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ANTIPSYCHIATRY AS THE STIGMA

Izet Pajević & Mevludin Hasanović

Department of Psychiatry University Clinical Center Tuzla, School of Medicine University of Tuzla, Tuzla, Bosnia and Herzegovina

SUMMARY

The authors presents their perspectives on the relationship between antipsychiatry and the stigma of mental illness. The present paper aims to provide a short review of the basic principles of the antipsychiatric movement, and to discuss the atitudes of its most important theorists. The authors searched recent literature, as well as drawing upon some of the basic antipsychiatric texts. Antipsychiatry dates from 18th century, and as an international movement it emerged during the 1960s as part of the historic tumult of the period rather than as a result of the evolution of scientific ideas. During that period psychiatrists began to see heredity as the cause of mental illness, became pessimistic about restoring patients to sanity, and adopted essentially a custodial approach to care that included use of physical restraints. Radical attitudes of antipsychiatry gave a significant incentive to review psychiatric theory and practice, especially with protecting the rights of mental patients and giving importance not only to somatic, but mental, social and spiritual sides of human existence. But, at the same time, they led to unwarranted attacks on psychiatry as a medical discipline, encouraged different views of its stigmatization and in a certain measure affected the weakening of social awareness about the importance of medical and institutional care for the mentally ill persons. After the 1970s, the antipsychiatry movement became increasingly less influential, due in particular to the rejection of its politicized and reductionistic understanding of psychiatry.

Key words: *antipsichiatry – psychiatry - stigma*

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Introduction

Stigma has existed at least from biblical times, when insanity as demonic possession and punishment for wrong doings became codified in religious belief and practice. The antipsychiatry movement dates from the 18th century, when psychiatry appeared as a medical specialty and the first mental hospitals were established. Over the time psychiatry has been a bull's eye for anti-psychiatry groups competing for influence or authority over the mentally ill persons. During the various periods these groups have included neurologists, social workers, new religions, consumers, and psychiatrists themselves. Antipsychiatrists radically opposed what they understood as a hospital-centered medical specialty legally empowered to treat and institutionalize mentally disordered individuals (Berlim et al. 2003). During the last decades of the 19th century, the ways how hospitalized mentally ill patients were treated, increased the stigma of mental illness and provided fuel for the anti-psychiatry movement (Dain 1994). Indeed, many anti-psychiatrists argued against the very existence of mental disorders themselves (Berlim, Fleck & Shorter 2003).

During the sixties and seventies of the 20th century, radical antipsychiatry movement developed psychological thought connected with the names of philosophers Michel Foucault (1926-1984) in France, psychiatrists Ronald Laing (1927-1989) in England, Thomas S. Szasz (1920-2012) in the United States of America (USA), Franco Basaglia in Italy (1924-1980) and David Cooper (1931-1986) from South Africa.

Discussing with the classical psychiatry, anti-psychiatry has overemphasized its own basic starting points (Makushkin, Oskolkova & Fastovtsov 2017).

Radical antipsychiatry over several decades has changed from an antiestablishment campus-based movement to a patient-based consumerist movement. The antecedents of the movement are traced to a crisis in self-conception between biological and psychoanalytic psychiatry occurring during a decade characterized by other radical movements (Rissmiller & Rissmiller 2006).

The overemphasis of some attitudes has damaged antipsychiatry itself, as the feedback in some theoretical regards; but it is undisputed that this movement has significantly contributed to the revision of attitudes towards the phenomenon of mental illness, but also has become the source of different aspects of additional stigmatization towards psychiatry.

A brief insight on the history of understanding mental illness

In the pre-psychiatric era, the views on human and his/her mental life were in compliance with religious understanding of the world, so the character traits, personality traits and lifestyle habits, relationship with self, with others, with social norms and nature were important guidelines if the individual and in what measure was mentally or spiritually healthy and in which he/she was ill.

Soul – Psyche was understood as the divine essence that manifested through corporeality, using it's organs for achieving own goals and intentions. It has four basic abilities at disposal, which are, if properly directed; give four basic ethical virtues – character traits:

- ability of intellect – wisdom
- ability of anger – courage

- ability of passion – nobility
- ability of imagination – righteousness.

