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Contents

Introduction

'The times they are a changin'

We live through exciting times. Across the world, new ways of thinking about mental health are opening up, ways which few would have thought possible even 10 years ago. Everywhere, groups of service users[1] are coming together to challenge prejudices in the system and to raise demands for more thoughtful forms of support. This user movement is here to stay. Its voice is loud and will not be silenced.

In the preface to his book *Madness and Civilization*, the French philosopher Michel Foucault famously wrote that, since the time of the European Enlightenment, 'the language of psychiatry (has been) a monologue of reason *about* madness' (Foucault 1971, xii–xiii). However, at the dawn of the 21st century, there are signs that real *dialogues* are beginning to take place between those who experience episodes of madness and dislocation and the society in which they live. 'Voluntary sector' or 'non-governmental organizations (NGOs)' which represent the views of service users and/or carers are playing an increasingly important role in both the economically advantaged (EA) and economically disadvantaged (ED) countries. Although these organizations all work to different agendas, they are beginning to provide interventions that are very different in form and orientation from those in the hospitals and clinics of more traditional statutory services.

The winds of change are also beginning to blow through the professional sector. Many mental health nurses, psychologists, occupational therapists, managers and social workers, who have long argued for user involvement in the planning and development of services, are now being joined by a growing number of psychiatrists who are waking up to the positive benefits of working in collaboration with users and carers, and are joining the call for change. Many professionals have been genuinely appalled by the stories of service users and their suffering within 'the system', and want to make services more accountable.

Before we are accused of hopeless optimism, let us quickly say that we are acutely aware that there are other forces working to steer the mental health agenda in a very different direction. The power and wealth of the pharmaceutical

[1]We use the terms 'service user' 'user' 'client' 'patient' and 'survivor' interchangeably throughout the text. We are aware that there is an on-going debate about the significance of different forms of terminology.

industry has pushed a great deal of academic psychiatry down a very narrow path. Independent scientific research on the biology of distress is increasingly hard to come by, as medical schools and universities across the world dance to the tune of corporate sponsors. In some countries, sections of the media seem very keen to portray users of mental health services as a 'threat to society', and unfortunately some politicians have been happy to jump on board this particular bandwagon. Some governments are intent on legislating for more coercion. Professionals often feel overburdened with bureaucratic paperwork and are intimidated by a 'blame culture' which is very prevalent in many sections of the public service. Adequate funding for the sorts of interventions that allow people with mental health problems to participate fully in society is hard to come by.

Nevertheless, we are convinced that change is happening and new possibilities are beginning to arise. We hope that our book will contribute to this process. Although we are psychiatrists and our focus is on the fundamental assumptions of our own discipline, our intention is to make what we write of interest to users, carers, managers, other professionals, indeed to anyone who feels that the ways in which we look after one another in times of distress is something that concerns us all.

We do not propose a new 'model' for mental health work; there are plenty of these around already. In fact, we find that our professional models, agendas and frameworks are sometimes part of the problem. We want to expose the ways in which the formulations and interventions of psychiatry can serve to silence any other debate. In the past 10 years, we have had the privilege of working closely with service user organizations mainly in England, Wales and Ireland, but also internationally. We have developed a profound respect for the sort of agendas emerging within this movement. We believe that this is where the future lies. If postpsychiatry means anything, it means an end to the 'monologue of reason about madness'.

In the rest of this introductory chapter, we will first introduce the basic thrust of our analysis and then give a brief chapter by chapter account of the book's contents. We expect that few people will read the book from cover to cover. Indeed, we intend it more as a book that people might come back to from time to time. Likewise, we expect that different readers will find some chapters of more interest and use than others. We expect that few will agree with everything we write! At the same time, we are hopeful that our arguments will stimulate discussion, debate and change.

An emerging contradiction between clinical and academic psychiatry

We first used the term 'postpsychiatry' as the header for a series of articles written for the UK mental health magazine *Open Mind* at the end of the 1990s. We do not claim to have originated the word. Peter Campbell first used it in a

chapter in the anthology *Speaking Our Minds*, published in 1996[2]. While we had learned a great deal from the various forms of antipsychiatry and critical psychiatry that emerged between the 1960s and 1980s, we wanted to show how our approach differed from these. We described it as something positive: an attempt to imagine a form of medical encounter with states of distress, alienation and madness, which did not operate with the central assumptions that had guided psychiatry through the 20th century[3].

In these articles, we questioned traditional psychiatric ideas about the nature of knowledge and expertise, and such things as diagnosis, treatment and the social position of psychiatrists. Our critique had the explicit aim of opening up spaces in which other voices could be heard. We repeatedly made the point that service users (individually and in partnerships) had the answers themselves. They were developing new ways of understanding states of madness and distress and had clear ideas about how professionals could help or hinder. Our primary task was to listen to and support this emerging discourse. Feedback on the articles we wrote was generally positive and a number of people asked us to elaborate on the idea of 'postpsychiatry'. We did so in a paper published by the *British Medical Journal* in 2001. This paper generated a good deal of controversy, and from it the idea for this book came into being.

Since 2001, we have been asked to address psychiatrists throughout the UK and have had positive contacts from many others in North America, Europe, Australia and New Zealand and a number of ED countries. While our ideas are still controversial and by no means mainstream, a growing number of our colleagues are telling us that the things we are saying resonate with their own experiences. As we write, a session on the theme of postpsychiatry is scheduled for the next AGM of the Royal College of Psychiatrists, to be held in Edinburgh in June, 2005, in a day devoted to critical psychiatry.

Interestingly, we have found that psychiatrists who work mainly in clinical settings are more interested in (and open to) the challenges we present. In general, academic colleagues[4] appear less prepared to doubt and to question their assumptions. In the UK and other countries, an increasing number of clinical psychiatrists work in multi-disciplinary teams and are actively involved in planning and developing services. Increasingly, they are working outside hospitals, and in their day-to-day work they meet with user groups and other non-medical organizations. Through such encounters, they have become sensitized to the

[2]Campbell (1996).

[3]In this sense, postpsychiatry means 'after psychiatry'. However, we also wanted to connect our work with the insights of a number of postmodern thinkers such as Michel Foucault and others. These connections will emerge in the text.

