ARTICLE

Towards a more relational psychiatry: a critical reflection

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SUMMARY

Criticism of the biomedical model of psychiatry that regards mental illness as brain disease has been labelled 'anti-psychiatry'. Critical psychiatry arises out of so-called anti-psychiatry, but has additional roots in transcultural psychiatry, its alliance with psychiatric user/survivor groups, and the methodological critique of the neuroscientific basis of mental health problems and psychiatric treatment effectiveness. It is not opposed to psychiatry as such and argues for a person-centred shift for practice and research. This article discusses how a more truly biopsychosocial model, which critiques the biomedical model to produce a more relational practice, is needed not only for psychiatry but also for medicine in general.

LEARNING OBJECTIVES

After reading this article you will be able to:

- give a historical perspective on anti-psychiatry and critical psychiatry
- recognise how moving from a biomedical model of mental illness creates a basis for a more relational practice in psychiatry
- understand how medicine in general as well as psychiatry needs to shift from a disease-centred to a more person-centred focus

KEYWORDS

Critical psychiatry; anti-psychiatry; relational psychiatry; person-centred care; biopsychosocial model.

Wessely (2002) in his choices for the *BJPsych* 'Ten books' series noted that Ivan Illich, Erving Goffman and R.D. Laing had been the intellectual inspiration for distinguished careers in psychiatry. However, he admitted that he had become doubtful and confused about psychiatry because of the so-called 'anti-psychiatry' critique associated with these authors. He therefore chose Clare's (1976) *Psychiatry in Dissent* as the first of his ten books, because it demonstrated to him that psychiatry was not quite as damned as the anti-psychiatrists made out.

This article is written from the position that Clare's avoidance of ideological conflict did not really solve the anti-psychiatry debate. There has always been conflict between psychic and somatic approaches to mental illness in the history of psychiatry, at least since its modern origins in the Enlightenment. The dominant biomedical model in psychiatry that primary mental illness is due to brain disease continues to be contentious.

The Critical Psychiatry Network is a small group of psychiatrists that has promoted critical psychiatry for over 20 years (Double 2019). Although psychiatrists in general may be aware of its critique, there is a tendency to dismiss its perspective as 'anti-psychiatry'. Critical psychiatry has never hidden its association with the so-called anti-psychiatry of the 1960s–1970s but sees itself as an advance over the polarisation in that debate.

Anti-psychiatry, perhaps most associated with the names of Thomas Szasz and R.D. Laing (although both rejected this designation), is generally regarded as a passing phase in the history of psychiatry. In this sense it was an aberration, a discontinuity with the proper course of psychiatry. However, it is difficult to accept that there was no value in the approach and what may be more beneficial is to look for the continuities, rather than discontinuities, with mainstream psychiatry.

In fact, the term 'anti-psychiatry' has particularly been applied by mainstream psychiatry to denote criticism of itself that it does not accept. For example, Roth (1973), when he was the first president of the Royal College of Psychiatrists, identified an international movement against psychiatry that he regarded as 'anti-medical, anti-therapeutic, anti-institutional and anti-scientific'. Critical psychiatry is not 'anti-psychiatry' in this sense. It argues that its challenge to reductionism and positivism, including mechanistic psychological approaches, creates a constructive framework that focuses on the person and has ethical, therapeutic and political implications for clinical practice and research. The aim of this article is to describe and elucidate the position of critical psychiatry further, and to see it as the basis for a more relational mental health practice.

Anti-psychiatry in retrospect

Looking back at the history of anti-psychiatry may help to provide a context for understanding the more recent perspective of critical psychiatry.

Burns (2020) makes the point that anti-psychiatry's core message across the decades has been surprisingly similar. The term 'anti-psychiatry' was coined by Cooper (1967). It came to incorporate earlier writings by R.D. Laing, Michel Foucault, Erving Goffman and Thomas Szasz (Box 1). It was broadened to include the work of Franco Basaglia to abolish the asylum in Italy (Foot 2015) and the application of social labelling theory to mental illness (Scheff 1999). Seeing all these authors as part of an anti-psychiatry movement (Fig. 1), as did Roth for example, hid the extent to which they had different standpoints. For example, Szasz (2009) equally rejected both mainstream psychiatry and Laing's views.