In the psychiatric era, the view on human individual and his/her mental life went towards finding biological foundation in mental processes, character traits, personality traits, lifestyles habits, etc., therefore to make the somatic state the basic entry on mental health and mental illness.

The father of American psychiatry, Benjamin Rush (1746-1813) has pointed this out in 1774, stating: „Maybe humanity will be saved from vices by doctors in the time that is coming, like priests are doing today“. This statement was commented by Thomas Szasz: „To distinguish himself from the doctor of divinity, the doctor of medicine could not simply claim that he was protecting people from sin, or vice as Rush put it. Badness remained, after all, a moral concept. As medical scientist, the physician had to claim that badness was madness, that his object of study was not the immaterial soul or "will", but a material object, a *bodily disease*. That is precisely what Rush did. His following assertions illustrate that he did not *discover* that certain behaviours are diseases, he *decreed* that they are: "Lying is a corporeal disease. / Suicide is madness. / Chagrin, shame, fear, terror, anger, unfit(ness) for legal acts, are transient madness." Today, some of these and many other unwanted human behaviours are widely accepted as real diseases, their existence ostensibly supported by scientific discoveries (Szasz 2001).

How did this process flow?

With the secularization of science and the development of psychiatry as a medical discipline and of psychology as a science, the term of spiritual was left to religion and religious sciences; and the term of mental was firstly stripped of its supernatural dimension (the principle that connect a human to God) hence its meaning was reduced to mental processes and mental traits.

„The Philosophers Stone“(the inability to differentiate between „good“ and „evil“) has been lost. The system of values „good" – „evil“ and the human moral responsibility was abandoned. The concepts of human soul and sin are replaced by images of human consciousness, and psycho- and socio-pathology. The lack of individual morality is seen not as a personal shortcoming that should be improved upon by the process of repentance, but as a product of inadequacy in processes in which people may be socialized.

The dogma of „*mental illnesses are the illnesses of the brain*“ is being pushed to the foreground. It gave the incentive to the development of neuroscience and biological psychiatry, but the conviction that *if the neurobiology of the brain is acquainted correctly*, then the mental life and its disorders will be familiarized with, was imposed.

The achievements and limits of psychiatry

As an offspring of secular society based upon materialistic worldview, psychiatry took upon itself a too heavy burden:

- To answer on many existential questions related to human as a psychical, social and spiritual being.
- To take care of the spiritual side of human life.
- To help human individual in solving everyday life problems, hardships, stressful situations.
- To explain mental illnesses and find methods of their treatment that will produce expected results.

In that way, psychiatry was supposed to take on a pastoral role of religion by relying on modern psychological and social theories, which objectively was not possible if we have in mind the three key functions of religion that Sigmund Freud himself pointed out and said: „If we want to perceive the magnificent essence of religion, we must have in mind what does it provide to humans: 1. it explains the origin and the creation of the World, 2. gives them protection and a final joy in all changes in life, and 3. it manages their thoughts and actions using guidelines that it represents with all its authority“ (Freud 1979).

In the context of biological orientation and the need to attain the status of a medical discipline for itself based on the foundations of natural science and social role that was meant for it in secular society, to take gradually over the pastoral role of religion, psychiatry could not fulfill those unreal expectations of both psychiatrists and other mental health professionals, also of the patients and society as a whole.

Antipsychiatry as a surrogate of psychiatric introspection

Through that disproportion between social expectations and objective capabilities of psychiatry, the antipsychiatric movement of the sixties should be observed as a surrogate of critical introspection of many important questions in and around psychiatry. Those ideas that were accepted as „revolutionary“ in that time by non-psychiatry circles, can look naive and outdated in the circles of psychiatrists who are immersed in their practices today. But, they should be looked upon as a still living source of additional stigmatization of psychiatry, psychiatrists and psychiatric illnesses from which they are preliminary powered, followers of antipsychiatric movement among wich can be recognized:

- Psychiatrists that were disappointed in psychiatry from subjective reasons;
- Non-medically educated professionals for mental health;
- Semi-professionals;
- Different categories of those that did not get what they expected from psychiatry;

- Psychiatric patients that were dissatisfied with the treatment that was given to them by a psychiatrists;
- Socially and morally deviant persons that don't want to set any boundaries between mentally healthy and mentally ill.