[4]There are notable exceptions here. We are aware of the important stand taken up by Alec Jenner who, for many years as professor of psychiatry in Sheffield, maintained and fostered an interest in philosophy. His pioneering work resulted in the birth of the radical mental health magazine *Asylum* (http://www.asylumonline.net/index.htm) which involved many local service users in writing for and producing the magazine. Today, our colleagues Joanna Moncrieff, Mike Crawford and Jonathan Bindman are now senior academics working in London.

ways in which many users of mental health services have experienced psychiatry as oppressive. Until recently, contact between doctors and patients only happened in clinical settings, and the power differential in these meant that the patient's views were often silenced.

The changes in the way that psychiatrists encounter service users in their daily work has led to more and more psychiatrists wanting to examine the assumptions behind their work. This is reflected in the fact that the Special Interest Group in Philosophy and Psychiatry is one of the largest of such groups in the UK Royal College. Other large Special Interest Groups are dedicated to spirituality, religion, history and transcultural issues. These groups are made up of ordinary working psychiatrists who are questioning the outlook of psychiatry in an open and exciting manner.

At the same time, increasing numbers of psychiatrists are participating in the Critical Psychiatry Network (CPN)[5]. This is a loose grouping of psychiatrists in the UK who are attempting to prevent any extension of the coercive side of psychiatric practice while also struggling to expose and limit corporate (largely pharmaceutical) influence on the discipline. At the time of writing, there is much interest in developing similar networks in other countries, such as the USA. Although we are aware that there are still many psychiatrists who prefer to hold on to traditional ways of practising and are not prepared to question these, we are also increasingly aware of those who want to work closely with service users to develop different sorts of services, with different goals and priorities, and as a result are interested in examining the role and values of psychiatry in a non-defensive manner.

However, whilst these developments have been taking place, as reflected in developments in the UK Royal College and elsewhere, much of *academic* psychiatry has been moving in a very different direction. In parallel with other branches of medicine, psychiatry has been a major growth area for the pharmaceutical industry[6]. Many medical academics have close links with the industry and there is evidence that many prominent research agendas have been developed on the back of these links. With a few notable exceptions, most university-based psychiatrists are involved in some form of biological research (particularly genetic or biochemical), as reflected in the types of articles that are published in the British and American Journals of Psychiatry. Some academics are even showing frustration with the increasingly divergent

[5]http://www.critpsynet.freeuk.com/. The Critical Psychiatry Network first met in Bradford in January 1999, when a group of consultant psychiatrists met to express their opposition to government plans to extend compulsory treatment into the community. The group is also opposed to attempts to widen the definition of mental disorder. It is also campaigning against the growing influence of the pharmaceutical industry on the psychiatric profession. As well as its campaigning functions, the group is also an important source of mutual support for colleagues who dare to think differently in these days of uniformity. Increasingly, the group offers informal advice to young doctors contemplating a career in psychiatry, but who are concerned about the contradictions involved.

[6]Moncrieff (2003); see also more extensive discussion in Chapter 6.

concerns of many of their clinical colleagues. In the UK, this frustration is often directed at colleagues in the Royal College of Psychiatrists. In a recent interview, one prominent academic, a professor of clinical neuropharmacology, was asked: 'what is the greatest threat (facing psychiatry)'. He replied: 'The Royal College of Psychiatrists and all the spawning self-serving bureaucracies in medicine that give medical men respectability when their enthusiasm for research or patient contact dries up' (Kerwin 2004: 313).

Such a strident dismissal of the College, its debates, concerns and priorities, by such a prominent academic is striking. We believe that it reflects an emerging gap between the interests and priorities of clinical and academic psychiatrists. While we do not wish to exaggerate this division, we believe that unless there is a major shift in the thinking of academics, the division will grow over the course of the next decade. At the heart of it are, we believe, two fundamentally different views about the identity of doctors who work in the realm of madness and distress, and about how medicine should be related to this realm.

This book is centrally concerned with these differences. Put simply, we believe that until now, most psychiatrists wanted to hold on to an identity centred on the idea that they were delivering science-based technologies to patients suffering from certain identified illnesses. This continues to be the governing ideology of many academics: that the authority of psychiatry is based on its identification with science and technology. As such, psychiatry is very much a modernist venture. Its *primary* discourse is scientific, mainly around biology and positivistic[7] versions of psychology. Issues such as meanings, values and assumptions are not dismissed but they are relatively unimportant, *secondary* concerns.

However, the search by a growing number of clinical psychiatrists for a new identity reflects a new framing of the relationship between knowledge, power and expertise. We identify this as a move beyond modernist psychiatry, hence the idea of *postpsychiatry*. It is an explicit attempt to redefine a discourse about meanings, relationships and values as *primary*. It is not anti-science. Enterprises such as psychopharmacology and cognitive psychology are still important but will get their direction from this discourse. Whatever this is called, at its heart is an attempt to reach beyond the traditional modernist understanding of our role as doctors.

However, modernism, and with it a belief that science and technology are the main way forward, is not the sole preserve of psychiatrists. Many other professionals and service managers are also keen to assert that the way forward will involve technologies such as pharmacology, genetics, cognitive interventions, service frameworks, and so on. Some service user organizations are

[7]Positivism is associated with the work of Auguste Comte, who in the mid-19th century proposed that human thought evolved through a series of stages, the religious, metaphysical and scientific. Positivism stressed the unity of natural and human sciences, with the implication that human experience and human problems are best approached through the formal methods of scientific inquiry.

happy to define their problems in medical terms and look to medical science for solutions.

Postpsychiatry has implications way beyond the profession of psychiatry. In the next section, we attempt to spell out these issues a little further. We will then provide an overview of the content of the various chapters.

Psychiatry as a modernist enterprise

Our argument rests on the idea that 'psychiatry' was a creation of the European Enlightenment and the sort of modernist culture and ideas which ensued from this. Two central themes preoccupied the thinkers of the Enlightenment.

