

POSTPSYCHIATRY: HOW TO THROW OUT THE BABY WITH THE BATHWATER

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Postpsychiatry is of comparatively recent origin. The term 'postpsychiatry' was coined by Campbell, in 1996 (Campbell 1996). It does not indicate psychiatry that comes after psychiatry. The term itself comes from postmodernism. The same as modern-day psychiatry is psychiatry of modern times, postpsychiatry is supposed to be psychiatry of the postmodern era. Patrick Bracken and Philip Thomas, from Bradford, UK, are the main protagonists of postpsychiatry (Bracken & Thomas 2001, 2004, 2005, Bracken 2003). Joanna Moncrieff (2006), Duncan Double (2002), Bradley Lewis (2000), to name but a few, propagate the same ideas as Bracken and Thomas.

Postpsychiatry is one variant of critical psychiatry, the others being antipsychiatry (R.D. Laing, D. Cooper), alternative or democratic psychiatry (F. Basaglia), political psychiatry (F. Fanon) and radical psychiatry (Cl. Steiner).

So far, sociologists (Levin 1987, Fee 2000, Gottschalk 2000) have criticized psychiatry from a postmodern perspective. Bracken and Thomas are the first psychiatrists to do so from the same standpoint. Their criticism and their view of which kind of assistance should be delivered to the mentally ill is more binding than that of sociologists because psychiatrists have first-hand experience with the mentally ill people. At the same time it has more serious implications because psychiatrists deal with the mentally disturbed people.

Although postpsychiatrists 'wish to avoid the polarization created by the antagonism between psychiatry and antipsychiatry' (Double 2002) the ideas of the proponents of postpsychiatry have much in common with the ideas of antipsychiatrists. That is quite understandable because both draw on the same conceptual background: the critique of the modern mind by Michel Foucault and Martin Heidegger, among others. Thus both antipsychiatrists and postpsychiatrists question the validity of the biomedical model, criticize positivism and reductionism of modern psychiatry, normalize madness, disapprove of decontextua-

lization when diagnosing mental disorders (against methodological individualism), point out the serious limitations of scientific methods in psychiatry, underlie the importance of values and meanings in grasping mentally ill people, and analyze the downsides of the 'great confinement' as well as other repressive aspects of psychiatric practice.

Nevertheless, there is something specific to postpsychiatric concepts, something that puts them apart from the views of other critical psychiatrists. It is the campaigning for deprofessionalisation, that is, depsychiatrization, and in the last instance demedicalization of psychiatry. Before postpsychiatrists social psychiatrists and those who pursued the ideas of Franco Basaglia advocated that laypersons should partake in the provision of services to, and care for, the mentally ill and their families. However, they did not consider psychiatric knowledge less important than the experience of carers and service users in mental health work. Although postpsychiatrists advocate the 'marriage of professional expertise and laypersons' experience', they in fact give such a prominent role to service users and carers, and favor such a large lay involvement (voluntary sector organizations and self-help groups) in diagnosing and treating the mentally ill that psychiatrists appear mainly sidelined.

Antipsychiatrists, Ronald David Laing first of all, also questioned the diagnostic and therapeutic processes of modern-day psychiatry, but they did it without overstating the importance of non-professionals in the whole business of helping those who mentally suffer either because they are labeled as mentally ill or because they are genuinely mentally disturbed.

Yet over the last fifteen years or so the authority of psychiatrists has been exposed to the sway of two opposite currents. On the one hand, the dominance of the biomedical model, favored by pharmaceutical companies, has strengthened the power and authority of psychiatrists. On the other hand, challenges to medical dominance are

represented by the legislative empowerment of a range of previously subordinated groups of professionals and paraprofessionals, as for example by the National Health Service and Community Care Act of 1999, in the U.K. (Samson 1995).

Moreover, as, these years, the principles of economic rationalism and cost-effectiveness ever more get into health service, the more legitimate becomes the question whether some alternative approaches could more effectively than biomedical model meet the needs of people with mental disorder, and thus enable them to less slowly 'get back on the track'.

Eventually, as far as likeness and dissimilarities of antipsychiatry and postpsychiatry are concerned, antipsychiatry is part of a large social and political movement that took place in the U.S. and most European countries in the late sixties, and had a marked revolutionary ethos, whereas postpsychiatry comes up at a time and in a milieu which is not very turbulent in social and political terms.

