Chapter

20

Critical Friends: Anti-psychiatry and Clinical Psychology

Tom Burns and John Hall

The immediate post-war period in the UK was focused on the establishment of the welfare state. There was a broad consensus that the old order had failed and that those who had served and sacrificed should be heard. Mental health services had been absorbed into the NHS from the local authorities, although this had not been a foregone conclusion.[1] This aligning with NHS practice threw the disparities in care into stark relief. The Percy Commission was established in 1957 to enquire into the care of mentally ill and learning disabled patients. This resulted in the 1959 Mental Health Act and also mandated social services spending on discharged patients. As well as tightening up the supervision of compulsory care, it brought health and social care together, enabling the development of geographical catchment area services and the growth of British community and social psychiatry.

These developments were accelerated by the discovery of antipsychotics in 1954 and the first tricyclic antidepressants in 1958 and 1960. Confidence in psychiatry's future outside the asylum was high. This is nowhere more evident than in the health secretary Enoch Powell's much-quoted 'Water Tower' speech to the Mind conference in 1961 and in legislation with the 1962 *Hospital Plan*.[2]

Despite its unprecedented progress (or perhaps because of it), the 1960s onwards found psychiatry's legitimacy challenged on two fronts. In the 1960s and 1970s, a dramatic onslaught came from the celebrity 'anti-psychiatrists' (a term coined by David Cooper in 1967). Also, alongside this, a relative newcomer to mental health services – clinical psychology – was rapidly growing in power and influence.

The Anti-psychiatrists

The anti-psychiatry movement can be understood as one front in the baby boomers' assault on the old order. Social turmoil and rebellion characterised the next two decades, from the civil rights movement in the United States, through the Vietnam protests and the student revolts that erupted in Paris in May 1968. The established order was challenged and in many aspects upended. Psychiatry's prominence in this counterculture owes much to the anti-psychiatrists and, in particular, to four iconic books. These all appeared within eighteen months of each other in 1960–1.

Each of these very different books was entirely independent – their authors had no connection with each other before or after their publication. They came to be seen as the four seminal texts of the anti-psychiatry movement. This term was never accepted by the authors themselves but it has endured. All four spoke powerfully to psychiatry's relationship with society, with an unflinching demand that both must change.

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Laing

The first to appear was R. D. (Ronnie) Laing's *The Divided Self* (1960),[3] which went on to become an international campus bible. Laing was a Scottish psychiatrist who trained in psychoanalysis in London. He was heavily influenced by existentialism, particularly by Jean-Paul Sartre. He saw the struggle of the 'psychotic patient' through the existentialists' lens of becoming rather than being. As agents of our own identity and destiny, we create ourselves by the choices we must constantly make (as Sartre wrote in 1946, 'Man is condemned to be free').[4]

Laing believed that psychotic patients were struggling against confusing and contradictory messages to make sense of their experiences. Their confusion communicates itself to us as a threat to our ontological security (our confidence in our own stable identity). We then contain this anxiety through diagnosis. Laing proposed an approach of 'existential phenomenology', which seeks to understand the patient's struggle for identity rather than clarifying signs and symptoms as in classical phenomenology. This existential phenomenology requires full engagement rather than traditional professional distance.

Such direct engagement was to avoid 'objectifying' the patient. Sartre insisted that humans simply cannot be understood as objects because identity inheres in active agency (choices). A 'snapshot' diagnosis would miss the individual's most important quality – their agency.

Laing was a wonderful writer. He had an ability to engage fully with very disturbed patients and conveyed these experiences vividly and humanely. A striking and charismatic speaker, his message was taken up enthusiastically by a youthful readership. His second book (*Sanity Madness and the Family*, with Aaron Esterson 1964) became an iconic film, *Family Life*, in 1971, spreading the message even wider.[5]

Laing was a restless individual in both his intellectual and his personal life. His later writing became increasingly obscure, partly coloured by his alcohol and drug abuse. His impact on psychiatry began to fade as he shifted his focus to the emerging global counterculture.

Foucault

Madness and Civilization is the English translation of Foucault's abridged PhD thesis published in 1961.[6] Foucault's approach was historical and he argued that 'madness' was timeless but 'the madman' was a recent construction. Foucault ascribed this new identity to the 'great confinement', which occurred in France in the mid-seventeenth century. The enormous 'grands hôpitaux' had been established in Paris to contain the poor, the mad and the socially disruptive. They were a response to France's rapid economic and social development and new categories were required to facilitate this extrajudicial incarceration.

Foucault's writings continue to have enormous influence in the social sciences and wider cultural circles. 'Mental illness' as a convenient label to remove uncomfortable and supposedly deviant individuals, who are unable to contribute economically, remains a pervasive trope. Franco Basaglia, responsible for Italy's radical reforms in the 1970s, repeatedly insisted that psychiatric diagnoses were based on economic inutility and resulted in social exclusion. Current thinking around stigma derives much from these ideas and those of labelling theory – that an imposed identity, once accepted, becomes a self-fulfilling prophecy and an impediment to recovery and social reintegration.