That can best be illustrated by questioning the basic „dogmas" of antypsichiatric movement gurus:

Michel Foucault: "Today, lunatics are social outcasts" (Foucault 2006).

Ronald David Laing: "Lunacy is a meaningful act; it is a search for authenticity" (Laing 1990). Thomas Szasz: "Mental illness is a myth, it does not exist" (Szast 2011).

Antypsichiatryc „dogmas"

We can observe those „dogmas" like misconceptions that have got no foundations if actual reality if we expose them enough, but the others are like key guidelines for all those „critics" that insufficiently know and understand psychiatry but would like to give their judgment on what psychiatrists do, mostly based on subjective, negative emotionally charged attitudes which should not be given much attention so they do not require fighting against stigmatization in psychiatry and mental health.

According to Michel Foucault, the diagnosis of lunacy is a vile type of social labeling that creates a category of people planned for scapegoats. Today, the so-called lunatics are social outcasts, similar to what leprosy patients were in the middle ages. Psychiatry cannot adequately diagnose them and treat them, given the fact that psychiatry itself is involved in their labeling and segregation (Foucault 2006).

Laing and Szasz have taken over this conspiracy theory, especially regarding to diagnosing and treating of schizophrenia. According to them, such a labeled illness isn't exclusively a trait of an individual who has recurring symptoms, but equally of his family and social environment (Laing 1990, Szasz 2011).

Ronald David Laing, (anti)psychiatrist, psychoanalysist, „guru", poet, philosopher and mystic

His fundamental thesis was that *the sane one is the only one who opposes general alienation with lunacy,* who chooses *the path of madness in search of authenticity.*

The second basic thesis: "*It is possible to understand the meaning that is the dynamics of the formation of what psychiatrists perceive as delusion, madness, and psychosis of a patient.*"

The second thesis is logically associated with the first in such a measure in which "*the departure for lunacy is treated as a meaningful act*" (Laing 1990).

Laing's first encounter with psychiatric practice was in Glasgow hospital where he met with the examples of that which he deemed as dehumanization of human. Attending to everyday „routine" lobotomy procedures, insulin comas and electroshock treatments, Laing concludes that something isn't right with his profession. The decision to continue his studies with Karl Theodor Jaspers (1883-1969) in Basel is interrupted by his mandatory military service transfer as a psychiatrist (1951-1953) (Gavin 2004).

Laing did his first "trip" in 1960, he smoked his first joint and experienced the vastness of hallucinogens, psilocybin and mescaline. LSD is a drug that occupied him and for which he got permission to use for therapeutic purposes. That practice gained a reputation for being mystical, mostly thanks to using LSD in therapy purposes (Beveridge 2011).

Even though the title of his vital work is „Divided Self", (finished in 1957, and published in 1960), was inspired by the eighth chapter of the book „The Varieties of Religious Experiences" (1902) of William James (1842-1910), it is evident that Ronald Laing experimented with hallucinogens in search for „authenticity". He was a mystic without spiritual orientation. From his ideas that served as a basis to patrons of antipsychiatry, it is evident that (at least in that time) he did not know spiritual, religious and mystic traditions and teachings of the east and west, so he could not clearly perceive the spiritual dimension of human, the confines in which it must be situated and its role in the entire structure of psychological functioning (Laing 1990, 1985).

In an effort to find the significance in psycho-pathological content, Laing tried to bridge the gap between mental illness and mental health by giving it dimensions that are, before all, unique to common sense and spiritual (mystical) conversion (Laing 1985).

That postulate is incorrect because mental illness is a disintegrative process in its roots whose base is preoccupation of the unconscious contents that evade conscious control, which in a large amount disrupt and disable the realization of spiritual potentials of a human. In the other hand religiosity is an integrative process that moves forward the conscious binding to transcendent contents, with which a spiritual experience of higher levels of consciousness is achieved that mankind cherishes since its inception.