Since the critique of modern psychiatry is the key objective of both antipsychiatry and postpsychiatry it is worth underlining that there are many critical issues of contemporary psychiatry: comparatively rarely questioned allegiances to the assumptions of the natural sciences; preoccupation with diagnostic and classificatory problems; drugs considered as the preferred treatment modality regardless of the kind of mental disorder; steady increase in the number of various forms of mental disorders from one to another revision of DSM; the question of values-based or values-neutral practice; the decontextualization of mental in DSM-III and DSM-IV; the dismantling of mental hospitals and the failure of the community to provide care to patients with severe mental illness; the consequent rise in the number of places in residential care and supporting houses which amounts to reinstitutionalization and transinstitutionalization of seriously ill mental patients; the insufficient attention paid to patients' difficulties in dealing with real life problems; restricted involvement of patients in decision making regarding their true needs and rights.

Any critique of psychiatry should indicate how these and other critical issues of psychiatry should be resolved of psychiatry should be rectified.

Postpsychiatry, as the most recent critique of psychiatry, to a great extent failed to do so.

Postpsychiatrists identified the biomedical model as the major stumbling block on the way to a better psychiatry. That is why they disputed nearly all aspects of psychiatry that they perceived as medically based. By doing so they challenged the basics of psychiatry.

The goal of this paper is to show why the postpsychiatric deconstruction of psychiatry along these lines is flawed.

Diagnosis does not matter

By the admittance of Bracken and Thomas themselves, diagnosis has traditionally been the preserve of medically trained psychiatrists. 'It is at the heart of psychiatric theory and practice' (Bracken & Thomas 2005).

Postpsychiatrists do not consider diagnosis as important. In their view, (postmodern) psychiatrists, let alone the mentally ill people, would do better without diagnosis.

Thus Bracken and Thomas assert that 'it is possible to practice good medicine in the area of mental health without a primary focus on questions such as, "what is the diagnosis?"' (Bracken & Thomas 2005). In order to lend credence to their view they report that they worked with teams who were primarily interested in what the needs of a person and their family are like, and how they could help that particular person 'cope with the crisis without a loss of dignity' (Bracken & Thomas 2005).

One might remark that a team's concern for a patient's needs does not mean that the diagnosis of his or her mental problems is not important. Numerous social circumstances along with the patient's mental state and the diagnosis of his or her mental suffering co-determine both the patient's needs and the actions that a team should undertake so as to help the patient to cope better.

The scope of postpsychiatrists' criticism of psychiatric diagnosis is quite large: from a team's estimation that diagnosis is not of primary concern to a critique of the Jaspersian phenomenology, which is one of the pillars of contemporary psychiatry. Thus Bracken and Thomas criticize the Jaspersian phenomenology for being an empirical science, 'concerned with identifying and defining the forms of psychopathology' (Bracken & Thomas 2005). According to postpsychiatrists, the primary goal of phenomenology is not interpretation (hermeneutics). Phenomenology is

concerned with ‘the selection, delimitation, differentiation and description of particular phenomena of experience which then, through the use of the allotted term, become defined and capable of identification time and again’ (Jaspers 1963). In the view of Bracken and Thomas, Jaspers’s ‘static’ phenomenology is ‘false to the lived world of patients, doctors and the society in which they live’ (Bracken & Thomas 2005) because ‘it does not seek to interpret or even to understand, but to identify and describe’ (Bracken & Thomas 2005).

The main protagonists of postpsychiatry find the remedy for these (putative) imperfections of the Jaspersian phenomenology in reversing the course of ‘diagnostic approach’. ‘A postpsychiatric perspective sees context first’, they say (Bracken & Thomas 2005). It means that, unlike mainstream psychiatrists who ‘seek to identify symptoms first and then to explain or understand them later’ (Bracken & Thomas 2005), postpsychiatrists see ‘an understanding of the context: social, cultural, temporal and bodily as the first step’. Reportedly such an approach makes possible the emergence of a sense of what the problems are.

But how should psychiatrists grasp the origin of someone’s problems – one may ask – if they do not know what the problems are, that is, what the symptoms are. It is through someone’s symptoms that psychiatrists become aware of the kind of mental suffering of those who seek their help.

