DIFFERING APPROACHES TO PSYCHIATRY

Background

Until 1930, the mental health services were organised to meet the need for custodial care and people were admitted to mental hospitals if certified insane. The Mental Treatment Act, 1930, opened these hospitals to patients on a voluntary basis. Just before World War II, the introduction of electro-convulsive therapy and the now discredited insulin coma treatment for schizophrenics, paved the way for recognition of psychiatry as a specialty on a par with other branches of medicine.

Since around 1945, there have been major changes in the practice of hospital psychiatry which have had far-reaching consequences both for the mentally ill and for the psychiatric health professions.

A number of inter-related factors have contributed:-

1. Experience in the treatment of war neuroses led to liberalised conceptions as to what causes and constitutes mental disorders. This led to the opening of the first neurosis centres in the health service.

2. The introduction of major tranquilisers in 1952, and the subsequent increase in, and sophistication of drug control, have enabled the traditional, custodial hospitals to unlock their doors and discharge many patients into the community.

3. A growing realisation of the enormous cost involved in maintaining a permanent resident population in mental hospitals.

4. The development of out-patients and day care services made possible new concepts of community care.

5. Dr. George Bell had already proved to the public, in the 1940s, that mentally ill patients were capable of mixing freely in the community. His successor, Dr. Maxwell Jones, as physician superintendent in the 1960s saw that it was also time that staff moved into the community as well, and thus, Dingleton Hospital in Scotland, became an early pioneer of community psychiatry.

6. An ideology of the therapeutic community was spreading, and with it the awareness of what Dr. Russell Barton called 'institutional neurosis', (a condition of chronic passivity caused by de-personalisation due to the structure and organisation of the hospital as a 'total institution'). This further reinforced the notions emerging that the emphasis in psychia should change from long term institutional care, to the investigation and early treatment of mental illness and discharge back into the community as soon as possible.

Positivistic Method and the Medical Model

The 1959 Mental Health Act embodied the idea that mental illness was comparable to physical illness and came within the medical orbit, i.e. the medical model of physical pathology was equally applicable to psychopathology.

A bald statement of the medical or clinical model, might go something as follows:-

> People are healthy until they fall ill. Illness is caused by a disease which is usually an invasion of the body by a poison or a germ or an accident. Ill people go to doctors who study their signs and symptoms

and diagnose the disease. They then apply treatment, medications, surgery, or special regimes which cure the disease, mend the injury, drive out the poison or kill the germs. Some illnesses can be cured at home, but for some it is necessary to go into hospital. There the doctors carry out their tests and later their treatment while the nurses provide care, make the patients comfortable and carry out the doctors' orders. Hospitals are basically places in which patients are cured by the doctors' skill and cared for by the nurses' compassion.

This model is established, and since the 1930s, many psychiatrists laboured diligently to make their hospitals as much like general hospitals as possible.

The medical model is a logical consequence of a major component of Western thought, which is logic. Ideas of the 'rational' led to 'scientific method'. The latter is that system of thought that is embodied in the introduction to the typical high school text book. It claims that by building up facts that are scientifically repeatable, we can arrive at a theory that will then predict further events. Critics of positivist or scientific method claim that this empiricism destroys the validity of human sensory experience, translating real phenomena into scientific categories. Certain theories become enthroned and are considered unchallengable, and this empirical view of the world is put into a position of absolute truth. It claims that science is value-free, without social ethical or political bias.

David Clark, himself a psychiatrist, suggests that one of the greatest defects of the medical model is that it takes no account of people's feelings. The patient is seen as entirely passive - his only function in the whole process is to provide the body which is to be diagnosed, treated and cured. Vital to the medical model is the fact that medicine is judged to be morally neutral.

The medical, or clinical model of illness, mental and physical, is, therefore, inextricably linked to the positivist method used in scientific endeavour - its findings are assumed to be neutral truths.

The Anti-psychiatry movement.

'Anti-psychiatry' gathered momentum in the 1960s against a background of economic expansion, which coincided with the rise of various liberation movements, and a heightened concern with the more negative values of Western civilisation.

The positivist framework within which medicine as well as other disciplines operated, underwent a hammering.