First was the idea that the path to discovering *truth* was by way of human *reason* rather than by religious revelation or the veneration of ancient civilizations. This was a U-turn from the ways of thinking of the medieval and renaissance periods. Enlightenment thinkers believed that by the use of reason we would overcome our superstitions and begin to 'assert our natural superiority' over the rest of nature. Rationality was valued in itself. Proponents of this idea maintained that all the problems of our lives on this planet would ultimately yield to scientific investigation and to the application of one sort of technology or another.

Secondly, there was a concern to explore different aspects of what it was to be a person. The idea of human rights and the primacy of the *individual* came into being. As a result of this, the exploration of motives and individual personalities became a central concern in art and literature.

In a similar way, the impetus for a 'mental science', and hence psychiatry, grew out of this. Most historians of psychiatry (even those who defend the discipline against the critique of Foucault, Scull and others) would agree that, unlike the history of Western medicine which dates back to Hippocrates and the ancient Greeks, the history of psychiatry would not, and could not have come into being had it not been for the Enlightenment.

Our challenge to modernist psychiatry is reflected in a wider intellectual questioning of the ideas engendered by the Enlightenment, which has gathered strength over the past 30 years. The notion that human reason could lead us to the truth led to discourses as diverse as Marxism, liberalism and psychoanalysis. Each of these grand narratives claimed to be a path to truth, each claimed to have some foundational and universal insights into the 'human condition'. However, many philosophers are now questioning the possibility of such foundational truths. This is broadly what postmodernist thought has been about[8]. The term postmodernism has been used in different ways, but we use it in this book to refer to a coming to terms with the downside of the modernist

[8]See Bracken (2003), Lewis (2000), and Laugharne (2004) for overviews of postmodernism and psychiatry.

Enlightenment dream: a world ordered according to the dictates of reason; a world shaped by science, technology and the primacy of efficiency. As Barry Smart writes, postmodernity involves:

> . . . a form of reflection upon and a response to the accumulating signs of the limits and limitations of modernity. Postmodernity as a way of living with the doubts, uncertainties and anxieties which seem increasingly to be a corollary of modernity, the inescapable price to be paid for the gains, the benefits and the pleasures, associated with modernity. (Smart 1993: 12)

To us, postmodern thinking does not involve a *rejection* of Enlightenment values and ideals, but instead reflects a concern to understand their limitations. When it comes to developing a critique of our social realities, postmodernism does not reject the insights of discourses such as Marxism, liberalism or psychoanalysis. It simply rejects their claims to be foundational and *universally valid*. It does not dismiss their insights into the contradictions of our personal and cultural worlds, but posits their truths as partial, contingent and local.

In Fig. 1, we have linked the Enlightenment to psychiatry by three sets of arrows. These represent three basic orientations that lie at the heart of psychiatry. They provide the framework for our analysis of psychiatry's identity and provide the basis of the postpsychiatry way forward.

Psychiatry developed as a separate area of medical practice in the 19th century. It emerged with these assumptions in place. We believe that while challenges were presented to these assumptions during the course of the last century, they

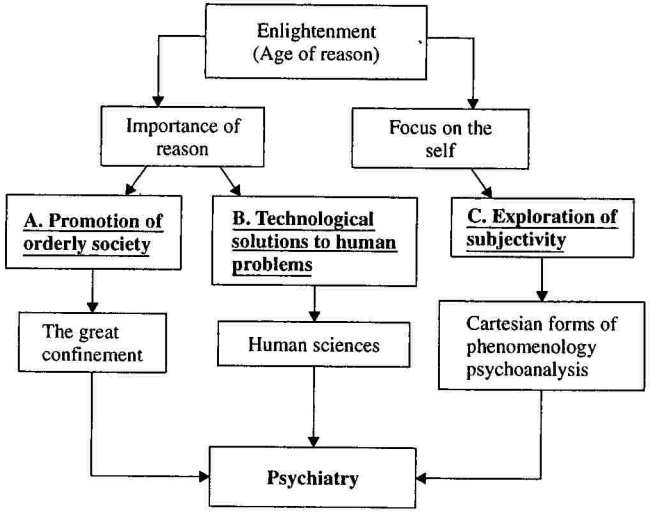

Fig. 1 Psychiatry and the Enlightenment.

continued to guide the basic orientation of the discipline throughout this period.

Madness and distress need to be excluded and controlled: the growth of professional expertise and authority

With its focus on reason and order, the Enlightenment spawned an era in which society sought to rid itself of 'unreasonable' elements. As the historian Roy Porter writes:

> ... the enterprise of the age of reason, gaining authority from the mid-seventeenth century onwards, was to criticise, condemn and crush whatever its protagonists considered to be foolish or unreasonable .... And all that was so labelled could be deemed inimical to society or the state—indeed could be regarded as a menace to the proper workings of an orderly, efficient, progressive, rational society. (Porter 1987: 14–15)

Hence 'unreasonable people', such as the insane, were incarcerated in institutions. Historians have pointed out that the emergence of such institutions was not in itself a 'progressive' or medical, venture; it was simply an act of social exclusion. According to Foucault, doctors became involved with them initially in order to treat physical illness and offer moral guidance, not as experts in disorders of the mind. Scull has shown how the involvement of the medical profession changed, after doctors fought a successful battle for control of the insane against lawyers and the lay sector, and began systematically to order and classify the inmates (Scull 1979). Roy Porter writes:

> ... the rise of psychological medicine was more the consequence than the cause of the rise of the insane asylum. Psychiatry could flourish once, but not before, large numbers of inmates were crowded into asylums. (Porter 1987: 17)

In the 20th century, psychiatry's promise to control madness through medical science went hand in glove with the increasing social acceptance of the role of technical expertise. In most countries, substantial power was invested in the profession, and psychiatrists were given the right and the responsibility to detain patients and to force them to take powerful drugs, and other treatments such as electro-convulsive therapy (ECT). The discourse of psychopathology became the accepted framework in which coercive medicine was practised. In spite of the enormity of this power and responsibility, until recently there has been little discussion about the coercive aspects of psychiatric practice within the profession. Psychiatrists have generally been keen to downplay the differences between their work and that of their medical colleagues. There are echoes of this in contemporary writings about stigma, in which professionals seek to educate the public about the equivalence of psychiatric and medical illness. However, patients (and the public) are well aware that a diagnosis such as diabetes does not lead to compulsory detention in hospital, whereas the label schizophrenia is a major risk factor for this.