The presumption of the sequence of diagnostic activities proposed by postpsychiatrists – first an understanding of the context and then the description of symptoms – is that the origin of mental disorders is in the social context, a proposition that is largely doubtful. Social variables are concurrent in the generation of mental disorders. Least of all they are key variables to the point of justifying first the psychiatrists’ understanding of the context and then the description of symptoms.

One should not be mistaken by postpsychiatrists’ mention of ‘bodily’ as part of the context. The following assertion indicates that postpsychiatrists by ‘context’ mean social (cultural) rather than ‘bodily context’. Bodily context is of second rate importance.

‘While postpsychiatry does not rule out causal explanation of what is happening for the individual patient, it argues that a hermeneutic exploration of (i) meaning; (ii) significance; and (iii) value should

always precede the move to causal explanation’ (italics mine) (Bracken & Thomas 2005).

If implemented, such an order of diagnostic procedures might have very serious, even fatal consequences. For example, frontal lobe tumor may underlie someone’s low energy levels, depression, confusion, forgetfulness, lack of initiative and loss of interest in people and matters. Should psychiatrists first look for the meaning of such symptoms in the patient’s social context, and thereby let his or her mental and most likely physical state as well deteriorate; or should they first rule out any possible physical-biological cause of the said symptoms? Postpsychiatrists are unequivocal in advocating the priority of the former option. ‘We propose that an attempt to grapple with the meaning of an episode of low mood should precede attempts to dissect out any biological causes’ (Bracken & Thomas 2005).

Such a proposition is at odds with the medical reason, and for that matter, the psychiatric one. (This does not mean that psychiatric approach can be reduced to the medical one.) And psychiatrists are those members of a team who are if not only than surely most familiar with the medical reason. They hold it up.

Doctors define the patient’s world, postpsychiatrists contend, from the point of view of a detached expertise that arrives with its definitions and demarcation already in place. That is what is called medical and psychiatric knowledge which doctors (including psychiatrists) are thought.

Postpsychiatrists do not totally reject such knowledge, but refuse to prioritize it, or, more accurately, they do not want psychiatrists to play a leading role in diagnosing. In their view, diagnosis should be a process of exploration pursued together by the professional and the patient. ‘A doctor may well bring a knowledge of genetics, medicine and pharmacology to bear on this process, but in a postpsychiatry approach this type of knowledge is not privileged over others’ (Bracken & Thomas 2005). In other words, (post)psychiatrists should not have either the first or the last say in the diagnostic process. They have to negotiate the diagnosis with the patient (service user), who has ‘the right to negotiate how his/her own reality is defined’ (Bracken & Thomas 2005). Briefly, a patient’s own understanding of his/her world has to move center-stage. (Bracken & Thomas 2005)

Of course, psychiatrists (and other doctors) should not pay lip service to how a patient perceives and understands his or her problems ('world') because in medical practice, in psychiatric one in particular, the patient's presentation and interpretation of his or her own symptoms and signs might help the doctor (psychiatrist) in diagnosing the kind of illness someone is suffering from. However, that is not what postpsychiatrists have in mind when they say that the patient's own understanding of his or her world moves center-stage. What they mean is that (post)psychiatrists should open up to the patient's perspectives, to his or her way of seeing the kind and background of his or her problems. They advocate that patients should partake in the diagnostic process on an equal footing with psychiatrists (doctors). Psychiatrists should respect the patient's own 'diagnoses of his or her problems. They should accept that diagnosis is not their preserve.

If psychiatrists let service users diagnose their mental problems then the question arises what role would psychiatrists play in the diagnostic process? And, further on, what would happen if psychiatrists disagreed with a patient's interpretation ('diagnosis') of his or her own problems, which is quite common. Would a patient's diagnosis of his or her own mental problems or a psychiatrist's diagnosis of a patient's problems be more legitimate and compelling? And which one would be the basis for ensuing therapeutic procedures?

Postpsychiatrists are short of answers to such questions. They actually do not pose them at all. In line with their downplaying of the role psychiatrists play in the diagnostic process they pose another question. They ask, 'what right do we have to impose on others explanations for their experiences that may conflict with their understanding' (Bracken & Thomas 2005).

This is a key question that – Bracken and Thomas are right – has ramifications for all levels of mental health care. Hence it is worth a closer examination.

