Constructive criticism of critical psychiatry

Everyone agrees that psychiatric services need to improve. The state of mental health services is, as I write, headline news in the UK. The government promises to reform the current Mental Heath Act*, described in briefings as 'not fit for purpose', in the face of relentlessly increasing numbers of compulsory admissions. Sir James Munby, President of the Family Division, stated baldly in a widely publicised judgment: 'The lack of proper provision for X – and, one fears, too many like her – is an outrage' (Munby, 2017; para 22). Both HM Government and Lord Justice Munby believe there is a problem, although their analysis of the problem differs radically.

Improving psychiatric services

In this issue, de Silva (https://doi.org/10.12968/hmed.2017.78.9.503) offers a prescription for improvement that is written from a 'critical psychiatry' perspective. It is worth examining the construct, which emerged during the 1960s and 1970s in the context of extreme dissatisfaction with the ways that 'mental illness' was identified and managed and the perceived power of the psychiatric establishment (Ingelby, 1981).

The Critical Psychiatry Network does not provide a neat definition of the term, referring on its homepage to being open to people sympathetic its unspecified 'ideals' (www.criticalpsychiatry.co.uk/). Its contemporary meaning can be inferred from the writings of prominent critical psychiatrists (see for example Bracken and Thomas, 2005; Moncrieff and Middleton, 2015). Key ideas can be summarized as:

1. Scepticism about the validity of diagnosis in psychiatry and a rejection of the 'disease model' of mental health problems
2. Scepticism about the value of psychotropic medication and concern over the potentially sinister role of 'big pharma' in encouraging the definition of mental disorders in a way that maximizes their profits
3. Interest in the role of narrative, largely from the perspective of the person who becomes a service user
4. Concern over or outright rejection of the use of coercion in the care and treatment of people with societally-identified mental disorder
5. A commitment to service user involvement and empowerment and 'co-production' of mental health
6. Some suggestion that psychosis can have positive value.

History of critical psychiatry

These views are, of course, not unique to adherents of critical psychiatry or necessarily that new. Thomas Szasz rejected psychiatric diagnosis as not reflecting true 'disease' (Szasz, 1960). He was also, throughout a very long life, vehemently opposed to any form of coercion in psychiatric practice, likening compulsory treatment to slavery and rape in his introduction to the 50th anniversary edition of *The Myth of Mental Illness* (Szasz, 2010). RD Laing, whose ideas Szasz vigorously rejected, found meaning in the content of psychosis and embraced a transcendental view of psychosis (Laing, 1960). Erving Goffman vividly described the numbing, dehumanising effect of institutional care (Goffman, 1961). Anthony Clare, later to become a famous media psychiatrist, published *Psychiatry in Dissent* (Clare, 1976). This book summarized the debates about the nature of mental illness and the appropriate response to it that were raging more than 40 years ago. It remains relevant today with only very minor changes in the terms of engagement.

Moving to more recent times adherents of the principles of recovery endorse the role of narrative and the importance of the development of a sense of agency (see, for example Davidson, 2003; Slade, 2009). Peter Kinderman, a past president of the British Psychological Society, has published *A Prescription for Psychiatry*. This is, as the publisher's blurb tells us, 'a manifesto for an entirely new approach to psychiatric care; one that truly offers care rather than coercion, therapy rather than medication…' (Kinderman, 2014). It is based on a deep scepticism over the validity of diagnosis and the efficacy of biological treatments for mental illness. This scepticism reaches into the heart of the biologically oriented psychiatric establishment. The Research Domain Criteria programme of the US National Institute of Mental Health very specifically channels research away from traditional psychiatric diagnoses towards a dimensional approach that encompasses a set of neurobiological domains (such as 'threat', 'reward', 'memory', 'attachment' and 'arousal') (Cuthbert, 2014).

The place of the practitioner

de Silva's solution to improving psychiatric services is focused on the practitioner. He describes some of the cognitive biases that are seen in all forms of decision making, which have been accessibly described by Daniel Kahneman (2011). de Silva omits 'hindsight bias', which allows people to conclude that something that was statistically unlikely (for example a suicide or homicide) was inevitable because it happened, and the 'sunk cost' fallacy, best described as throwing good money after bad. Various ways in which psychiatrists can get things wrong are described and there is an implicit and likely accurate criticism that psychiatrists do not receive adequate training in what GPs call 'consultation skills'.

De Silva emphasizes the importance of critical appraisal of the literature. However, for certain subjects this may require specific technical skills in the relevant field: I am

* The Mental Health Act 1983 (as amended in 2007) applies to England and Wales only. Scotland and Northern Ireland have separate legislation

Dr Frank Holloway, Emeritus Consultant Psychiatrist, South London and Maudsley NHS Foundation Trust, London (f.holloway1@gmail.com)

reasonably competent to appraise the psychiatric literature on epidemiology, nosology and treatment but would not be able to appraise a paper reporting results of a functional magnetic resonance imaging study of tractomes or genomics.

To the critical psychiatrist 'the underlying function of the mental health system [is] the care and containment of people who behave in distressing and disturbing ways' (Moncrieff and Middleton, 2015). This does not resonate with my experience. In my career I have had a primary focus on helping people either recover from their episode of mental illness or live as good a life as possible with continuing disorder or disability, while always being aware of the important discourse in relation to public safety.

That being said there is much merit in the critical psychiatry project since it questions received orthodoxies and encourages scepticism about lazy diagnostic and therapeutic practices. This must be a good thing. The effective psychiatrist must be able to work between different paradigms and, when the clinical and/or social issues are highly complex, break them down into bite-sized chunks. Good psychiatry is interesting and rewarding.

With his focus on the individual practitioner de Silva does not address the problem that Munby (2017) was so concerned about: the mental health system as a whole. In Munby's view what X urgently required was a highly coercive intervention in a hospital under the Mental Health Act to save her life. **BJHM**

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