Although there were excesses in anti-psychiatry, it should not merely be regarded as a negative contribution to psychiatry. It may be difficult to define exactly what integrates the various points of view. A unified perspective would include a challenge to the biomedical model of mental illness, in the sense that anti-psychiatry did not regard primary mental illness as brain disease. It also had a tendency to go further by wanting to abandon the notion of psychopathology altogether. However, there was considerable variation in the extent to which this kind of argument was followed. For example, the Italian reforms spearheaded by Basaglia did not necessarily reject the organic aetiology of mental illness, nor the willingness to use psychotropic medication.

The 'anti' element could be said to have more to do with concern about the tendency of psychiatry to objectify people, which can make psychiatry part of the problem rather than necessarily the solution to mental health problems (Jones 1998). Defence of psychiatry against this accusation seeks to justify its practices. The question then becomes whether this defence of psychiatry requires belief in the physical basis of primary mental illness, and, depending on the answer, what practices can subsequently be justified.

Cooper's anti-psychiatry became a rather bizarre mixture of family, sexual and revolutionary politics, which even Laing found embarrassing (Mullan 1995). Laing himself was taken up by the counterculture of the 1960s–1970s and, despite his hankering to be reconnected with mainstream psychiatry, he ultimately became more interested in promoting personal growth and authenticity than in changing psychiatry. Although Szasz, like critical psychiatry, argued against a biologically reductionist view of mental health problems, his trenchant critique was primarily directed against society incarcerating people on the basis of the 'myth of mental illness'. He was scathing about the Critical Psychiatry Network for what he called 'prettifying the psychiatric plantations' (Szasz 2012).

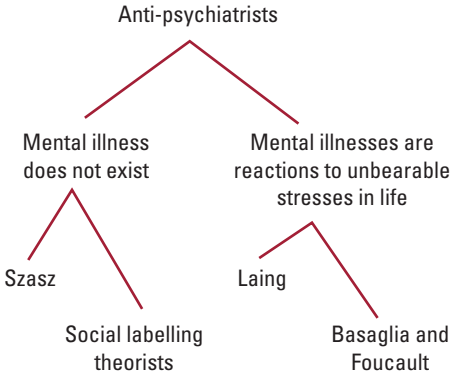

FIG 1 Subdivisions of anti-psychiatry. Based on information from Roth & Kroll (1986).

Anti-psychiatry caused a crisis for mainstream psychiatry. The main response was to insist that psychiatry's position is eclectic and biopsychosocial rather than narrowly biomedical (Clare 1976). Operational criteria were introduced in DSM-III in an attempt to make psychiatric diagnosis more objective because of fears created by anti-psychiatry that unreliable diagnosis may invalidate psychiatric practice (Blashfield 1984).

Mainstream psychiatry now tends to regard anti-psychiatry as a 'straw man' argument, in the sense that its attack is seen as fallacious because it was directed at a more biomedical model than psychiatry actually uses in practice. Anti-psychiatry is seen as having been sustained by the counterculture of the 1960s–1970s and without this support it has waned away. Social cultural critiques expressed through radical leftish movements, with which anti-psychiatry was aligned, are no longer as academically respectable. Critical psychiatry, by apparently resurrecting anti-psychiatry ideas, may therefore seem like an embarrassing hangover from the 1970s (Double 2020).

Foundations of critical psychiatry

The origin of the term 'critical psychiatry' was probably in an edited book by Ingleby (1981). Published at the end of the anti-psychiatry period, Ingleby moved critical psychiatry on from Szasz's theme of the 'myth of mental illness', in the sense that

BOX 1 Four seminal texts of the anti-psychiatry movement

R.D. Laing (1960) *The Divided Self*

Michel Foucault (1961) *Folie et Déraison: Histoire de la folie à l'âge classique* (Abridged version translated as *Madness and Civilization* (1965) and complete edition as *History of Madness* (2006))

Erving Goffman (1961) *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates*

Thomas Szasz (1961) *The Myth of Mental Illness*

(from Burns, 2020)

Ingleby, unlike Szasz, accepted that the concept of mental illness is valid. Mental illnesses are meaningful responses to difficult situations, and, in his chapter in the book, Ingleby suggested that unconscious interpretations from psychoanalysis may be required to make sense of any residue of mental health symptoms that remains refractory to common sense understanding.