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Goffman

The Canadian-American sociologist Erving Goffman spent 1955–6 in participant observation (effectively 'undercover') in a large Washington mental hospital. *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates* (1961) was the result and had an enormous impact on psychiatry.[7] Unlike Russell Barton's 1959 book *Institutional Neurosis*,[8] explaining the apathy of psychotic inpatients as a side effect of institutional care, Goffman believed it resulted from deliberate policy.

Goffman coined the term 'total institutions' to include mental hospitals, prisons, monasteries and even the military. Such all-embracing organisations needed to 'manage' large numbers of people efficiently. Goffman described a range of initiation rituals, rigid rules, hierarchies and roles that stripped away individual identity. The result was predictable and pliable individuals. Monotonous routines and the absence of personal choice generated dependency and apathy. This process of 'institutionalisation' served the institution's needs, not the individual's.

Goffman's also observed that real power within the institution often originated low down the organisational hierarchy. Rather than the doctors and senior nurses controlling the wards, the nursing aides, cleaners and even more-established patients made the day-to-day decisions. They ran the ward on simple moral concepts of good and bad behaviour and punishment and reward rather than on notions of symptoms and treatment.

Like Laing, Goffman could write striking prose and captivate his reader. He, however, presented evidence, not just a theoretical revision. Despite its highly critical message, *Asylums* was readily taken up by the profession. Underscored by regularly occurring scandals, it became a central text in the deinstitutionalisation movement. His observations of hospital power structures fed into the development of modern multidisciplinary working.

Szasz

Thomas Szasz escaped Soviet-dominated Hungary at age eighteen and trained in medicine and psychiatry in the United States. He remained active as a psychiatrist in both private and university practice for the rest of his life. He wrote more than thirty books, of which *The Myth of Mental Illness* (1961) is the most famous.[9] He makes two basic points (reiterated throughout his subsequent books). The first is that mental illnesses are not 'real' illnesses because they have no physical markers (such as glucose levels in diabetes). The second, following on from this but clearly reflecting experiences of oppression under Soviet occupation, is that there is absolutely no justification for treating 'mental patients' against their will. As any special treatment is an abuse of power, no allowance can be made for any criminal or deviant behaviour. There is no 'insanity clause'. So the murderer with psychosis goes to prison and can there receive treatment but even then only if they consent.

Szasz had, and continues to have, a powerful influence outside the profession. His message is immediate and simple and resonates with liberalism and anti-authoritarianism. He was also an effective communicator and used vivid (albeit questionable) examples to make his points: 'If I speak to God I am a Christian, if God speaks to me I am schizophrenic.' Szasz became a figurehead for anti-psychiatry groups such as the Scientologists, and his ideas find a home with civil libertarians. However, because their message is essentially so simplistic, with no striking insights or reinterpretations of established assumptions, they rarely figure in professional discourses about psychiatry.

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Anti-psychiatry's Impact

Although often perceived as infuriating and superficial by many clinicians, anti-psychiatry certainly raised public interest in the profession. In the late 1960s and early 1970s, it was 'cool' to be a psychiatrist. Recruitment, ironically, improved. By this time, the British anti-psychiatrists were moving away into the broader worldwide counterculture. In 1967, they staged the Dialectics of Liberation Congress at the Roundhouse in London with keynote speeches from anti-psychiatrists, beat poets, black activists and more. By 1970, Kingsley Hall (the most high-profile manifestation of UK anti-psychiatry) had collapsed amidst acrimony and discord. The caravan had moved on.

British Psychiatry's Response to the Anti-psychiatrists

The mainstream psychiatric response to the anti-psychiatrists was essentially to ignore or dismiss them.[10] Some brave individuals engaged publicly with the argument but it was rarely constructive or successful. The sight of the eminent Michael Shepherd spluttering with incredulity on TV at proposals from a young enthusiast that psychiatry really had nothing to offer a psychotic young mother left most reluctant to engage in what seemed a dialogue of the deaf. Responses based on pragmatism and experience simply had no impact on ideology. In their article about Basaglia's reforms, Kathleen Jones and Alison Poletti record this impotence:

> [we] remained mystified by the insistence of Psichiatria Democratica on 'closing the mental hospital' when it was patently obvious that mental hospitals were not being closed. ... When the Trieste team say 'We closed the mental hospital' they do not mean 'We closed the mental hospital'. They mean 'We broke the power of the mental hospital over the patients'.[11]

In his 1970 book *Psychiatry in Dissent*, Anthony Clare tried to engage with the debate, particularly in his chapters 'Concepts of mental illness' and 'What is schizophrenia?'[12] He forensically examined Laing's proposals and Joseph Berke's portrayal of Mary Barnes's 'journey' through psychosis. Experience is impotent, however, against what Andrew Scull calls 'word-magic'.[13] In addition, Clare is preaching to the converted – few who bought *The Divided Self* also bought *Psychiatry in Dissent*.

Radical (Critical) Psychiatry and Post-psychiatry

In understanding the impact of the anti-psychiatrists in the 1960s and 1970s, it is important to remember that psychiatry has never been without vociferous critics. In the following decades up to 2010, there have constantly been groups of dissident voices, both within and outside the profession. The most prominent of these critical groups are the radical psychiatry group and the post-psychiatry movement.

The radical psychiatrists include senior and respected figures, several with academic appointments. