

## Whither critical psychiatry?

David Cohen, PhD (cohenda@fiu.edu)

Professor, School of Social Work, Florida International University, Miami, USA

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I wish to thank the Critical Psychiatry Network for inviting me and supporting me to address this conference, and affording me the pleasure to renew my connections with some of its members and forge new connections.

It's an honor for me to speak here, on the occasion of the tenth anniversary of the only network by that name in the world. For what it's worth, I appreciate that the British seem more receptive than the Americans to critical views about psychiatry, as illustrated by the fact that your medical and psychological journals still occasionally publish articles by Thomas Szasz, the original critical psychiatrist of the 20<sup>th</sup> century, who is now in his 89<sup>th</sup> year and still kicking, whereas he appears to have been shunned by American mental health journals. Also, I dare say that the *Journal of the American Medical Association* has never published anything with the phrase "critical psychiatry" in it, whereas the *British Medical Journal* has, at least a dozen times (although in most cases the phrase refers to this network).

I still think there is still a need to define just what critical psychiatry is. I hope we can all agree that the term "anti-psychiatry," originally coined by David Cooper (1967) is not suitable because it implies being against *anything* psychiatric. Yet it may be useful to recall that David Cooper enunciated his original concern about psychiatry as follows: "Above all, I have been concerned with the question of violence in psychiatry and have concluded that perhaps the most striking form of violence in psychiatry is nothing less than the violence of psychiatry..." (1967, p. 12). Cooper had in mind "the subtle, tortuous violence" of society that psychiatry "chooses to refract and condense on to its identified patients" (p. 29), regardless of the sincerity and devotion to the patient of psychiatrists and others whom Cooper called "the 'sane ones'" (p. 29). By this he meant that the sane ones denied that others might experience in their bodies and consciousness the contradictions and conflicts created by living in advanced capitalist societies. It was an "everyday" sort of violence, though one that Cooper felt could be most intense and overwhelming.

There's another sort of violence that psychiatrists and sane ones inflict on people who disturb families, communities, the social order, and that is the violence of involuntary commitment and treatment justified by the myth of mental illness, which Cooper didn't quite denounce or discuss extensively as such. This is the main issue which I would like to discuss today.

A brief look at the Wikipedia site under the entry "antipsychiatry" reveals a list of worthy activities and positions of critical psychiatrists, including a critique of the use of the medical model, of abuses of power in psychiatry, of the use of drugs in psychiatric practice, of the influence of the pharmaceutical industry on psychiatric research and practice. It's clear also that critical psychiatry is no longer the province of psychiatrists and mental health professionals. Its ideas, though usually in diluted form, are now spread far and wide among ex-patients, philosophers, and especially nowadays, journalists. Some journalists and bloggers, such as, in the United States, Martha Rosenberg, Margaret Healy, Philip Dawdy, and Evelyn Pringle, seem to be more critically informed, and seem to fulfill more of the duties of public intellectuals, than virtually any psychiatrist alive today. Their exposes of the fads and follies of psychiatric practices—especially as concerns the symbiosis with Big Pharma, which is impossible to ignore as soon as you follow the money—are more enlightening than any other mental health reading by that name.

But for serious critical thinking, we must go elsewhere than the media. Today's journalism requires every paragraph of an article to have no more than one or two sentences and to stand alone for easy digestion and scanning. Every idea is thus chopped to its lowest common denominator. This sort of

“base rhetoric” does little to help people think or to bring people to themselves. But the main reason for the media’s incapacity to be critical about psychiatric matters is that it’s one thing to crusade against Big Pharma, it’s another thing entirely to challenge everyday assumptions, the glue that binds respectable people and groups together. As Thomas Szasz (2007) points out, “Faced with vexing personal problems, the ‘truth’ people crave is a simple, fashionable falsehood” (p. xv).

The two issues that I believe journalists and most critical psychiatrists never, ever tackle directly are (1) the metaphorical nature of the term mental illness and (2) the distinctive use of outright, legal coercion by psychiatry. Let me suggest that where critical psychiatry goes will be determined by its stance on these two issues, that indeed, no other stance is possible for a genuinely critical psychiatrist than categorically rejecting the myth of mental illness and the practice of psychiatric coercion. Everything else is just commentary.

These two issues are probably never addressed directly by the swarm of *nouveau*-psychiatric critics of the last two decades because expressing them today comes as close as possible to expressing a delusion in respectable company. It’s akin to expressing a blasphemy in religious company. To discuss psychiatric coercion plainly and squarely would lead to a most difficult quandary, and the speaker would immediately feel the stigma. Speaking about it plainly and openly might make us feel that we should do something about it, and doing something about it might put us in the position of pushing off the very cornerstone of the entire psychiatric edifice.