Critical psychiatry accepts that there were some excesses in anti-psychiatry. It differs from anti-psychiatry in some ways and is at least similar in its recognition of the need for change in psychiatry. Kirmayer et al (2015) note how the critical psychiatry literature builds on anti-psychiatry. As they say, 'This renewed critique emphasises the dehumanisation of care that has come from a narrow, reductionistic medical model and advocates for the central place of the voice and agency of people with lived experience and the key role of community-based interventions aimed at recovery'. The research and thinking of critical psychiatry create an integrative view of the origin and nature of mental health problems. Let's look at these similarities and differences of critical psychiatry and anti-psychiatry (see Box 2 for key texts of critical psychiatry).

Critical psychiatry and anti-psychiatry: differences and similarities

A first way in which critical psychiatry differs from anti-psychiatry is that anti-psychiatry had little to do with issues of race and culture. By contrast, a core root of critical psychiatry is in transcultural psychiatry (Fernando 1991). Both critical and transcultural psychiatry have a similar emphasis on the ecological context of mental health problems. Mental health services in low- and middle-income countries in the 'global South' need to be developed without undue influence from rich countries in the West. The multicultural and global context of modern societies challenges notions of racial and cultural supremacy and domination. The institutional practice of psychiatry can be complicit in the harm caused by racism through pathologising Black people (Fernando 2017). Being able to reflect critically on the nature of psychiatry highlights the ways in which these issues of power and knowledge require an anti-racist agenda to decolonise psychiatry, which means that psychiatry should take a global rather than narrowly Western perspective.

A second difference is that anti-psychiatry may have influenced the development of the user/survivor movement (Crossley 2006), but critical psychiatry is more explicit about its alliance with mental health service users/survivors. The best-quality care requires the expertise of both patients and professionals to work together. There have always been individual complaints from patients about their treatment since the early days of the asylums, and since the 1970s–1980s a collective identity of users/survivors has become organised in its critique of psychiatry. Its major concern is the lack of focus of psychiatry on the personal experience of patients. For critical psychiatry, it is essential that mental health services engage with these 'user/survivor voices' and meaningfully collaborate to co-produce true equity.

A third way in which the two differ is that critical psychiatry is more prepared to engage with research evidence about the aetiology and treatment of mental health problems. Methodological bias leads to exaggerated claims for the neuroscientific basis of mental health problems (Dumas-Mallet 2012) and for the effectiveness of psychotropic drugs (Fisher 1997). For example, unmasking ('unblinding') in clinical trials can lead to placebo amplification, meaning that any statistically significant difference in trials could be an artefact. Critical psychiatry is making the case not so much for 'the myth of mental illness', as was Thomas Szasz, but for 'the myth of the chemical cure' (Moncrieff 2008).

Having looked at these three ways in which critical psychiatry differs from anti-psychiatry, it is important to emphasise the sense in which critical psychiatry continues along the same path set by anti-psychiatry. Before he became infamous and the term 'anti-psychiatry' had been coined by Cooper, Laing (1964) talked about a radical shift taking place in the clinical point of view of psychiatry towards one that is both existential and social. This change did not happen, of course, as mainstream psychiatry attempted to restabilise itself after what was seen as the onslaught of anti-psychiatry. Nonetheless, the important point is that, at least initially, Laing was not opposed to psychiatry as such, but saw it developing in a way that would make it less objectifying of people. In this sense critical psychiatry seeks to continue this trend. Its essential message is that psychiatry can

BOX 2 Four key texts of critical psychiatry

- Sami Timimi (2002) *Pathological Child Psychiatry and the Medicalization of Childhood*
- Pat Bracken & Phil Thomas (2005) *Postpsychiatry: Mental Health in a Postmodern World*
- Suman Fernando (1988) *Race and Culture in Psychiatry* (3rd edition published as *Mental Health, Race and Culture* (2006))
- Joanna Moncrieff (2008) *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*

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be practised without postulating brain pathology as the basis for primary mental illness.

Positivism and reductionism

There are two related aspects to the critique of critical psychiatry. The first is about psychiatry's positivistic tendencies; the second about its reductionist tendencies. Positivism is the philosophical view that the methods of natural science can be extended to human behaviour. Essentially, a mechanistic world-view seems to provide an apparently predictive and systematic way of understanding and manipulating nature, including human nature. Applying these scientific methods seems to afford an attractive way of understanding and treating mental health problems. The problem is that a mechanistic conception of nature fails to provide a complete characterisation of living systems. Living things are purposive systems and are different from inanimate objects. Organisms, unlike machines, are self-organising and self-reproducing systems. This means that if science is defined as determinism, in the sense of one-to-one causal correspondence to explain human action, it is bound to fail. Complete prediction of human behaviour is not possible.

