in Germany in the late 19th century: this led to the separation of mental patients into 'the curable' and 'the incurable'. In turn, those ideas had a powerful impact on the development of the clinical entity '*Dementia praecox*'¹⁰³ - later conceived as 'schizophrenia' - and kinds of diagnosis and prognosis which are false and profoundly obstructive to any patient's recovery. The prognosis of schizophrenic chronicity still remains in textbooks used widely to train psychiatrists.¹⁰⁴ Together, the founding greats - Kraepelin, Bleuler (who early on refined the concept of schizophrenia) and Freud - established a form of 20th century psychiatry that held out little hope for the recovery of anyone diagnosed with schizophrenia. Eugen Bleuler started his career optimistically but ended up a pessimist. His son, Manfred Bleuler, further refined the concept of schizophrenia, and moved from pessimism to optimism. Since about 1980, every study that has followed diagnosed schizophrenics for more than twenty-five years has found that about 35% recover fully, and a further 35% function independently and are self-supporting but with possible residual symptoms.¹⁰⁵

The lay public - and unfortunately too many doctors - believe in a fatalistic prognosis for schizophrenia. This is contradicted by prolonged studies, by various statistical analyses and by patients making late recoveries. Actually, poor prognosis was criticised from the very beginnings of psychiatry; it has more recently been contested again, and termed 'destructive prognosis'.¹⁰⁶ A bad prognosis is anti-therapeutic and condemns the patient by a self-fulfilling prophecy.¹⁰⁷ It would be more accurate to attribute chronicity to certain social expectations - those of the family, doctors, psychiatrists and psychiatric workers - and to certain institutional arrangements of social and psychiatric life.¹⁰⁸ Any tendency to consider the person as a product of a genetic determinism risks denying the fact of his genetically endowed *plasticity*, which is the basis of humanity's great experiential and intellectual richness, diversity and adaptability.

Following all the trails to a conclusion, it can be seen that the figures for concordance rates for schizophrenia are not very different from rates for neurotic patients. In the case of anxiety neurosis, a concordance rate of 65% for mz and 13% for dz twins has been found.¹⁰⁹ A study of a consecutive series of twin probands with obsessional neurosis found six of the 12 mz twins had had psychiatric treatment: three had definite obsessional features, and a further two had possible features; only one of the twelve dz co-twins in the study was obsessional.¹¹⁰ Another study describes two pairs of mz twins concordant for obsessional neurosis. In each pair, the proband and co-twin developed their

101 As employed in the works of Morel and Magnan. See Morel, BA (1857) *Traite Des Degenerescences de l'Espece Humaine*. Paris: JB Bailliere; Magnan, V & Legrain, P (1895) *Les dégénérés état mental et syndromes épisodiques*. *Bibliothèque médicale Charcot-Debove* 83.

102 As used by Morel. See Morel, BA, op. cit. (n. 101).

103 Kraepelin, E (1904) *Psychiatrie*. Leipzig: JA Barth.

104 E.g., Mayer-Gross, W, Slater, E & Roth, M (1974) *Clinical Psychiatry*. London: Balliere, Tindall & Cassell. This textbook was popular in the 1970s and 1980s for training psychiatrists who today hold the most senior positions. A popular current textbook which presumes a genetic basis to the emergence of schizophrenia is *The Shorter Oxford Textbook of Psychiatry* (5th and 6th editions), Gelder, M, Harrison, P & Cowen, P, op. cit. (n. 9, Ch 3), and Cowen, P, Harrison, P & Burns, T, op. cit. (n. 19, Ch 1). The groundless assertions of these joint-authors are scrutinised in Chapter 3, above, in the sections: The confusion of the psychiatric medical model, and The psychiatric medical model is unproven, unhelpful and harmful.

105 Karon, BP (1995) Introduction. In Modrow, J, op. cit. (n. 35, Ch 2), xi.

106 Baruk, H (1990) The battle of schizophrenia. *Bulletin de l'Académie Nationale de Médecine* 174:2 191-196.

107 Menninger, W & Hannah, GT (Eds) (1987) *The Chronic Mental Patient*. New York: American Psychiatric Press; and Ellenberger, HF (1970) *The Discovery of the Unconscious: The history and evolution of dynamic psychiatry*. Harmondsworth: Allen Lane.