Thomas Szasz, a professor of psychiatry, defined the inappropriateness of the medical model thus:-

The enthusiasm for bringing psychiatry into line with other medical specialties has led to an insistence on classifications of disease and an emphasis on the control of symptoms rather than considerations of the whole person. Szasz' basic stance is that mental illness is a myth - a moral and political con-game. Problems of human conduct have a moral and political character which is masked by psychiatric labels; medical terminology is quite inappropriate in the sphere of human conduct. Psychiatry restricts the human freedom to confront and resolve where possible, moral and political problems. It is quite difficult to understand Szasz' arguments unless you put them into the context of his own

conservative and laissez-faire philosophy. He is vehemently opposed to the development of a national health service in the USA and his views reflect his deeply American traditionalist background of independence, self-improvement and stern disapproval of personal failure. Peter Sedgwick likens Szasz to the 19th century philosopher, Herbert Spencer, who advocated "negative beneficience" i.e. letting the weak go to the wall; this form of social Darwinism was a notion of some force in the era of Victorian industrialism, and Szasz' philosophy of neglect for psychiatric disability by denying that it needs medical attention, is akin to it.

Another psychiatrist, R.D. Laing, in his critique of traditional psychiatry, gave credibility - an inner rationality - to schizophrenic behaviour. His basic theme was that the requirements of normality, conformity and reasonableness, i.e. mental health, are a suffocation which stifles, blocks, and distorts the expression of a fully human consciousness. So, in these existential terms, people who 'break down' or 'break up' might also be involved in a breakthrough to a different and more complete experience of the self. Mental illness, Laing has argued, is one way in which men and women disengage from the taken-for-granted routines of everyday life and undergo a disturbing self-reflection.

Laing wrote further and more specific work on schizophrenia and the family for which perhaps he is more noted. The basic theme is something as follows:-

> Most people who are called mad and who are socially victimised by virtue of that attribution, come from family situations in which there is desparate need to find some scapegoat, someone who will consent at a certain point of intensity in the whole transaction of the family group, to take on the disturbance of each of the others, and, in some sense, suffer for them. In this way, the scapegoated person would become a disease object in the family system, and the family system would involve medical accomplices in its machinations. The doctors would be used to att ach the label 'schizophrenia' to the diseased object and then systematically set about destroying that object by the physical and social processes that are termed psychiatric treatment.

Another seminal writer during this era was Michel Foucault. In 'Madness and Civilisation' written in 1967, he suggested how the successive concepts of madnes in the last 400 years of European history paralleled and reflected the successive conceptions of reason. There is a relationship, Foucault argues, between the current ethos and the handling of the insane. His central theme is that conceptions and practices regarding insanity are intimately related to, and influence, contemporary sensibilities concerning reason and rationality, i.e. psychopathology is not independent of social history, for each age has drawn the split between madness and reason at a different point and in a fundamentally different fashion.

THE SOCIOLOGICAL CONTRIBUTION

Laing and Szasz were representatives, in their different ways, of the existential-phenomenological school in social psychology, which had developed as a counter to positivism. During the same time sociological research had been demonstrating an association between mental illness and such factors as social class, residential mobility, family dynamics, gender, and hospital social structure As a result it is now commonly recognised that the environoment, be it immediate or on a wider scale, does play a significant role in shaping the characteristics and the course of mental illness. However, this, as well as the traditional psychiatric perspective still left unquestioned the assumption that the defect or illness is located somewhere in the makeup of the individual. Some sociologists moved to approaching the phenomenon of mental disorder by focussing on the larger and more general context of deviant behaviour and on the process by which an individual comes to be identified as deviant. Within the sociology of deviancy it is possible to delineate two major schools of thought:-

functionalism and symbolic-interactionism.

The functionalist view would regard mental illness largely as a by-product of social disorganisation and in so doing concentrate on problems posed by violation of norms for the continuity and equilibrium of social systems.

A basic tenet of symbolic interactionism is that personality is generated through interaction, and consists of self/other systems. Thus, the interactionist approach is inclined to view deviancy as an outgrowth of interpersonal processes and is concerned primarily with effects on the individual and his associates.