Reductionism, or at least its explanatory variety, is the philosophical view that human behaviour can be explained in naturalistic terms. Complex life processes are thereby reduced to phenomena explained in terms of physics and chemistry. There is a hierarchical relationship between the basic, biological and human sciences, with the lower or simpler categories being pertinent to, but not explanatory for, higher or more complex categories. The problem with applying a reductionist perspective to mental health problems is that it can encourage a narrow focus on the brain. A more holistic viewpoint requires psychosocial explanations of mental health problems, retaining the meaning of human action. The brain mediates the life of a person, but mental illness is not just an epiphenomenon of a causal brain process. Of course, the brain can be studied as a functional part of the organism but the subject of psychiatry is the person as a whole.

This critical conceptual position creates a more truly person-centred focus for psychiatric theory and practice, which can be seen as a solution to the fundamental problem about the nature of psychiatry and its practice. Since its origins, psychiatry has been caught between different emphases on somatic and psychic aspects. Critical psychiatry of course recognises that other approaches, such as psychotherapy, emphasise psychic aspects. However, the social role of psychiatry needs to be accepted and, despite critical psychiatry's support for psychotherapeutic perspectives, it is not merely advocating for autonomous practice in the same way as individual psychological therapy. In fact, it recognises that psychological therapy can be as mechanistic as physical treatment.

This critique of psychiatry is part of an overall critique of health practice in general. Medicine tends to overemphasise somatic aspects at the expense of psychosocial issues. The effects of this bias are more obviously apparent in psychiatry than in the rest of medicine, as it is primarily focused on people not their bodies. This was what Engel (1977) meant when he proposed his biopsychosocial model as a new medical model to challenge biomedicine. As he said, the biopsychosocial model is not only a challenge for psychiatry, but also for medicine in general. It opposes biomedical reductionism in medical practice overall.

The crisis in medicine, not just in psychiatry

Medicine's technological approach to assessment and treatment can lead to an overemphasis on the impersonal and mechanical. By turning away from the person in this way, medicine has been said to be more interested in advocating for its own special interests and preserving its social power than really caring for patients. For example, Illich (1995) suggested that we might be better off with 'do it yourself' care. Despite whatever interest there is in the biopsychosocial model among doctors, there are real barriers to overcoming the dogmatism of medicine's biomedical structure.

The fundamental problem is the definition of illness and disease in physical terms, which encourages a lack of concern for psychosocial issues. These broader issues may even be seen as being outside the province of medicine's responsibility and authority. This crisis is particularly acute for psychiatry, which does not have biological markers for functional mental illness. Psychosocial factors, such as adverse childhood experiences and trauma, are obviously factors in the aetiology of mental disorder. Mental illness cannot be said to be equivalent to physical pathological disease. Psychosocial factors should not be ignored even by physical medicine and cannot be neglected by psychiatry.

Medicine in general has tried to correct this imbalance over recent years by making its training and practice more patient-centred (Stewart 2003). However, it has not always been very successful in this aim and arguably medicine still needs to change in the way originally suggested by Engel. Health services are not always providing the care that people need by treating them holistically (Montori 2020).

Models of illness and disease

Historically there have been various culturally derived belief systems about illness and disease. For example, humoral ideas, believing that illness is caused by an imbalance of blood, phlegm, black bile and yellow bile, persisted in the West into the 19th century. Although the dominant model in the West is now biomedical, with a focus on physical pathology, there is still much take up of alternative and complementary medicine. Nor have traditional indigenous views globally about illness and disease completely been colonised by biomedicine (Fernando 2018).

The biopsychosocial model is an intermediate position between biomedical reductionism and what Engel called an 'exclusionist' view that mental health problems should not be seen as illness. A technical distinction is made in the literature between illness as experience and disease as physical pathology (Kleinman 1988). In these terms, primary mental illness should not be reduced to physical brain disease.

René Descartes (1596–1650) was the first to apply a natural-scientific mechanistic approach to life. Animate and inanimate matter were understood by the same mechanistic principles. Animals are therefore machines; and human physiology is also mechanistic. Descartes stopped short, though, of including the human mind in this mechanistic framework. The soul was denied any influence in physiology. Descartes thereby avoided the materialistic implication that man himself is a machine. The split he created between mind and brain is what is referred to as Cartesianism.