Mental and emotional problems are best framed through a technical idiom

The Enlightenment focus on reason also gave birth to various human sciences such as psychology, sociology and anthropology. These set out to discover the universal laws underlying human behaviour and to develop causal accounts of how these laws operated. Psychiatry attempted to do something similar with regard to madness and distress. One important promise of the Enlightenment was that human pain and suffering would be overcome by the advance of rationality and science. To this end, psychiatry has attempted to replace spiritual, moral, political and folk understandings of madness with the framework of psychopathology and neuroscience. The culmination of this was the recent 'decade of the brain' when it was firmly asserted that the causes of madness are to be found in neurotransmitter abnormalities. These abnormalities are then targeted with drugs of different sorts. Other interventions, such as cognitive therapy, are only accepted as long as they work within the same technical idiom.

Perhaps the best example of this technical framing of our mental and emotional problems is the ever-expanding Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. Over 300 different mental illnesses are now described by the DSM, the majority 'identified' in the past 20 years. In a recent critical account of this expansion, Kutchins and Kirk wrote that:

> DSM is a guidebook that tells us how we should think about manifestations of sadness and anxiety, sexual activities, alcohol and substance abuse, and many other behaviours. Consequently, the categories created for DSM reorient our thinking about important social matters and affect our social institutions. (Kutchins & Kirk 1999: 11)

Madness and distress are located 'inside': methodological individualism

The Enlightenment concern with the individual and the quest to explore the nature of subjectivity (the 'internal world' of human beings) ultimately led to movements such as phenomenology and psychoanalysis.

Phenomenology is a subject that we shall meet at various points in this book. We shall not explore its various philosophical and psychological meanings here but will do so at some length in Chapter 4. At this stage, we simply want to make the point that in the hands of the German philosopher and psychiatrist, Karl Jaspers, phenomenology became primarily concerned with the identification of psychiatric symptoms in the individual patient. Jaspers provided detailed

definitions of individual symptoms and a way of classifying them, which has lasted to this day. Importantly, he sought to distinguish the *form* of a mental symptom from its *content*. For Jaspers, the *forms* of psychopathology were universal and arose because of phenomena happening inside the individual. The *content* of psychiatric symptoms was influenced by the social and cultural context, but this was very much of secondary importance. For example, if a person hears voices speaking about them in the third person such as 'look at what she's doing now', this is described by the Jaspersian psychopathologist as a *third person auditory hallucination*. This is the *form* of the symptom. According to this view, the fact that a person in one part of the world hears an ancestral spirit talking about them, while in another part it is an alien voice from another planet, depends on the person's culture. This is the *content* of the symptom; it relates to the context of the person's life and is of secondary importance.

Jaspers' influence on European psychiatry was profound. The prominent British psychiatrist, Aubrey Lewis described his *General Psychopathology* as 'one of the most important and influential books there are in psychiatry' (quoted by Beaumont 1992: 544). Psychiatry continues to separate mental phenomena from background contextual factors. Distress, dislocation, feelings of persecution and other experiences are understood at the level of the individual, and social and cultural issues are external 'factors' which may or may not be taken into account[9]. Although some changes are happening, most psychiatric encounters with patients still occur in hospitals and clinics, and the therapeutic focus is on the individual, with drug treatments or psychotherapy. Biological, behavioural, cognitive and psychodynamic approaches all share this conceptual and therapeutic focus on the individual self. Even social psychiatry has been dominated by an epidemiological approach, which sees its job as the identification of disordered individuals in populations.

Psychoanalysis is probably the best example of a discourse concerned with the 'exploration of subjectivity'. In our diagram representing the Enlightenment (Fig. 1) above, we show the focus on the individual as a 'search for individual truth'. Freud himself hoped that psychoanalysis might one day merge with biology and was committed to positivism. During the course of the 20th century, various schools of humanistic and interpretive psychotherapy emerged which rejected the idea that human reality could be grasped in a technical idiom. In books such as *The Divided Self*, R.D. Laing (1965) provided a brilliant critique of positivism in psychiatry. As an alternative, he essentially developed an approach centred on a modified form of psychoanalysis. While recognizing the importance of family dynamics, the focus was still very much on 'the self' and interventions that involved psychotherapy. Similarly, David Ingleby provided a powerful analysis of positivism and reductionism (see below) in the introduction to his book *Critical Psychiatry*[10] published in 1981. However, he also turned to Freud and psychoanalysis in an effort to develop an alternative. The American

[9]See Samson (1995) for a discussion of this.
[10]See Ingleby (1981).

Joel Kovel advocated a similar approach (Kovel 1988). While we are sympathetic to the analyses of Laing, Ingleby and Kovel, we regard psychoanalysis as a flower of the Enlightenment, saturated with assumptions about the inner depths of subjective experience, and falling prey to the problems of methodological individualism that downplay the importance of contexts in shaping and giving meaning to experience. We see it as a part of the problem, not the solution[11].

Postmodernity, postpsychiatry, and a new direction for mental health

At the dawn of the 21st century we believe that there is a need to interrogate these three assumptions. As we have already stated, postmodern thought does not involve a *rejection* of reason, science or technology but instead challenges the idea that these should be social goals *in themselves*. Moreover, postmodern thinkers argue that science and technology are not neutral and disinterested activities but instead are deeply imbued with values and assumptions[12]. The postmodern approach is to *begin with* a democratic debate about the goals, the methods and the applications of science. For example, in the field of agriculture and food production, the organic movement rejects the idea that 'efficiency' should be a goal in itself. It seeks a different form of food science, one that is built on a different way of understanding the relationship between human beings and the natural world. Postmodern thinkers also question the idea that the individual self is some sort of universal 'given'. Instead, they note the many different ways in which selfhood is constructed and experienced transculturally and across different historical periods.