First, psychiatrists are expected to have their view of how mental disorders have been generated and what is the preferred kind of the treatment of individual disorders. Although there has been a dominance of the biomedical model in modern times, individual psychiatrists' view of mental disorder has not been uniform. The social and the

psychological model have not lost their legitimacy, and have even dominated in some periods.

Second, except for cases of involuntary hospitalization, psychiatrists do not impose on others explanation for their experiences. They let the patient know what they think about the nature, treatment and prognosis of his or her (pathological) experience.

Third, in a good number of cases patients do not have their own view of where their mental problems came from. (After all, that is why they look for professional assistance.) They can accept or reject the psychiatrist's interpretation, or might be indifferent towards it. If they accept it, and the results of the treatment turns out to be below the patients' expectations, patients are free to seek assistance from another psychiatrist who follows the principles of another psychiatric model. Yet if patients are psychotic, and Bracken and Thomas generally refer to them, the patients' interpretation of their experience is nearly always at odds with the psychiatrists' mainly because the patients' explication of what is going on with them is part of their mental pathology. Most frequently, their mental disorder expresses itself among others in how they interpret their own experience. Therefore, in those cases psychiatrists do have the right to 'impose on others explanations for their experiences that may conflict with their understanding?' The same right *mutatis mutandis* a physician has to impose on a patient an explanation for his or her for example jaundice or bleeding, or impaired sighting that may conflict with the patient's reading of these troubles.

This last assertion however does not hold if psychiatric knowledge is *a priori* considered as invalid, or as valid as lay people's, or as a sort of knowledge that should not be prioritized when compared with mystical, religious, parapsychological and so on explications of service users.

Commenting on the proposal that psychiatric patients and professional equally share the task of developing psychiatric diagnosis Robert L. Spitzer (2005) contends that it is neither practical not necessary, and that it would be a recipe for nosologic disaster.

Treatment: is there such a thing?

Back and Thomas challenge the idea that 'successful mental health work is always best understood as 'treatment'' (Bracken & Thomas 2005). They prefer the term 'mental health work'

which to be good must be based on ‘meaningful relationship between helpers and clients, professionals and patients’. Central to this work is ‘human encounter focused on issues such as hope, trust, dignity, encouragement, making sense, empowerment, empathy and care’.

The truth is that modernist psychiatry acknowledges the importance of these aspects of mental health work but they have been considered as second-rate factors, as postpsychiatrists claim. Yet in postpsychiatrists’ vision they are the real agents of the change for the better.

Postpsychiatrists reject the idea that some biological therapeutic agents work. They actually do work, postpsychiatrists say, but not through cerebral biology. ‘In reality, current psychiatric interventions (biomedical ones, D.K.) are based on the manipulation of meanings, hopes and expectations’ (Bracken & Thomas 2005). Antidepressants produce some beneficial effect largely because there is a wide spread belief that neurotransmitters are responsible for mood (*social milieu*), and because both patient and doctor want antidepressants to work (*therapeutic milieu*).

Postpsychiatrists concede that ‘a substantial proportion of the healing effect of antidepressants is also biological’. However, they claim that physical changes brought about in the body of those taking antidepressants do not occur due to antidepressants but rather due to moral and psychological factors. The healing involved ‘does not start with drug effects on neurotransmitter levels but with the instillation of hope, the mustering of courage and generation of motivation. Any neurotransmitter changes observed are most likely to be secondary to this process’ (Bracken & Thomas 2005).

If a beneficial effect of antidepressants is conditioned by the instillation of hope, the mustering of courage and generation of motivation which then cause neurotransmitter changes, one cannot help wondering does the pharmacological structure and action of antidepressants have anything to do with healing effect of this kind of medication. In fact, it would appear that it is irrelevant which medication a client takes, or whether he or she takes any medication at all. Medications do no matter. Placebo is as beneficial as any drug. The acting principles are hope, courage and motivation. Psychopharmacological knowledge as part of psychiatric knowledge is beyond the point. It does not provide truthful

explanation of why and how taking a drug might be helpful. This is how postpsychiatrists view drug therapy.

Recovery is one of the key notions of psychiatric practice. It is the goal of psychiatric treatment or mental health work. Not so for postpsychiatrists if by recovery a reduction in the number and intensity of symptoms is meant. According to Bracken and Thomas, recovery is what those having voices and unusual beliefs think recovery is. And ‘if you do not believe that you have been suffering from an illness, it is not possible to talk of recovery in the sense of having recovered health after an illness’ (Bracken & Thomas 2005).