Coercion supports the false psychiatric theories that speakers have discussed and will discuss here today. Without coercion, none of this theorizing would matter except as merely academic issues. Coercion by psychiatry of our unwanted and disturbed allows society—and allows psychiatry, of course—to close its eyes as the silliness and unfalsifiability of its theories, chief among them being the idea that (mis)behavior is illness. Absent psychiatric coercion, the theories and their “evidence base” would need to fend for themselves, and it seems obvious that they could not withstand a critical assault from the human and the social sciences, let alone the medical sciences. (The *practices* resting on the theories would of course also need to withstand critical assault from the human service and other helping professionals, and here too it’s difficult to imagine how psychiatry could survive in its present form.)

Thus it’s quite difficult to imagine who might be interested in playing with this cornerstone of the psychiatric edifice, except those who have no need to remain within the psychiatric orbit. For those of us who make a living by the graces of the psychiatric establishment, or the mental health establishment, or the state—and that’s most of use here today I assume—the options are few and far between. I recognize that fully. It’s a question of keeping our jobs, earning our salaries, paying our bills. By and large, because of economic self-interest, we submit to the core psychiatric orthodoxy and tinker at the edges of the system where we generate “critical” ideas, and psychiatric orthodoxy recognizes that it can recycle our critical ideas as it has recycled every challenge ever thrown its way that did not fundamentally question its *raison-d’être*. Those challenges that did—the Szaszian assault on the myth of mental illness and on psychiatric coercion—were denied and their persistent proponents fully marginalized. Predictably, what followed the denial was a veritable orgy of creating *new* mental illnesses and renewing interest in so-called “therapeutic coercion.”

For others among us who cherish medical identity, who wish to be genuine medical healers, the option is simple: to practice real medicine. There is probably some room in medicine and medical research—in neurology, perhaps endocrinology—for psychiatrists who wish to practice real medicine with real patients. But remember: the law expressly forbids coerced *medical* treatment.

Two founders of this network, Pat Bracken and Phil Thomas (no date), made a constructive suggestion a few years ago: they proposed, as a first step, “to remove doctors from the assessment processes that lead to compulsory admission”, relinquishing to other professionals who might wish it, the power to commit. This is a constructive suggestion: it does not require denouncing the immorality of involuntary commitment, it recognizes that “society” acts as it will—but it reminds us of the choice that

professionals make when they participate or not in coercive social control (and when they affirm that coercive social control is a branch of medical science). Bracken and Thomas believed that such a first step “will not in itself reduce the power of psychiatry, as this is constituted largely through the domain of its knowledge.” Much as I respect Bracken and Thomas’ proposal, their view of psychiatric knowledge as procuring psychiatry power should be inverted, and extended: it is psychiatry’s socially accepted power that legitimizes psychiatric knowledge, and this knowledge is psychiatry’s weakest foundation.

Szasz (2007) commented that Ida Macalpine and her son, Richard Hunter, both psychiatrists, observed, in their monumental *Three Hundred Years of Psychiatry, 1535-1860*: “There can as yet be no definitive history of the subject since psychiatry is still too little differentiated from its past” (p. ix). Szasz asked what they meant, and answered it via another of their quotes from a Roy Porter (1994) volume: “Rather than a chronicle of feats, facts, and discoveries, the history of psychiatry presents a record of perennial problems, recurrent ideas, disputes, and treatments, trailing in the wake of medicine and exhibiting ... a mixture of as many false facts as false theories” (p. 87). The “progress of neuroscience” that is alleged today to underlie advances in the diagnosis and treatment of mental illness—what precisely does it amount to? Dennis Charney and colleagues (2002), the very proponents of “a neuroscience research agenda for DSM-V” and a “pathophysiologically based classification system,” concluded “that the field of psychiatry has thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacologic treatment” (p. 33). But my task is not to engage in a deconstruction of biological psychiatry, which is fairly easy to do.

Our task as critical psychiatrists and mental health professionals is first and foremost today on the definitional front: not merely to decry the encroachment of medicalized thinking on an ever-growing sphere of life, but to challenge the very purpose of medicalization. That purpose finds its justification in the category “mental illness” (or “mental disorder”). Back to fundamental principles: behavior is what you do. Illness is what you have. And never the twain shall meet—except of course in the category error of psychiatry, where they not only meet, but merge completely.

Because tackling the mental illness myth directly is so rarely done nowadays, “reformist” critiques are taken for critical or radical critiques. Most everyone takes for granted that a “core” of genuine mental illness—“schizophrenia,” for example, an extreme of despair, deviance, and disturbance—truly exists, and only the flat-earthers and the deluded would pretend otherwise. One therefore need only debate which “treatment” is most effective for this core. This erroneous view also leads to the stance that given the proper public health measures, the problems that psychiatry faces (“mental illnesses”) *can actually be made to disappear*. But pain and tragedy disappear only in utopian visions. This naïve and misguided view leads us to undertake absurd, nightmarish endeavors under the guise of public health.