For us, postpsychiatry is about a realization that the three guiding assumptions of modernist psychiatry are only that: assumptions. They are the products of a particular cultural change, and as we move beyond the embrace of that culture we need to interrogate those assumptions and seek new ways of understanding and relating to experiences of madness and distress. The following are some of the questions that we believe emerge from this analysis:

- If psychiatry is the product of the institution, should we not question its ability to guide the sort of care that we want to deliver in the post-institutional era?
- Can we imagine a relationship between medicine and madness which is different from that forged in the asylums and hospitals of a previous age?

[11]David Ingleby's analysis is in part inspired by Foucault's early work, but it is limited by virtue of the fact that *Critical Psychiatry* was published before Foucault's later writings about power and subjectivity really began to have an impact on critical thinking in mental health. This influence is apparent in the first two chapters of Nikolas Rose and Paul Miller's book, *The Power of Psychiatry*, which in many respects provide a starting point for our analysis. For an account of these two books and the development of critical psychiatry, see Thomas and Bracken (2004).
[12]Jerry Ravetz has used the term 'postnormal science' to indicate emerging scientific discourses that are grappling with these issues. The idea of 'normal' science comes from the work of Thomas Kuhn (1962).

- Can we begin to imagine different forms of mental health care which do not rely on psychiatry at all?
- If psychiatry is the product of a culture which was preoccupied with rationality and the individual self, what sort of mental health care is appropriate in the postmodern, multi-cultural world in which many of these preoccupations are losing their dominance?
- The Enlightenment understanding of rationality was dominated by a very (White) male perspective. Should we not attempt to develop a discourse about distress that incorporates insights from more than 30 years of feminist and postcolonial thinking and writing in this realm?
- Is Western psychiatry appropriate to cultural groups which do not share Enlightenment preoccupations, but instead value a spiritual ordering of the world and an ethical emphasis on the importance of family and community?
- How can we separate mental health care from the agenda of social exclusion, coercion and control to which it became bound in the last two centuries?

We believe that if we do not face up to these questions, we will replicate the failures of the last century as we move forward. For these reasons, we propose that mental health care should seek to unshackle itself from the three basic assumptions of modernist psychiatry in something like the following ways.

Rethinking the politics of mental health

Contrary to the path followed in the 20th century where the medical profession took a lead role when it came to controlling madness, we believe that the time has come for doctors to move in the opposite direction. This is not to say that *society* should never remove a person's liberty on account of mental disorder, but that the medical profession should not be making the key decisions. In place of medical authority, we envisage increased lay involvement (voluntary sector organizations and self-help groups), and the use of advance statements[13] (i.e. service users giving directions as to how they wish to be treated when they become unwell) and advocacy. The medical profession would have powers and responsibilities commensurate with its knowledge and would be able to provide advice if necessary. However, we believe that if genuine trust is ever to be established between the medical profession and those who suffer episodes of madness, there needs to be a substantial weakening of the link between treatment and coercion[14].

[13]Thomas Szasz (1982) was one of the earliest advocates of the advance directive (advance statement or 'living will') in psychiatric care.

[14]There are signs that a growing number of psychiatrists are unhappy with the prominent role given to them in involuntary interventions. As we write, under the leadership of Dr Mike Shooter, the Royal College of Psychiatrists has joined with other mental health organizations to oppose any extension of coercive treatments in the new Mental Health Bill in Britain.

However, psychiatric power is about something much wider than simply coercion; in fact, the psychiatric interventions that most patients experience are on a voluntary basis. To understand the power of psychiatry is to understand how something like the provision of a psychiatric diagnosis can in itself be experienced as destructive and controlling by service users. In addition, postpsychiatry is keen to point out that psychiatric knowledge shapes the way we understand ourselves, and the relationship between this understanding and the interests of the global pharmaceutical industry.

Ethics before technology

The major current concern of medicine is with 'clinical effectiveness' and 'evidence-based practice': the idea that science should guide clinical practice. It proposes that substantial progress would be made if clinical practice was guided by the research literature about the effectiveness of treatments and procedures. Psychiatry has embraced this agenda, and many in the profession believe that the 'evidence-based practice' framework holds the answer to many of the discipline's current problems. The difficulty with this is that the clinical effectiveness framework tends to ignore the role of values in research and practice. However, our argument is that because psychiatry is premised on certain assumptions about the nature of the self and the world (as is Western biomedicine generally), values are *built into* its diagnostic categories. This emerges in the historical work of Foucault (discussed above) as well as that of medical anthropologists (e.g. Gaines 1992), philosophers (e.g. Fulford 1994) and, more recently, psychiatrists themselves (e.g. Sadler 2005).

We believe that it is possible to practise good medicine in the area of mental health without a primary focus on questions such as, 'What is the diagnosis?' We have both worked with teams[15] for whom the primary questions were, 'What does this person, and this family, need at this stage?', 'How can we help this person cope with this crisis without a loss of dignity?' and 'How can we help this person avoid coercive interventions?' In addition, while these teams were acutely aware of the pain and suffering involved in states of madness, they also attempted to avoid the assumption that everything to do with madness was negative or meaningless.

Recognizing the importance of social and cultural contexts: methodological holism

In contrast to the dominant tendency in psychiatry to relegate issues of context (in terms of social, political, cultural and temporal locations) to secondary

[15]For example: the work of the Bradford home treatment team (Bracken and Cohen 1999) and the work of Ian Murray and colleagues in Dryll y Car, a crisis house set up in North Wales in 1992 (Williams *et al.* 1999).

status, we propose that they should be central to our understanding of distress and madness. A context-centred approach seeks to understand experiences of sadness, paranoia, self-harm, suicidal thoughts and all the other phenomena we lump together as 'psychiatric' not only in terms of what is happening in the individual at one moment in time but in terms of other dimensions of the person's reality. For example, one of us (P.B.) has argued that we can only understand how any particular individual will respond to traumatic events in their life if we understand the way of life of that person. Furthermore, helping someone recover from trauma is often more about helping to re-establish that way of life rather than any particular intervention on an individual level (Bracken 2002).