Hence psychiatrists are wrong, postpsychiatrists assert, when they define recovery in terms of symptoms resolution because clients do not think that their experiences such as hearing voices and having unusual beliefs should be considered as symptoms. It is small wonder that they do not think so because ‘many people who experience madness challenge the distinctions that are made between experiences that are considered ‘normal’ and those that are considered ‘abnormal’ (Bracken & Thomas 2005).

Normalizing madness is one of the key issues of postpsychiatry. In step with postmodernist insistence on the blurring of boundaries, multiplicity, ambivalence and indeterminacy they allege that ‘those diagnosed as schizophrenic are simply those who present with the most severe expression of traits that are to be found subclinically in the community’ (Bracken & Thomas 2005). They are also broadly in agreement with the argument of the group Mad Pride whose members and proponents embrace madness ‘as a fundamental feature of human life: feature that is sometimes painful and terrifying but also something that can be the source of creative and spiritual insight and renewal’ (Bracken & Thomas 2005).

So, how do postpsychiatrists define recovery? They do it as the survivor movement people do. ‘Recovery involves speaking out, the act of reclaiming language’ (Bracken & Thomas 2005). When those having voices and unusual beliefs (meaning delusions) are not silenced by modern-day psychiatry treatment, they can make themselves heard, and can tell their own stories. That is what recovery is all about.

In order to support their own view Bracken and Philip cite Rufus May (2004) who distinguishes three forms of recovery: social recovery (re-establishing old and developing new valued social relationships), psychological recovery (integrating the experiences of psychosis back into one's life, developing ways of coping with psychosis and distress, and establishing meanings and understandings of the experiences of psychosis) and clinical recovery. The point is that social and psychological recovery is independent of clinical recovery, and 'that recovery without professional help is perfectly feasible' (Bracken & Thomas 2005).

The underlining assertion is that symptoms resolution is not a prerequisite, let alone an integral part of a psychotic person's re-establishing old and new valued social relationships and of his or her psychological recovery. Moreover, one can be socially and psychologically recovered without having his or her symptoms reduced or vanished.

And that is another point postpsychiatrists want to make as far as treatment and recovery are concerned. Some people, they claim, who have psychotic experiences and who meet the criteria for psychosis accept those experiences, are comfortable with them and live their lives alongside them without difficulty (Bracken & Thomas 2005). So, what is the point of treating them? What should their recovery be like? Professional assistance is the last thing they need, indeed.

There is no doubt that a very tiny proportion of those who have psychotic experiences are comfortable with them. Notwithstanding, the number of psychotic people who do not disturb the social life in the micro milieu they live in is so negligible that it cannot be the basis for any inference about whether such people need or do not need professional help. In so far as psychotic people live their psychotic experiences they sooner rather than later trigger people's hostile reaction, which in turn causes (additional) suffering of those having the psychosis.

Conclusion

It is debatable first, whether all or most of the critical issues of contemporary psychiatry might be accounted for by the assumptions and ramification of the modern mind, and second, whether the said principles of the postmodern mind characterize today's world.

However, one thing is for sure, the undermining of key medicine-related aspects of psychiatry, as done by postpsychiatry, is not in the best interest of patients.

Psychiatrists have allowed the biopsychosocial model to become the bio-bio-bio model (Sharfstein 2005). This does not serve the best interests of patient, either. In so far the postpsychiatric criticism of the dominance of the biomedical model is well placed. As is postpsychiatrists' insistence on the need for greater involvement of (former) patients, paraprofessionals and other professionals in the care of the mentally ill people. However, psychiatrists as the protagonists of the biomedical model should not be sidelined in a comprehensive mental health care because it is hard to imagine psychiatry – no matter what prefix it has – without specific psychiatric knowledge.

The imperfections of the medical mind cannot be underestimated. Nor can the negative consequences of its claim to be the only legitimate psychiatric paradigm. However, psychiatry cannot do without the medical mind. Otherwise, psychiatrists run the risk of throwing out the baby with the bathwater. That is what postpsychiatrists have done. Jakovljevic (2007) rightly noted that, in psychiatry, the pluralistic and integrationist approaches are the most promising ones.

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