One of the first to challenge this perspective was Georg Ernst Stahl (1660–1734). Although Stahl erroneously took a vitalist position, claiming that living things possess a vital entity, his dualistic notion was different from that of Descartes, in that he differentiated organic life from the inorganic, not the soul from the body. Unlike Descartes, he proposed that the soul and body are not separate but integrated in the organism. Despite his vitalism, Stahl originated a holistic perspective in the life and human sciences. This perspective formed the basis for his emphasis on psychosomatic medicine, and a focus on clinical medicine rather than the physical sciences.

Modern psychiatry has its origins in the Enlightenment of the 18th century. Critical engagement of reason with itself created a descriptive approach to madness (Foucault 1961). An enlightened anthropological approach was concerned with the study of man as a psychophysical unity. In this context, medical psychology had its origin in two major variants of anthropological thinking (Verwey 1984). A medically oriented anthropology seemed to create the possibility of a natural scientific psychology. By contrast, Immanuel Kant's (1798) pragmatic anthropology believed that a natural science psychology was impossible to realise in practice. Kant was clear that it is futile to expect to be able to understand and explain life in terms of merely mechanical principles of nature.

Building on this proto-psychiatry, the first half of the 19th century saw the development of anatomo-clinical understanding and application. Relating symptoms and signs to their underlying physical pathology was a major advance for medicine and still underlies our modern understanding of disease. Pathology emerged as a distinct discipline, with autopsy findings of lesions in organs and tissues being related to clinical examination at the bedside. Histological studies established cellular abnormalities for disease.

This biomedical progress was made at a cost and medicine still needs to broaden its approach to illness and disease, as suggested by Engel, to include the psychosocial without sacrificing the advantages of biomedicine. Clinical practice is not just about diagnosing the patient's disease and prescribing a management plan appropriate to the diagnosis.

A person-centred approach is needed to attain an understanding of the patient as well as the disease (Boardman 2020). Patients' requirement for information and their concerns, including emotional concerns and life issues, need to be addressed. Broader socioeconomic conditions may be significant. The doctor–patient relationship itself needs to be recognised as a powerful factor in treatment and management. Sensitivity to both context and patient preferences is required. The boundaries between health and disease are not absolute and both patients and doctors can have views about what counts as the sick role (Parsons 1951). Patients and doctors, as far as possible together, shape what should be regarded as illness and how it is treated.

Psychiatry in training and practice

Doctors need to learn to be person-centred in their training, but there are barriers to achieving this outcome. This failure to be person-centred begins in medical student training. Empirical evidence often suggests that empathy tends to erode as students progress through medical school (Neumann 2011).

Clinicians need to be confident enough to evaluate their judgements in relation to their knowledge, experience and power (Brown 2020). They should not be acquiring beliefs and attitudes in training

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that merely bolster medicine as a profession to pursue its own interests. If they do, they are at risk of exploiting patients. In particular, there needs to be a focus on psychosomatic aspects of illness, which should not be overlooked by an excessive orientation to physical pathology.

Doctors need to learn to cope with emotionally difficult, indeed sometimes traumatic, situations. This may create understandable defensiveness and it is not always apparent that medical training deals adequately with students' feelings. Patients may support doctors' myths about themselves as healers, and students may therefore find it difficult to learn about the limitations of medical interventions. Tolerating uncertainty may be anxiety provoking, leading to oversimplification of complex clinical situations. This personal vulnerability may be difficult to negotiate openly and honestly with patients, despite the expectation that doctors will integrate their expertise with patient expertise. Being emotionally sensitive, if this can be achieved over time, needs to be acquired without burnout and exhaustion.

Even in psychiatric training, with its particular focus on psychosocial matters, the personal dimension may understandably become reified in biological correlates of psychiatric disorder. Understanding human existence in certain natural ways is appealing to create a potential for establishing aetiology, treatment and prognosis. There may at least be unconscious attractions in retreating into the objectification of those identified as mentally ill and insisting on the somatic nature of their illness. An advantage of this tactic is that it provides some protection to those trying to provide care from the pain experienced by those needing support. Notwithstanding self-evident understanding of mental illness as a disorder of the mind, it may be simpler to concentrate on its bodily substrate.

In practice, most psychiatrists are not purely biomedical, in the sense of simply reducing mental illness to brain disease, or at least some are more biomedical than others. Psychiatrists commonly deflect criticism of the biomedical model by declaring that they are eclectic in their approach, taking into account psychological, social and not just biological factors. Although psychiatrists tend to have no doubt that major mental illness is a disease of the brain, some incline to focus just on this aspect, whereas others want to integrate biological with more psychosocial perspectives.

