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editorial

PAT BRACKEN AND PHIL THOMAS

Authors' response. Invited commentary on . . . Beyond consultation†

Dr Holloway is right when he says that our editorial contains a significant challenge to professionals working in the field of mental health. However, he misses the point entirely that this challenge arises not from our analysis but from the growing service user movement. Our editorial is an attempt to articulate a positive response to this challenge. But it is the ideas of groups such as the Hearing Voices Network and the Icarus Project that throw down the gauntlet to the traditional assumptions of psychopathology. Although psychiatrists like Holloway may respond defensively and maintain that these ideas are 'dangerous', the fact is that this movement is growing from strength to strength. Since our editorial was written, Newsweek magazine has featured an article on the Icarus Project and the phenomenon of Mad Pride (www.newsweek.com/id/195694).

We agree with Holloway that 'Effective dialogue is . . . a core element of good medical practice for all doctors working in the UK'. However, the evidence suggests that this is lacking in at least some consultations between consultant psychiatrists and their patients who experience chronic psychoses. McCabe *et al*[1] in a conversation analytic study found that consultant psychiatrists had difficulty engaging with their patients' belief systems, especially when patients wanted to discuss the meaning and content of the delusional beliefs or hallucinations. The consultants in this study appeared to be embarrassed by their patients' attempts to raise these issues, and responded by changing the subject or giggling nervously. This corroborates service user narratives that a number of consultants are, contrary to Holloway's assertion, not '. . . sensitive to the explanatory frameworks that our patients and their carers hold'. This makes it difficult for some psychiatrists at least to work with patients in ways that are helpful for them.[2]

We agree with Holloway that some excellent work has been done by psychiatrists in relation to recovery, and are very familiar with the work not only of Davidson[3,4] in the USA, but of Glenn Roberts[5] and others in the UK, all of whom we applaud. In citing Davidson's work, however, Holloway inadvertently validates the point we make in our paper. In their work on recovery, both Davidson and Roberts choose not to use an approach grounded in traditional descriptive psychopathology, but turn instead to narrative theory and methods, seeing this as providing a rigorous empirical and clinical methodology in helping people suffering from chronic psychosis to move to recovery. For this reason we suspect that Holloway, like others, is highly selective in his reading of *Postpsychiatry*.[6] In our work, we have been keen not to throw the baby of the distress of psychiatric patients out with the bathwater of descriptive psychopathology by describing the value of narrative and other hermeneutic approaches in our work as psychiatrists.[7,8]

Moreover, we believe that an increasing number of psychiatrists are seeking to work with different frameworks and to engage positively with the diversity of the user movement. Our work is an attempt to think through some of the theoretical and practical implications of these developments. We deny that this is anti-psychiatry. We have always argued that medicine has a legitimate and important role to play in the lives of those who suffer episodes of 'madness', distress and alienation. But we need to rethink some of our fundamental assumptions if this work is not to be experienced as damaging. This is not anti-psychiatry, anti-medical or anti-scientific. But psychiatry deals with the most complex aspects of our experiences as embodied, encultured beings. An authentic science of human beings needs to face the fact that the meaningful world of psychological suffering will never be adequately grasped through the same scientific framework we currently use to understand bodily tissues such as livers, lungs and neurons.

We referenced the work of Thomas Kuhn in our editorial not, as Holloway maintains, because we believe that he is 'anti-science' but because he shows us that science does not evolve in a linear fashion. Holloway's assertion that paradigm shifts 'do not abolish previous scientific knowledge but absorb it into a better fit with the empirical evidence' involves a serious misunderstanding of what Kuhn's work was about. His central concern was to show that what counts as empirical evidence in the first place is determined by the paradigm at work. He points out that it is hard for scientists who have worked through one paradigm all their lives to give it up, as it shapes not only their beliefs about the world but also their perceptions of that world, indeed how they experience that world. Paradigms determine what we understand 'the facts' to be. Indeed, Kuhn says: 'when paradigms change, the world itself changes with them'.[9]

Holloway may be right that the comment by Peter Tyrer that we quoted was a 'throw away remark' and that somehow Tyrer really wanted to 'celebrate' the steady evolution of psychiatric knowledge and treatments. However, this does not tally with the *Lancet* editorial from January this year by the same author in which he comments: 'The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed. But how is it that for nearly two

†See editorial, pp.241–243, and invited commentary, pp.243–244, this issue.

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decades we have, as some have put it, "been beguiled" into thinking they were superior?'.[10]

This is far from a celebration of the steady advance of knowledge. Rather, it represents a serious indictment of our profession. The Critical Psychiatry Network came into being 10 years ago because some practicing psychiatrists were not 'beguiled' by the marketing forces of the drug industry, were sickened by the corruption of academic psychiatry, opposed the extension of coercive practices and sought ways of working more closely with organisations set up by service users. The credibility of our profession has been put in question, not by the activities of those of us in the critical psychiatry movement, but through the corruption of our research and training agendas by the interests of major drug companies in alliance with senior individuals from our profession. In the USA, the layers of these alliances are now being exposed by the work of Senator Grassley (www.nytimes.com/2008/07/12/washington/12psych.html?_r = 1). These exposures are the real 'wake-up call' for our profession.

It is unfortunate that Holloway reduces complex issues to simple binaries, 'heroes . . . [and] . . . villains', or psychiatry and anti-psychiatry. Critical psychiatry is concerned with moving our understanding of the contested nature of mental disorder beyond such crude distinctions.[11] In presenting his arguments in this way, Holloway obscures the complexity of the debate and perpetuates historical divisions that have no part to play in contemporary discussions about the role of psychiatrists in the care of people with mental disorders, their relationships with other professionals, and, most important of all, how they should seek genuine opportunities for meaningful engagement with service users and carers.

References

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