Erving Goffman was an influential theorist in the interactionist school. He described certain stages involved in the labelling process. In 'Asylums' Goffman suggests that labelling a person psychotic could be a self-fulfilling prophecy in a mental hospital. After a person had lost his clothes, his hair-style, even his own teeth, he became confused and disorientated. When he was treated like a child, and was refused any responsibility or control over his life, he regressed and became childish. If he was locked up, or abused in some way, he often became violently disturbed . Goffman suggested that the medical role had been developed to fit a physician operating in open society, but that this role creates specific problems where the doctor is in command of highly organised institution where obedience can be enforced - hence Goffman's concept of the 'total institution'. He pointed out that institutions which provide for all the needs of the people in them, develop certain characteristics. His examples were jails, monasteries, boarding schools and mental hospitals. He contrasted these with other institutions like factories, workshops, day schools, and police forces, where the members are only in the organisation for part of their day and do not have to accept its government over every item of their lives; the inevitable characteristics that develop within total institutions are:- stripping routines on entry to remove civilian identity, special rules, regulation and laws to cover activities normally free in the outside world such as eating, shaving, defecating, etc. also special jargon, and so on. These characteristic as well as being inevitable, produce people - patients and staff - who become less and less capable of facing the outside world.

In the late 1960s, Rosenham's now classic sociological 'pseudopatient' study further added to the growing case against traditional psychiatry; it exposed the myth of scientific/medical diagnosis. Published in 1973 in the prestigous review 'Science', entitled 'On Being Sane in Insance Places' it commanded an instant blaze of attention through its report that psychologically normal investigators (David Rosenham and his colleagues) who presented themselves at various mental hospital admission desks with a claim to one single (and entirely fabricated) psychotic symptom, were promptly committed to in-patient care for periods of between 7 and 52 days, even though they never subsequently

provided their medical assessors with either that particular sign or with any other evidence of a deluded psychopathology. The staff did not notice; in some cases a few patients did.

It is perhaps helpful at this point to view the various sociological imputs as divided into two categories; external theories and immanent theories – these are Peter Sedgwick's terms.

External sociological works analyse pathalogical 'givens' and this includes epidemiological studies and the functionalist approach to social problems.

Immanentist critiques view mental illness as a social construct. This latter is obviously not a coherent body of thought (neither is the former) as it includes sociological (interactionist) approaches to mental illness -as-deviant-behaviour, as well as the existential-phenomenological social psychology of Laing and Szasz and others. Many immanentist critics differ. For example Laing's views were confined to schizophrenia – Goffman is a micro-sociologist, not concerned with wider macro-structures of society, Szasz believes in an anti-collective individualism. However, all immanent theorists represent a consistent and convergent tendency of opposition directed against positivist method in the study of abnormal human behaviour. To that end they and other colleagues made their mark, and it is to their permanent credit that they have exposed the inadequacies of the traditional psychiatric perspective with its use and implicit acceptance of the medical model.

Under the external theories come epidemiological studies. Statistics showing differentials via socio-economic status are an impressive demonstration that different rates of illness and premature death are but part of a much bigger pattern of inequality.

But, an essential weakness in the large-scale surveys which produce epidemiological findings, is that there is enormous difficulty involved in trying to collect accurate and unbiased accounts of anything complex or of emotional depth.

George Brown and Tirril Harris feel that the survey approach has potential but its promise has not been fulfilled. For example, a sizeable association between social class background and psychiatric disorger might be shown in a survey study, but it gives no understanding of the reason for the correlation – the process by which the correlation has been brought about. Sociological research of the epidemiological kind have so far failed to fully link, in a testable way, broad social categories (eg. social class, gender) and problematic phenomena (eg. mental disorder) although such research has established such correlations. A good example, although not specifically about mental health and illness is 'Inequalities in Health' – the Black Report (HMSO 1980). A Penguin edition 1982 by the same title, is a slimmed down version of the Report by Peter Townsend and Nick Davidson.

Brown and Harris in 1978 attempted to move beyond getting stuck at the stage of establishing correlations, by concentrating on demonstrating that there is a link between clinical depression and a women's daily experience, in the belief that once this is done, we will then be in a stronger position to sort out the intricate links with wider structures.

The authors' strength is that they show the present is generally more instrumental than the past in causing depression. They found that depression was brought about by severe 'Life Events' – incidents in a person's life which produce great change. (eg a husband's unemployment) or by major difficulties which continued for at least two years, like overcrowded or damp housing. These factors were held to be Provoking Agents, but they were hypothesised to only have an aetiological role in depression if the women also experienced Vulnerability Factors:- these were:-

1) Lack of an intimate and confiding relationship with spouse or similar.
2) Women who lost their Mother before age 11 years.
3) Having 3 or more children under 14 years of age living at home.
4) Lack of an outside job seems to lower resistance to depression.