Illness models as justifications of treatment approaches

Medicine and psychiatry are cultural systems (Geertz 1993). Our beliefs about illness, including mental illness, function to justify treatment. So, using humoral theory again as an example, these beliefs justified bleeding, purging and the use of emetics. For many years, this theory made sense of symptoms and indicated remedies to correct health problems. This was reassuring for patients and provided a rationale for doctors.

Dismissing humoral theory, and other historical approaches, as erroneous means that we are not always as aware as we might be about the way in which our current beliefs about illness serve a similar purpose in justifying treatment. As religion provides a worldview to help us live as human beings, so views about medicine and psychiatry assist us in managing our illnesses, including mental illnesses. Such beliefs may be held with a certainty that, if challenged, can create anxiety. Just as giving up belief in God may feel traumatic, so dispensing with the biomedical model of mental illness may produce the gravest concern for the professional viability of psychiatrists. The biomedical model may have created what Geertz (1993) called an 'aura of factuality' but that does not necessarily mean that it is true. Taking the view that the dominant biomedical model is invalid is not straightforward, as it may be perceived to be outside accepted practice.

The contention that primary mental illness should not be reduced to brain disease must not be misunderstood. Critical psychiatry is not saying that mind and brain are separate. What it is saying is that minds are enabled by but not reducible to brains. As Adolf Meyer said, 'All person disorders must show *through* the brain but not always *in* the brain' [his emphasis] (Double 2007).

The belief that brain pathology is the basis for major mental illness may avoid having to deal with complicated metaphysics about the mind–body problem. It may also appear to bring psychiatry closer to the rest of medicine by seeing mental illness as having a material basis as do physical illnesses in general. It also creates a scientific ambition and associated research programme to uncover the neuroscientific causes of mental illness. All these wishes and desires are understandable, but they may be more based on faith than science. In fact, we may not need to justify psychiatric treatment with the biomedical model. And if the model leads to people being unnecessarily objectified by reducing their problems to brain disease, then any apparent advantages may be insufficient.

Person-centredness in psychiatry

Not believing in the biomedical hypothesis of mental illness may not be as unorthodox as it may seem. In fact, there is a long and respectable tradition of

thought about the human condition that is far greater than the tendency to reductionism and positivism in general and in psychiatry in particular. As we have seen above, reductionism, by focusing too much on the brain, can lead to the loss of meaning of human action by neglecting psychosocial explanation. Also, as again shown above, an integrated mind–body perspective means that a mechanistic, deterministic psychology is impossible to realise in practice.

In clinical practice, descriptive psychopathology is not studied organically at the level of neurobiology. History and mental state examination instead produce a formulation of people's problems in terms of differential diagnosis and aetiology. An integrated understanding of mental dysfunction in the context of the whole person, including emotional needs and life issues, forms the basis for clinical practice. It is this foundation that makes psychiatry relational. Marginalising the intentions of critical psychiatry to make practice more relational by labelling it as anti-psychiatry is therefore unhelpful. Its critique has consequences not only for clinical practice but also for psychiatric research, which has become far too focused on presumptive neuroscience.

New perspectives: phenomenology, subjectivity and enactivism

Although critical psychiatry has never hidden that it grew out of what mainstream psychiatry has called 'anti-psychiatry', there are more recent developments that come to the same conclusion. Recent conceptual understandings could be said to have made a physical disease model of mental illness outdated. Examples of these anti-cognitivist phenomenological and enactive accounts of psychopathology would be Fuchs's (2018) *Ecology of the Brain* and de Haan's (2020) *Enactive Psychiatry*. Similarly, Kirmayer (2019) proposes what he calls an ecosocial psychiatry.

Fuchs takes an ecological approach to understanding the brain. Although he recognises the importance of neurobiology, he describes how our everyday experience with others is our primary and actual reality. Mental disorder depends on subjective and cultural factors that fall outside the domain of natural science. De Haan sees mental illness as abnormal sense-making. She understands the person as an organism interacting with its environment, not as an isolated individual, let alone as its brain. Kirmayer argues for a shift in perspective from a psychiatry centred on brain circuitry to one that focuses clinical experience on social predicaments, and that provides explanations and interventions in social context.

