the columns

correspondence

A big tent?

I have carried out neurobiological research in academic psychiatry for 30 years and find much to endorse in the editorial by Bracken & Thomas.[1] Being trusted with the life experiences of others is a privilege, and participating in the construction of shared narratives is a key psychiatric skill. My reservation is how far the authors relish diversity when it comes to views that are not in agreement with their own. For example, while Holloway's balanced and well-reasoned response[2] is castigated for reducing 'complex issues to simple binaries, "heroes . . . [and] . . . villains,"' the authors seem to me rather binary themselves ('sickened by the corruption of academic psychiatry') and also curiously disengaged from a central problem – that of coercion.

The notion that people with bipolar disorder have 'a dangerous gift to be cultivated and taken care of' makes a lot of narrative sense to me and, anyway, how could I possibly object if that is how a person wants to see it? However, if that person's behaviour threatens the well-being and safety of others, there may well be irreconcilable conflicts of understanding, which could lead to compulsory hospitalisation and treatment, no matter how expert a psychiatric team might be in engaging with diverse perspectives. I do not know what the answer to this problem is, or even whether psychiatrists should be involved in it, but it seems to me an overwhelmingly political issue that marks psychiatry off from other medical specialties much more clearly than the social construction of diagnosis, which after all is as much the case for heart disease as it is for psychiatric disorder.[4] On the other hand, if someone wishes to see their heart disease as a spiritual problem and reject biomedical treatment, even if it puts their life in jeopardy, they run no risk of being compulsorily admitted to hospital and forcibly administered aspirin and statins.

I think that Bracken & Thomas might also be more open-minded about what biomedical science can do for us. I say this with trepidation (and the near-certainty of betraying 'serious misunderstanding'), because the authors obviously have a healthy respect for their expertise in continental philosophy and the philosophy of science. Nevertheless, how far our culturally based scientific practices can give us access to a real external world is a complex and contested issue.[5] What does seem to be the case is that modern science not only provides explanatory models (innumerable discourses do that), but uniquely, for better or worse, gives us some degree of mastery over the natural world. The ability of vaccination to eradicate smallpox was not culturally contextual, even though the germ theory might be.

Of course, it may be that the tools of biomedical science are simply inappropriate for helping people with what we currently call psychiatric problems. This is a perfectly coherent intellectual view, and ultimately it is up to a democratic society to decide whether it wants to pay for medical doctors and medical science to be involved. Bracken & Thomas seem to believe that there is a role for medicine and science in psychiatry, but I just do not know whether their 'authentic science of human beings' accommodates, for example, cognitive neuroscience. If it does, we have an exciting project.

1 Bracken P, Thomas P. Beyond consultation: the challenge of working with user/survivor and carer groups. *Psychiatr Bull* 2009; **33**: 241–3.

2 Holloway F. Common sense, nonsense and the new culture wars within psychiatry. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 243–4.

3 Bracken P, Thomas P. Authors' response. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 245–6.

4 Searle JR. *The Construction of Social Reality*. Penguin Books, 1995.

5 Dreyfus HL. How Heidegger defends the possibility of a correspondence theory of truth with respect to the entities of natural science. In *The Practice Turn in Contemporary Theory* (eds TR Schatzki, K Knorr-Cetina, E von Savigny): 151–62. Routledge, 2000.

Declaration of interest

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doi: 10.1192/pb.33.10.395

Critical psychiatry seeks to avoid the polarisation engendered by anti-psychiatry

Frank Holloway wonders whether he has missed a subtle distinction between the constructs of post-psychiatry and critical psychiatry.[1] Post-psychiatry is one form of critical psychiatry, perhaps the best articulated.[2] Critical psychiatry covers a broad range of opinion. A fundamental debate within critical psychiatry is about how much can be achieved within psychiatry. Critical psychiatry is not necessarily tied to postmodernism, as is post-psychiatry.

Holloway also suggests that post-psychiatry is 'strikingly similar to the anti-psychiatry movement of the 1970s', but does not explain in what way. Indeed, there are links between anti-psychiatry and critical psychiatry, which critical psychiatry has not been afraid to hide.[3] However, it should be remembered that both R.D. Laing and Thomas Szasz, perhaps the two psychiatrists most commonly associated with the term, disowned the use of it of themselves. Moreover, there are significant differences between the views of Laing and Szasz, which are frequently glossed over. Essentially, 'anti-psychiatry' has been used by the mainstream to disparage any opposition. I worry that Holloway is also using the term in this way when he talks about the new culture war between critical psychiatry and academic psychiatry.

Holloway expresses concern that the casualties of this war will include most mental health professionals who take an eclectic approach to their work. True, eclecticism was the compromise outcome of the anti-psychiatry debate, perhaps