108 As argued by Szasz, TS, op. cit. (n. 46).

109 Slater, E & Cowie, V, op. cit. (n. 85); Gottesman, II & Shields, J (1972) *Schizophrenia and Genetics: A twins study vantage point*. New York: Academic Press.

110 Carey, G (1978) Clinical genetic study of obsessional and phobic states. PhD thesis. Minneapolis: University of Minnesota.

symptoms independently and without prior knowledge of the other's disorder, and yet there was a marked similarity of symptoms within each pair.¹¹¹ However, the objections about similarities arising from environmental influences apply to this study as much as to any others.

It is true that the known number of mz twins reared apart and concordant for schizophrenia is generally bigger than the known number of mz twins living apart and discordant for this mental disorder.¹¹² This only constitutes a very small number of cases, though, and no definite conclusions can be drawn from them. It should be remembered that twin pairs are often reported - or chosen for research and publication - precisely because *they are* concordant for schizophrenia: discordant pairs appear more typical for systematically collected series. We have already discussed the social influences and expectations surrounding the lives of children known to have been born of schizophrenic parents. Detailed examination of case histories shows that most twin pairs, although reared apart, were in fact subjected to very similar social, economic and cultural conditions: many of them grew up in fairly deprived conditions, in orphanages, or raised by relatives in poor social conditions.

For all these reasons, it appears that the first studies of mz twins were rather uncritical when they suggested that their findings proved the decisive significance of heredity in the aetiology of schizophrenia. A significant aetiological role should only be ascribed to genetic factors in cases where mz pairs had been separated very early in life and raised in quite different but emotionally secure family conditions. Also, concordance between siblings of schizophrenic parents should be significantly higher than that between siblings of normal parents when they have been adopted at an early age and raised in emotionally stable environments. To avoid obstetric questions, studies would need to show positive results when following siblings only from schizophrenic and normal *fathers*. Further, results would have to be similar for siblings from mothers and fathers diagnosed with schizophrenia. There should be significant differences between experimental and control groups in three categories: the siblings from the fathers, from father and mother, and between the parents of the control and experimental groups. So far as we know, no study fulfils these requirements.

It is true that most of the research reviewed in this Appendix, and originally cited in Professor Jenner's book, is from the years before 1993. However, as we mentioned in Chapter 12, above, by 2017 there was still no evidence of a genetic predisposition for people to be diagnosed with schizophrenia,¹¹³ and the most recent systematic review of the research stated that

[t]he most comprehensive genetic association of genes previously reported to contribute to the susceptibility to schizophrenia [found that] none of the polymorphisms were associated with schizophrenia at a reasonable threshold for statistical significance... The distribution of test statistics suggests nothing outside what would be expected by chance.¹¹⁴

The best-designed studies about schizophrenia and heredity are simply inconclusive. Nothing is proved. Similar findings are achieved from studies of mental disorders for which there is no particular hypothesis of a genetic cause, such as anxiety or obsessional neurosis. Nobody has yet effectively gauged the subtleties or even the gross features of environmental influences - which are nevertheless accepted as causative for neurotic patients - and it is difficult to see how it could ever be done convincingly.

In spite of so many earnest studies in the intervening decades, the conclusions of a survey of bio-psychiatric research findings, fifty years ago, have yet to be gainsaid:

There are...no schizophrenic or for that matter neurotic genes... I do not think that the environmental factors operate as a release mechanism for schizophrenia; more likely schizophrenic development has to be looked upon as the result of a combination of endogenous and exogenous factors, a developmental interaction... The study of

111 McGuffin, P & Mawson, D (1980) Obsessional-compulsive neurosis: Two identical twin pairs. *British Journal of Psychiatry* 137 285-287.

112 Kringlen, E (1967) *Heredity and Environment in the Functional Psychoses*. London: Heinemann.

113 Mukherjee, S, op. cit. (n. 42, Ch 12).

114 Hamilton, SP, op. cit. (n. 41, Ch 12).

schizophrenia must be linked to the study of normal personality development. The solution of the so-called schizophrenia riddle will, generally speaking, not come from any simple bio-chemical breakthrough since there are no simple biochemical answers to variations in intelligence, height, weight, blood pressure, epileptic disposition. Part of the solution may well be found in the near future, possibly through meticulous research in the field of social science. Here, then, lie our hopes - which are not great - for social prevention..¹¹⁵

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115 Kringlen, E, op. cit. (n. 112).

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