Two diagrams. Beyond reductionism and towards a medical practice based on hermeneutics

In the past 20 years, as academic psychiatry has become ever more focused on biological research, this has been accompanied by a profound ideological commitment to what is known as reductionism. Reductionism is the belief that all sorts of events that happen at different levels of reality can be explained in terms of (i.e. reduced to) one type of knowledge. In psychiatry, reductionism involves the assertion that aspects of meaningful human behaviour (such as our worries, regrets, fears, beliefs, hopes, loves and doubts) can be fully explained in terms of 'non-meaningful' entities such as genes, neurotransmitters and ultimately atoms and molecules.

Reductionism is now the ruling ideology of mainstream academic psychiatry. It is very much a modernist idea. While the discipline may have flirted with interpretive and humanistic approaches to psychotherapy in the 1970s and 1980s, these have long been rejected. Cognitive psychology is acceptable as long as it is framed as a positivist science that also seeks to explain complex aspects of human life in a reductive manner[16]. In Fig. 2 we present reductionism as a central theme in late 20th century academic psychiatry; this also relates it to the analysis presented in Fig. 1 earlier.

We use hermeneutics as a way to to get beyond reductionism. Like phenomenology, the term 'hermeneutics' has many meanings[17]. Originally, hermeneutics referred to the science and methodology of interpreting texts, especially the books of the Bible, but in the past century it has come to refer to approaches to human behaviour and social organization that prioritize questions of meaning. In our attempt to think of ways in which medicine can engage appropriately with people in states of madness and distress, we put forward hermeneutics as a possible organizing principle.

[16]See Chapter 5 for a more extensive discussion of cognitive psychology.

[17]See Philips (1996) for a good discussion of hermeneutics in relation to psychiatry.

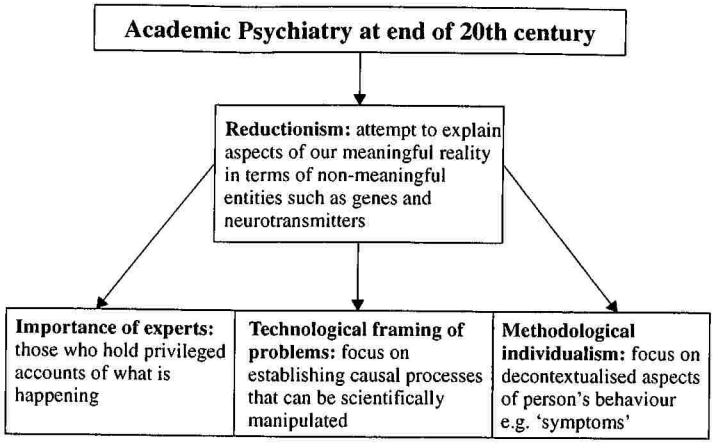

Fig. 2 Reductionism and Academic Psychiatry.

To us, reductionist approaches simply cannot account for the sort of problems we encounter in our day-to-day practice. In our understanding, the problems people bring to us as psychiatrists are essentially 'mental' as opposed to 'physical'. Neurologists deal with nervous system conditions that are primarily organic (physical) in nature. While not wanting to be too prescriptive, we think the word 'mental' usually denotes something to do with that aspect of the world in which meanings play a role. When we talk about 'functional impairment', we are already in a world of judgements, perspectives and values[18]. For the most part, these are problems that make sense only in a world structured by such things as language, cultural assumptions, personal roles, relationships, boundaries, moral dilemmas and priorities.

We maintain that attempting to understand phenomena such as hearing voices, sadness, withdrawal, euphoria, obsessionality, self-harm, suicidal ideation, fearfulness, and so on by reference to neurotransmitters and DNA alone is akin to someone attempting to understand a painting by an artist such as Picasso by analysing the chemical composition of the pigments on the canvas. To do so would give only a very limited and narrow interpretation of the process of Picasso's art. To have a greater understanding of the work, we need to know something about the artist: his life and outlook and his approach to art. We may want to compare it with other works by Picasso. We also need to look beyond the individual artist to what is happening in the world of art and culture more generally. This process of interpretation in order to make sense of things is what we mean by 'hermeneutics'. In Fig. 3, we present this as a central organizing principle of postpsychiatry.

[18]A discourse of 'values-based medicine' has recently emerged from this insight, see Fulford (2004).

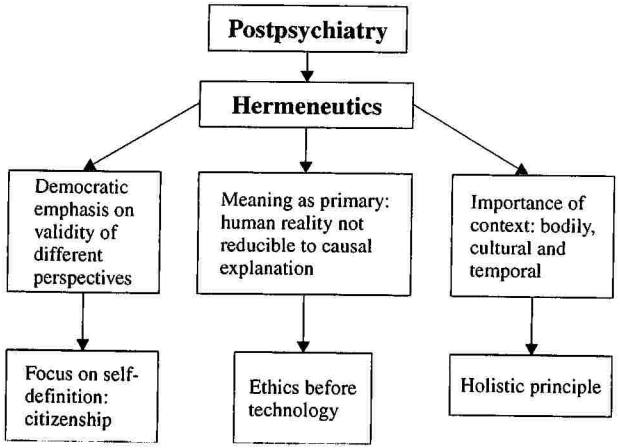

Fig. 3 Postpsychiatry and Hermeneutics.

Rather than investing an individual professional with the 'expertise' to interpret symptoms and to diagnose diseases, hermeneutics insists that a variety of different perspectives be brought to bear and insists that the service user has the right to negotiate how his/her reality is defined. It resists the impulse to reduce our actions to biochemical explanations and refuses the idea that technological interventions are neutral and value-free. Just as we never reach the 'correct' interpretation of a painting or a play, hermeneutics insists that human reality is something open, full of potential and unyielding to formulae or models. Meaning cannot be fixed. Central to hermeneutics is context. The interplay of our culture, our social world within that culture, the historical moment in which we live and the myriad other influences which have shaped and continue to shape our lives are what invest them with meaning. Only by looking at all these elements 'holistically' can we begin to try to understand the meaning of madness and distress.

