

Duncan Double is a consultant psychiatrist working in a community mental health team. He also maintains the critical psychiatry website [www.anti-psychiatry.co.uk](http://www.anti-psychiatry.co.uk). In 2000 he was temporarily suspended by his NHS Trust because of his views on psychiatry and told that his practice was a "clinical risk".

# THE ACCEPTABLE LINE

A GP who refers patients to my service recently had time to study my views on critical psychiatry. He concluded that they are not compatible with effective teamwork in a community psychiatric service.

This piece is written to explain why this GP is mistaken. It's not a comprehensive rebuttal, more of a look at what it is like for me as a critical psychiatrist in the modern NHS.

Conflicts like this have not made my professional life easy, notwithstanding that good medical practice requires doctors to respect colleagues and not allow personal views to affect professional relationships unduly.

## THE CRITICAL PSYCHIATRY NETWORK

The Critical Psychiatry Network, formed in 1999, has brought together psychiatrists who are prepared to challenge the stranglehold of a biomedical approach within the psychiatric profession. I have never had enough faith to believe that brain pathology is the basis for mental illness. Of course, I am not saying that mind and brain are separate. What is important is understanding the patient as a person. Reducing someone's problems to a brain abnormality avoids that meaning.

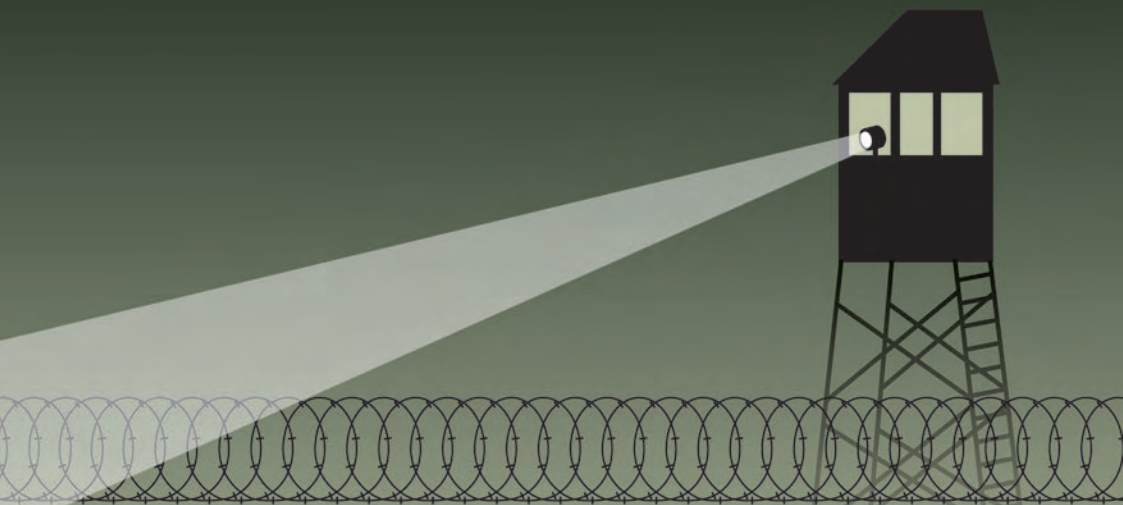
Nor am I saying that I do not use psychotropic medication. However, I am sceptical about its benefits and think that the evidence for its effectiveness is generally overstated and biased.

I therefore welcomed joining other psychiatrists that share these views in the Network. My involvement with the group led to the publication last year of my book *Critical Psychiatry: The Limits of Madness*.

## WHY DISHARMONY?

Why should the views of the Network cause misunderstanding and antagonism? The answer lies in the history of what has been called 'anti-psychiatry'. Certainly David Cooper, who coined the label anti-psychiatry, had his excesses, if only because he could not exclude sexual relations from therapy. Nor do I agree completely with Thomas Szasz, who is also seen as part of anti-psychiatry, even though he personally dissociates himself from the term. Szasz goes too far, to my mind, in arguing that society can manage without any mental health law.

Despite this immoderation, anti-psychiatry was correct to point to the peculiar tendency in psychiatric practice to reduce personal problems to brain pathology. Psychiatric intervention does



# UNITS OF PSYCHIATRY

not need to be justified by this prejudice. The attack by anti-psychiatry on the use of psychiatric diagnosis, drug and ECT treatment and involuntary hospitalisation created an inappropriate defensiveness in mainstream psychiatry. Opinions have tended to retrench into a dominant biomedical perspective. Hence the kind of remark by the GP with which I started this article.

The dominant biomedical view has been reinforced by claims that research has advanced understanding of the biological basis of mental illness, its genetic origins and the mechanisms of psychotropic medications. However, rarely does this research give more than indications and certainly not proof of such assertions.

## A NEW SYNTHESIS

What is needed is more openness about these issues. This is the sense in which psychiatry needs to be critical. It needs to be prepared to reflect on its own practice. The power and prestige of psychiatry needs to be justified. I think this seems reasonable, but it can lead to attacks. Indeed, my medical director has described my views as “outside the acceptable limits of psychiatry”.

Nonetheless, in my everyday work with colleagues,

any differences do not generally cause problems. After all, I am not trying to abolish psychiatry. My intention is to improve services.

I think critical psychiatry does need to be clearer about how it differs from mainstream psychiatry. Patients do want understanding and they may feel they need a diagnosis to explain their condition. There is nothing wrong with simple diagnostic labels if they fit. However, in practice, assessment is broader than this and it is rarely possible to be sure about the origins of personal problems. This should not prevent us from helping patients create their own understanding.

As far as treatment is concerned, social support and personal therapy may be beneficial. Medication has its place, but prescribing should not be beyond the evidence. The power of placebo needs to be recognised, if only because of the risk of discontinuation problems, which doctors have been slow to recognise.

Psychiatric practice is not easy to sustain. We need to make the most of therapeutic opportunities. There will be disagreements but we need to work together to improve modern mental health practice.

[www.criticalpsychiatry.co.uk](http://www.criticalpsychiatry.co.uk)