There are implications for biology, psychology and philosophy in these recent perspectives. To consider biology first: its aim could be considered to have been to explain all of biology in terms of physics and chemistry. However, there have been organicist biologists who have promoted life's dynamic, systemic and purposive character as a way of moving on from physicochemical reductionism. For example, recently a manifesto for a processual philosophy of biology has been proposed to explain biology in terms of dynamic processes rather than static unchanging entities (Nicolson 2018). The advantage of seeing life as self-organising is that its plasticity is acknowledged without neglecting its ongoing stability. Bodies are actually stabilised processes, not well-defined substances. Mechanistic explanations are insufficient for an account of the totality of living nature. Psychiatry needs to update its model of biology.

As far as psychology is concerned, cognition also needs to be understood in this dynamic, integrated, enactive way as it is embodied in the brain and the body more generally, and embedded in the environment, which is social and cultural, affording various possibilities of action to the organism. The brain is a relational organ mediating behavioural, emotional and cognitive relations with the world. It is not only part of a living and objective body, but it also brings about the lived and subjective aspects of the person. The mind needs to be appreciated in this context.

The phenomenology of subjectivity and existence has implications for the nature of consciousness. The study of a person's lived experience in the world shows that subjective experience and consciousness cannot be naturalised as physical processes. Our primary experience actually puts us in the world as embodied beings. It is what creates the foundation for scientific knowledge. An integrated personalistic concept of human beings is fundamental to any scientific understanding of the brain.

The implication for psychiatry is that mental illness should not be isolated in material processes in the brain, excluded from people's relationship with their environment. Neuroscience goes too far if it reifies the self, leaving people without control of their lives. Subjective experience cannot be reduced to neuronal processes. Examining the brain in a scanner, for example, does not tell us anything about the cause of thoughts, emotions and behaviour. This is not that dissimilar to what 'anti-psychiatry' said years ago. This message still has implications for current theory and practice in psychiatry.

Conclusions

Critical psychiatry may have appeared unnecessarily negative because it is seen as judging psychiatry

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too severely. Nonetheless, it recognises that biomedicine has been remarkably successful in correlating symptoms and signs with physical pathology. However, as Engel (1977) said, this has been 'at a cost'. For psychiatry in particular, primary mental illness can have functional causes without structural disease. Rather than psychiatric practice being based on the notion that primary mental illness will be found to have a physical cause, psychiatry needs to move on to a more relational practice.

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D.D. is a founding member of the Critical Psychiatry Network.

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References

Blashfield RK (1984) *The Classification of Psychopathology: Neo-Kraepelinian and Quantitative Approaches*. Plenum.

Boardman J, Dave S (2020) Person-centred care and psychiatry: some key perspectives. *BJPsych International*, **17**: 65–8.

Brown J (2020) Psychiatry, power and the person. *European Journal for Person Centered Healthcare*, **8**: 363–75.

Burns T (2020) A history of antipsychiatry in four books. *Lancet Psychiatry*, **7**: 312–4.

Clare A (1976) *Psychiatry in Dissent: Controversial Issues in Thought and Practice*. Tavistock Press.

Cooper D (1967) *Psychiatry and Anti-Psychiatry*. Tavistock Press.

Crossley N (2006) *Contesting Psychiatry: Social Movements in Mental Health*. Routledge.

de Haan S (2020) *Enactive Psychiatry*. Cambridge University Press.

Double DB (2007) Adolf Meyer's psychobiology and the challenge for biomedicine. *Philosophy, Psychiatry and Psychology*, **14**: 331–9.

Double DB (2019) Twenty years of the critical psychiatry network. *British Journal of Psychiatry*, **214**: 61–2.

Double DB (2020) Critical psychiatry: an embarrassing hangover from the 1970s? *BJPsych Bulletin*, **44**: 233–6.

Dumas-Mallet E, Gonon F (2012) Messaging in biological psychiatry: misrepresentations, their causes, and potential consequences. *Harvard Review of Psychiatry*, **28**: 395–403.

Engel GL (1977) The need for a new medical model: a challenge for biomedicine. *Science*, **196**: 129–36.

Fernando S (1991) *Mental Health, Race and Culture*. Macmillan/MIND Publications.

Fernando S (2017) *Institutional Racism in Psychiatry and Clinical Psychology*. Palgrave Macmillan.

Fernando S, Moodley R (eds) (2018) *Global Psychologies: Mental Health and the Global South*. Palgrave Macmillan.

Fisher S, Greenberg RP (eds) (1997) *From Placebo to Panacea: Putting Psychiatric Drugs to the Test*. John Wiley & Sons.

Foot J (2015) *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care*. Verson Books.