The latest example of such an endeavor is the soon-to-be released report from the U.S. National Academies of Science, entitled *Preventing Mental, Emotional, and Behavioral Disorders Among Young People* (O’Connell et al., 2009). A blue-ribbon panel of public health scientists urge systematic screening of children and adolescents for anxiety disorders, mood disorders, attention-deficit hyperactivity disorders, and schizophrenia. This is the second major US government panel to urge mass screening of the population to detect and treat mental illnesses. (The first was from President George Bush’s New Freedom Commission). The imagery in the report is as follows: humans walk the earth, and mental diseases strike them from nowhere and insidiously take hold. There’s no way biological way to detect the diseases, but we can diagnose them using the DSM-IV, and, thank heaven, we can treat them with modern effective treatments. Why wait to prevent them?

Our failure to keep the definitional issue (there are no mental illnesses, there are only problems of living) front and center in the minds of the public led of course to DSM-III. Psychologist David Jacobs points out that even though the DSM requires diagnosticians to distinguish between on the one hand,

so-called reactions to culturally-sanctioned and expectable stressors, and on the other hand, “mental disorders,” the DSM doesn’t leave much room or at all for the former. Jacobs (2009) writes: “I think the core ethic/tenet of contemporary American biopsychiatry is to be found baldly stated under Adjustment Disorder [APA/DSM-IV-TR, 2000, p. 679]: ‘...a reaction to a stressor that might be considered normal and expectable can still qualify for a diagnosis of Adjustment Disorder if the reaction is sufficiently severe to cause significant [social] impairment.’ In short, with the exception of bereavement for a two month period, no one can be excused from failing to perform as expected ‘in one or more important areas of [social] functioning’ for any reason or set of circumstances without the judgment of mental disorder and whatever social and/or legal consequences may flow from that.” This is the official position of the American Psychiatric Association.

Once a behavior, however rare or seriously impaired, becomes mental illness, there is no stopping *anything* and everything from becoming mental illness. And this of course has nothing to do with whether those who participate on DSM Task Forces have financial ties with drug companies or not: psychiatric diagnosis long preceded drug treatment. If drug companies exerted no influence, psychiatric diagnostic judgments would be no more “objective” than they are today.

When we look at religious extremists and fanatics, who might pronounce a death sentence on someone because their ideas are different, we might feel smug and superior. So we should we ask ourselves, as Szasz (1993) does: “What argument do we regard as at once so important and so true that its rejection justifies coercing persons who have not deprived anyone of life, liberty, or property?” For him, the answer was obvious: “We seek truth in what Science “tells us,” much as our forebears sought truth in what God “told them.” We believe in mental illness and psychiatric treatment, much as our forebears believed in possession and exorcism.” (p. 102). But he also reminds us that “As mere abstractions, religion and science are simply blank checks; in actuality, each is what we, fallible and fallen human beings, make of them” (p. 103).

In Florida, population about 18.7 million people, 83,629 people were “Baker-acted” in 2007, which means they underwent at least 1 officially recorded involuntary psychiatric examination (~123,000 examinations in all) (Christy, 2008). As is typical for such involuntary psychiatric procedures worldwide (in contrast with involuntary criminal justice procedures), the quality of the Florida data doesn’t allow knowing how many were actually incarcerated as inpatients. But the figures indicate that for 2/3 of these 83,629, the reason was listed as “harm,” and for two thirds of this last group, it was harm to self (threat of suicide). If we can extrapolate from these figures, we can conclude that psychiatrists’ main legal duty today is to coerce people who speak about or threaten to kill themselves.

Naturally, psychiatric coercion is not linguistically transparent: it is always justified by appeal to mental illness. Suicidal people are not merely suicidal, humiliated and overwhelmed by disappointment, disruptive to the social order or unfeeling about their families—they are displaying symptoms of *illness* and doctors treat illness. That is why psychiatric coercion is justified by the myth of mental illness, and doing away with one must mean, inevitably, inexorably, doing away with both. And until both are done away with, “critical psychiatry” will remain, if you allow me the analogy, a fringe guerilla tactic, an annoying form of harassment that does not fundamentally engage with the enemy, and one that is likely to perpetuate the same regime even if it accedes to power.

Let me conclude by stating that there is of course nothing original in what I am advancing, I am merely trying to remind ourselves of what I believe are the fundamental issues for a critical psychiatry, and that we are indebted to Szasz for first stating them, nearly 50 years ago. So it’s fitting to conclude with a quote from his 2007 book, *Coercion as Cure*: “The institution of psychiatry, like the institution of slavery, consists of a socially sanctioned relationship between a class of superiors coercively controlling a class of inferiors. The system rests on the idea of mental illness, its semantic clones, and their legal implications; it is destined to engender disdain on the one side, and defiance on the other. The juxtaposition of persuasion and coercion lies at the heart of mankind’s great moral conflicts—relations

between men and women, leaders and followers, capital and labor, expert and lay person. The true healer of the soul is a 'doctor' of persuasion, not coercion. Psychiatric peace and tolerance are contingent on the recognition that 'mental illness' is a misleading metaphor and on the rejection of psychiatric coercion as a crime against humanity" (p. 227).

Thank you.

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