Also that postulate is not correct even by definition, because:

- *BELIEVING* is a willful and completely conscious decision of an individual to accept a specific idea or a set of ideological beliefs (Mental illness is not chosen!).
- *FAITH* engages the entire personality on a much larger scale and influences all the aspects of an individual's life. Faith provides boundaries within which a person builds their own life (Mental illness is the exit from those frameworks).
- *RELIGION* represents a cumulative tradition of rituals, beliefs and cultural norms of a people (Mental health is individually conditioned and does not represent that!) (Table 1).

Table 1. Pajević (2010) gave basic characteristics of schizophrenia in opposition to mystical experience

Shizoprenia experience	Mistical experience
unpleasant and painful	pleasant and ecstatic
unwanted	desirable
imposed	freely elected
it splits	combines
eradicates from reality	dives into reality
feeling divided	a feeling of unity
narrowing own world	expanding of own world
thoughts dissociation	concentration of thoughts
emotional impoverishment	emotional enrichment
experience alienated of self	experience of true self

Thomas Szasz thinks that illnesses are only the disorders that have a clearly identified organic-biological etiology. Since those states that are called mental disorders have no confirmed organic-pathological basis, it cannot be talked about mental disorders or mental illnesses. „Mental Disorder is a Myth“ – such is the title of Szasz's book, written in 1961.

- The term „mental disorder“ or „mental illness“ is used to legally apply pressure measures on people who are social dissidents.
- Mental disorder or illness would be a moral, and not a medical category.
- Mental disorders do not exist because no one else has discovered such an illness, but because *any one cannot find such an illness:* the only type of illness that medical researchers can find is a somatic illness (Szatz 2011).

Consequences

However, recent advances in biological treatments have undercut antipsychiatry and rekindled optimism about recovery that may go far in eliminating stigma (Dain 1994).

With reference to the results of a significant number of works, Read and Haslam claim that believing in exclusive or primary biological origin of mental disorder *amplifies* the stigma of mental disorder (Read & Haslam 2004).

With the belief in the biological origin of mental disorder, the thought that not only is the belief that mental disorder is invariable and the individual who is mentally ill cannot do a thing to improve his/her condition, but also that mentally ill people are biologically different, as though they are a special species of humans, which again has a stronger dissociation effect from those people, their marginalization and discrimination as a consequence.

The results of most recent researches about the influence of the apprehension that major depression and alcoholism are of neurobiological origin on the stigmatizing attitude of people with mental disorders also show that the ones who believe that these serious mental disorders are conditioned by neurobiological factors are more prone to stigmatize people with the disorders stated above from those who don't share their opinion about the origin of major depression and alcoholism (Pescosolido et al. 2010).

And in terms of stigma, the evidence consistently finds that it is the idea that mental illness is like any other illness that is most likely to lead to stigma (Angermeyer et al. 2011) and so to more potential pain and suffering for patients (Timimi et al. 2014).

Antipsychiatrists championed the concept that personal reality and freedom were independent of any definition of normalcy that organized psychiatry tried to impose. The original antipsychiatry movement made major contributions but also had significant weaknesses that ultimately undermined it. Today, antipsychiatry adherents have a broader base and no longer focus on dismantling organized psychiatry but look to promote radical consumerist reform (Rissmiller & Rissmiller 2006).

After his atempt to answer on the question: „The antipsychiatry movement: dead, diminishing, or developing?“ Whitley (2012) concluded that a renewed yet amorphous critique of psychiatry is emerging, even though the tarnished name of antipsychiatry is studiously avoided by all. This critique may intensify, given the likely media and public interest surrounding the recentla released of DSM-5.

Conclusions

Radical attitudes of antipsychiatry gave a significant incentive to review psychiatric theory and practice, especially with protecting the rights of mental patients and giving importance not only to somatic, but mental, social and spiritual sides of human existence.

But, at the same time, they led to unwarranted attacks on psychiatry as a medical discipline, encouraged different views of its stigmatization and in a certain measure affected the weakening of social awareness about the importance of medical and institutional care for the mentally ill persons.

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Izet Pajević: design of the article, drafting the article, review of literature, revising it critically for important intellectual content;

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Correspondence:
Izet Pajević, MD, PhD
Department of Psychiatry, University Clinical Center Tuzla
Rate Dugonjića b.b., 75000 Tuzla, Bosnia and Herzegovina
E-mail: pajevic.izet@gmail.com