Foucault M (1961) *Folie et Déraison: Histoire de la folie à l'âge classique*. Reprinted in English translation (2006) as *History of Madness* (ed J Khalfa, trans J Murphy, J Khalfa). Routledge.

Fuchs T (2018) *Ecology of the Brain: The Phenomenology and Biology of the Embodied Mind*. Oxford University Press.

Geertz C (1993) *The Interpretation of Cultures: Selected Essays*. Fontana Press.

Illich I (1995) *Medical Nemesis: The Expropriation of Health*. Marion Boyers.

Ingleby D (1981) *Critical Psychiatry: The Politics of Mental Health*. Penguin.

Jones C (1998) Raising the anti: Jan Foudraine, Ronald Laing and anti-psychiatry. In *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (eds M Gijswijt-Hofstra, R Porter): 283–92. Wellcome Institute.

Kant I (1798) *Anthropologie in pragmatischer Hinsicht*. Reprinted in English translation (1974) as *Anthropology from a Pragmatic Point of View* (trans VL Dowdell). Southern Illinois University Press.

Kirmayer LJ, Lemelson R, Cummings CA (2015) Introduction: psychiatry at a crossroads. In *Re-Visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health* (eds LJ Kirmayer, R Lemelson, CA Cummings): 1–38. Cambridge University Press.

Kirmayer LJ (2019) Toward an ecosocial psychiatry. *World Social Psychiatry*, **1**: 30–2.

Kleinman A (1988) *The Illness Narrative: Suffering, Healing, and the Human Condition*. Basic Books.

Laing RD (1964) Schizophrenia and the family. *New Society*, 16 April: 14–17.

Moncrieff J (2008) *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*. Palgrave Macmillan.

Montori V (2020) *Why we Revolt: A Patient Revolution for Careful and Kind Care*. Mayo Clinic Press.

Mullan B (1995) *Mad to be Normal: Conversations with R.D. Laing*. Free Association.

Neumann M, Edelhäuser F, Tauschel D, et al (2011) Empathy decline and its reasons: a systematic review of studies with medical students and residents. *Academic Medicine*, **86**: 996–1009.

Nicolson DJ, Dupré J (eds) (2018) *Everything Flows: Towards a Processual Philosophy of Biology*. Oxford University Press

Parsons T (1951) *The Social System*. The Free Press.

Roth M (1973) Psychiatry and its critics. *British Journal of Psychiatry*, **122**: 373–8.

Roth M, Kroll J (1986) *The Reality of Mental Illness*. Cambridge University Press.

Sheff TJ (1999) *Being Mentally Ill: A Sociological Theory* (3rd edn). Aldine de Gruyter.

Stewart M, Brown JB, Weston WW, et al (2003) *Patient-Centred Medicine: Transforming the Clinical Method* (2nd edn). Radcliffe Medical Press.

Szasz T (2009) *Antipsychiatry: Quackery Squared*. Syracuse University Press.

Szasz T (2012) Varieties of psychiatric criticism. *History of Psychiatry*, **23**: 349–55.

Verwey G (1984) *Psychiatry in an Anthropological and Biomedical Context*. Springer.

Wessely S (2002) Ten books. *British Journal of Psychiatry*, **180**: 81–4.

MCQs

Select the single best option for each question stem

1 Which of the following psychiatrists was not considered to be part of the anti-psychiatry movement of the 1960s–1970s?
a R.D. Laing
b Thomas Szasz
c Martin Roth
d Franco Basaglia
e David Cooper.

2 Which of the following has not provided key contributions to critical psychiatry?
a Sami Timimi
b Pat Bracken
c Joanna Moncrieff
d Suman Fernando
e Anthony Clare.

3 The biomedical model of mental illness:
a is the only model used in psychiatric practice
b does not accept the concept of mental illness
c reduces mental illness to brain disease
d takes an anti-positivist perspective on psychiatry
e formed the basis for humoral theory.

4 George Engel's biopsychosocial model of mental illness:
a is a critique of biomedical reductionism
b separates mind and brain
c is built on the theories of Michel Foucault
d no longer applies in psychiatric practice
e does not really deal with psychosomatic aspects of illness.

5 Person-centred medicine:
a ignores physical pathology
b can be understood as deriving from George Engel's biopsychosocial model
c is centred on the interests of doctors
d was critiqued by anti-psychiatry and critical psychiatry
e should be able to establish the physical aetiology of primary mental illness.

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