The reason these factors should make a women especially susceptible, Brown and Harris suggest, is that the feature they all have in common is that all four contribute to the lowering of self-esteem. Women who have a high sense of self worth are more likely to weather it with self respect intact. This might explain why only one-fifth of the women researched, all of whom had the pre-requisite provoking agent, actually got depressed. The other four-fifths did not break down.

There remains one important and ongoing criticism of Brown and Harris' work, despite the fact that it undoubtedly is of major importance. The authors elected to study clinical depression as diagnosed by psychiatrists. They are not interested in the minds of the depressed, or depression as a single manifestation of some more general malaise, say Celia Davies and Sheila Roche. In other words they adopt an essentially clinical definition of depression. This could be seen as sociology in medicine, but not sociology of medicine. But, Brown and Harris claim that by using ready made diagnostic categories, it in no way precludes one from advancing new aetiological ideas. Sociologists can work, they claim, with medical categories without losing their independent perspective. The main task is to arrive at a decision on the phenomenon to be explained and to get on with the job. Davies & Roche however, say that this approach has certain consequences. Depression remains an entity, they say, something people 'have' and 'present with' and by necessity it has an ontological status apart from the individual - for how else could it be conceived as an element within a causal model ? Where then is sociology's de-mystifying role ? Where is the opportunity for new insights, Davies and Roche continue, which so often comes from questioning and contesting the conventional formulation of problems and denying conventional forms of conceptual bondage.

Here then, we come round to similar questions being asked during the rise of the anti-psychiatry movement. The separation between external and immanent theorists still continues. The two strands remain either apart or become circular.

Peter Sedgwick suggests a move away from this impasse by advocating an integrated theory of illness. The immanentists' dismissal of clinical positivism in psychiatry is founded on a contrast with non- psychiatric medicine. Physical medicine belongs to the world of fact and the natural sciences, whereas psychiatry belongs to the world of value, ethical judgements on behaviour and covert social and political control. An integrated theory of all illness has one singular advantage over separate mental/physical perspectives. An integrated theory if not beset by the kind of crises we now have in psycho-pathology and psychiatry, whose conceptual and moral foundations have been successfully criticised now that illness has acquired a technical-physical definition excluding disorders of the whole person from its purview. With the integrated concept of illness we are dealing with the whole embodied individual but the medical technology of the 19th and 20th century has succeeded in classifyi illnesses as particular states of the body only. Hence, the growing popularity of holistic medicine, eg. acupuncture and the unitary-materialist systems of healing stemming from India. i.e. those systems which do not split the therapeutic enterprise into a collection of specialisms dealing in different body pa rts, and further segments allocated to the mind and the emotions.

Because of this process of segmentation and objectification psychiatry is left with two seeming alternatives.

1) Positivist - personal, psychological and emotional disorders are really

states of the body, objective features of the brain tissue, the genes, etc.

2) A continuing anti-psychiatry movement, which denies the positivist stance, and logically results in psychiatry becoming more and more analogous to value-laden and non-medical disciplines such as moral management and moral education, criminal punishment, or religion.

Sociologists when studying psychiatric phenomena have so far had to choose one paradigm or the other - positivist or immanentist. The fundamental flaw of the latter, for an activist like Sedgwick, is that they have so far theorised themselves into inertia. In trying to remove or reduce the medical concept of mental illness, they have made it that bit harder for a powerful campaign of reform in the mental health services to get off the ground. Brown and Harris offer more practical and applicable social material. Sedgwick argues that sociologists and others need the concept of illness (meaning mental and physical) in order to improve the health services we have already, and in order to understand further what health services we need and also what can be prevented.

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BIBLIOGRAPHY

Differing Approaches to Psychiatry:

Background, Positivistic Method and the Medical Model, The Anti-Psychiatry Movement

Clark, D. (1974) Social Therapy in Psychiatry, especially Chpt.3

Cooper, D, (ed) (1968) Dialetics of Liberation

Foucault, M, (1967) Madness and Civilisation

Laing D and Esterson (1969) Sanity, Madness and the Family

Sedgwick, P, (1982) Psycho-Politics

Szasz, T., (1971) The Manufacture of Madness

The Sociological Contribution

Brown G and Harris T (1978) Social Origins of Depression: a study of psychiatric disorder in women

Davies C and Roche, S (1980) The place of Methodology-a critique of Brown and Harris, in Sociological Review vol. 28, No. 3

Goffman, E (1968) Asylums

Rosenham D et al (1973) On being Sane in Insane Places

Townsend P and Davidson N (1982) Inequalities in Health, The Black Report