Outline of the book

We appreciate that most people are unlikely to pick up this book up and read it from cover to cover. However, we hope that while dipping into the book people may find ideas or examples that suit their own purposes, rather along the lines of Gilles Deleuze's proposition that theories can be used like tools from a toolbox[19]. The book is *not* meant as some sort of blueprint or manifesto; it is *not* a guide to what should be done. Rather we hope that by developing

[19]'A theory is exactly like a box of tools.... It must be useful. It must function. ... it was Proust who said it so clearly: treat my book as a pair of glasses directed to the outside; if they don't suit you, find another pair' (Deleuze; quoted in Foucault 1977*b*: 208). This quotation is from an article called 'Intellectuals and Power'. This is essentially the transcript of a 1972 discussion between Deleuze and Foucault. In the same article, Foucault says: 'the intellectual's role is no longer to place himself "somewhat ahead and to the side" in order to express the stifled truth of the collectivity; rather, it is to struggle against the forms of power that transform him into its object and instrument in the sphere of "knowledge", "truth", "consciousness", and "discourse" (pp. 207–208). This was Foucault putting some distance between himself and Marxist intellectuals of the 1970s who claimed to be in the 'vanguard of the masses', believing that their analysis gave them a guide to how social change should proceed.

a critique of some of the fundamental assumptions underlying psychiatric theory and practice, we will help to open up spaces in which different sorts of dialogues and discourses might flourish.

This book is structured in three broad sections. The first (Chapters 1 and 2) examines the real contexts in which service users live their lives and use mental health services, and in which mental health professionals work to deliver those services. **Chapter 1** begins with a brief examination of the World Health Organization's global project to try to persuade the governments of all the countries of the world to prioritize the development of services for people who experience madness and other states of distress[20]. We then move on to consider the British Government's attempts since 1997 to change the ethos of the National Health Service. We recognize that this is a singularly local context, but it is the one in which we have worked as clinicians for many years. In any case, our view is that there are certain underlying commonalities in the way that advanced liberal democracies are currently thinking about psychiatry. One of the things we find particularly striking is the chasm that has opened up between the rhetoric of government policy on the one hand, and responses of policy makers and professional groups to that rhetoric on the other.

This book would not exist were it not for the courage of the growing number of mental health service users and survivors who have written about their experiences. In the last 10 years or so, this has evolved into a recognizable body of personal testimony and narrative. This includes what is now known as 'user-led research'. In **Chapter 2**, we examine some of this literature. We discover a remarkable diversity of experiences and views. Yes, there are attitudes that some might regard as 'anti-psychiatry', but there are also people who write in positive terms about their experiences of diagnosis and treatment within psychiatry. The majority of the views expressed fall somewhere in between these two extremes. People recognize that psychiatry has brought some benefits into their lives but there are personal costs to be borne. In addition, many people describe a deep sense of ambivalence about the significations and meanings attached to psychiatry, and particularly psychiatric medication. In this chapter, we are trying to re-establish contact with the voices that are customarily excluded from debates about madness.

[20]We use expressions such as 'madness', 'states of distress' and 'alienation' throughout the text. We also use terms such as 'psychosis' and 'mental illness' at times. While attempting to use a non-medical language as much as possible, we are aware that medical terms are now part of the vernacular vocabulary of distress.

The second section deals at length with the underlying philosophical issues that we have found valuable in helping to orientate ourselves to the problems and conflicts implicit in mental health practice. It deals specifically with the three key elements that we described earlier: the power of psychiatry and its role in social exclusion (Chapter 3), methodological individualism (Chapters 4 and 5) and psychiatry as a technical idiom of distress (Chapter 6).

In **Chapter 3**, we examine the first theme of postpsychiatry: the relationship between psychiatry, exclusion and coercion. At issue here is the nature of power and the role of professionals in the lives of service users. We draw attention to the work of members of groups such as Mad Pride, Mad Women and the Hearing Voices Network, who refuse the psychiatric way of framing their experiences as 'symptoms'. We examine the idea of citizenship in the field of mental health. In recent years, citizenship has become a fashionable idea in advanced liberal democracies, and it is not surprising to discover its influence in liberal discourses about mental health. However, we argue that 'a citizenship agenda' has real value in helping mental health professionals to think outside their biological or psychosocial frameworks, and to consider issues that are of greater concern to mental health service users.

In many respects, **Chapter 4** is at the heart of the book. This is centrally concerned with what we might call the 'gaze' of psychiatry: how it 'sees' or encounters the problems people bring to it. This is a complex issue involving questions of diagnosis and framing, as well as power and priorities. We have already mentioned the work of Karl Jaspers and his understanding of phenomenology. In Chapter 4, we argue that this version of phenomenology is deeply Cartesian[21]; it presents phenomenology as a rigorous science of human experience, which we believe to be problematic. It also tends to separate the person's experiences from the human contexts that render them meaningful, and from the body, through which any experience is brought into being. In the second half of the chapter, we spell out how the philosophy of Martin Heidegger serves to challenge this Cartesian viewpoint and thus opens up the possibility of very different starting points for psychology and medicine.

In **Chapter 5**, we continue to develop some of the themes that emerged in Chapter 4, this time with regard to cognitivism and the relationship between mind, language and meaning. We trace the common roots of cognitivism (and its therapeutic offshoot, cognitive therapy) and psycholinguistics, through the theories of George Miller and Noam Chomsky. Cognitivism and psycholinguistics have played an important role in recent theories of psychosis, especially the experiences that are associated with the diagnosis of schizophrenia. We consider the theories of Chris Frith as an example of this. The second half of this chapter mounts a critique of this work using the later philosophy of Ludwig Wittgenstein.

[21]That is shaped by the outlook of the philosopher Rene Descartes.

Chapter 6 marks the end of the central section and also starts the process of opening up some of the implications of our analysis for the world of mental health practice. If postpsychiatry is to be remembered by an aphorism, then that aphorism would be 'ethics before technology'. In Chapter 6, we dwell in detail on this. Our most important proposition here is that, despite claims to objectivity and neutrality, the technology and evidence on which current mental health practice are based are laden with assumptions and particular interests. Our position is that there is no such thing as a truly objective human knowledge or understanding, and that the sooner we recognize this and start attending to issues of transparency and accountability, the better for all concerned. We start by challenging the way that the profession conventionally interprets the evidence (from randomized controlled trials) for the effectiveness of psychotropic medication. Related to this, we consider the cultural significance of the 'Prozac phenomenon' and the highly problematic links between academic psychiatry and the pharmacological industry. We propose that, to a large extent, the effectiveness of drugs used in psychiatry is to be understood in terms of their cultural significance. This is an important issue that we return to in the final section of the book. At the end of Chapter 6, we argue the case for the priority of ethics in mental health practice and examine a key event in the history of psychiatry: the opening of the York Retreat at the end of the 18th century.

The final section tries to develop some of the understandings gained in the middle section in relation to the world of mental health practice. We begin with an attempt to foreground the issue of ethics by turning the moral gaze on ourselves as writers. In **Chapter 7**, we explore the historically important role of case histories in medicine as a prelude to a more detailed consideration of case history as narrative. Using the work of the psychiatrist and anthropologist Robert Barrett, we examine critically the idea of 'case' in psychiatry, and how psychiatric writing in case notes and other clinical material serves to describe much more than illness; it becomes a way of constructing a person. These days, the role of case history as one of the principal begetters of evidence has been replaced by evidence-based medicine, but this move has been partly offset by recent interest in what is called 'narrative'. We are sympathetic to the idea of narrative-based medicine, but we also consider it important to expose narrative to the same type of critical scrutiny as that to which we subjected phenomenology and cognitivism.

Chapter 7's critical approach to narrative is directly relevant to the notion of 'recovery' that we expound in **Chapter 8**. Recovery is a buzz word at the moment. We believe that, in general, the recovery movement is a very positive development. Essentially it involves professionals and service users working together in a spirit of hope. It involves people seeking different ways of moving forward, different ways of establishing a life independent of services and labels. However, across America and, to a lesser extent, in Britain, so-called experts in recovery are developing 'recovery training packages'. We are deeply sceptical at this turning of recovery into a commodity, to be marketed, sold and

turned into profit. Instead, we look to some recent qualitative studies of recovery, most of which have relied on the methodology of service user-led research, or have been undertaken from a service user perspective. We summarize some of the principal relevant findings.

This leads conveniently to the final perspective on recovery. In Chapter 7, we argued that we should not consider *narrative* apart from its ethical and moral dimensions. We apply this principle to recovery, with reference to Susan Brison's book *Aftermath*. This is a powerful and moving account of her personal experiences of recovery from a life-threatening sexual assault. One of many important themes to emerge from her writing is the idea of recovery as a moral process. We consider the implications of her ideas for our own engagement with suffering, as doctors.

In **Chapter 9**, we try to describe how our ideas have influenced our work as psychiatrists. Postpsychiatry, as we have said already, is not a new form of 'therapy'. We are not attempting here to describe 'cases'. Instead we focus here on the broader, community-based aspects of our work in Bradford. We begin by describing the city, its history and origins, and the important historical role played by migrant workers in the last 200 years of the city's history. We outline the work of *Sharing Voices Bradford*, which demonstrates the value of community development in creating safe spaces (or 'ethical' spaces) in which different understandings of, and responses to, madness and distress can be articulated. We believe that such an approach has the potential to bring particular benefits to Black and minority ethnic communities. But it does not stop there. The idea of safe spaces in which people can explore their own understandings of madness applies to all communities. This is amply demonstrated by Rufus May's work with *Evolving Minds*, in the Pennine town of Hebden Bridge. We revisit the concept of citizenship and describe how Bradford District Care Trust has set about working towards a *citizenship agenda*. This is a courageous endeavour, but one fraught with difficulties and problems.

In **Chapter 10**, we return full circle to some of the issues that we began with—the contexts, national and international, in which we live and work. This gives us the opportunity to look at some work that we regard as important, for example that of the late Loren Mosher. The latest twist in the context of British policy is the realization that the country cannot go on spending on health at the rate it has been doing for the last 10 years. Politicians and policy makers are realizing that the benefits to be gained by endless spending on technology in health must be questioned. In our view, this debate has to be set against a global context in which gross disparities exist between the resources available to EA and ED countries. This shows that the ideas we developed in the central sections of this book, dealing with the ways in which we would want to be cared for were we to experience madness (promoting the importance of contexts and ethics and the meaningfulness of human relationships and community), help us to begin the task of thinking through these complex issues in ways that are ethical and sustainable.

There is one last point we want to make. Whenever clinicians write books about their work, they feel obliged in some way to describe 'cases'. What point is there writing about clinical practice without presenting examples? Everyone is curious to find out how you do it. We debated the pros and cons of presented case examples, and Chapter 7 reflects the debates we had with ourselves (and friends and colleagues too). We decided that writing case histories based on our clinical work with Bradford's Home Treatment Service or Assertive Outreach Team would be unsatisfactory. How would we decide which cases to represent, on what basis and for what purpose? How would we handle the issues of confidentiality, of consent and editorial control? In any case, how would others interpret such representations? Would people regard them as a form of therapy? We would certainly hope not! Had we written just one case history, it would merely have represented selected scenes from an individual's life. The issues of power and representation in such narratives are so all-encompassing that in our view, we cannot justify the use of case histories in a work like this. As discussed in Chapter 2, service users are writing their own stories and doing their own research.

Nevertheless, we still wanted to convey something of the world in which we work. In the end, we decided that the best way to do this was through the medium of short stories. Scattered throughout this text are six fictional narratives, set in italics to separate them from the main text. They are placed at certain points in the text in order to emphasize certain points in the adjacent chapters. They are deliberately set to disrupt the calm rational flow that normally takes us through an academic text. The characters and situations are imaginary, although it would be disingenuous to propose that that they are unrelated to our experiences as clinicians. The great advantage of writing fiction in this way is that it enables us to negotiate a complex manoeuvre—that of relinquishing the privileged, all-encompassing, omniscient narrative voice from nowhere and everywhere, and of putting the story-telling into the voice of the main protagonist. Besides, the act of engaging with a piece of fiction means we enter different worlds, and that is exactly what we are striving to achieve in writing this book.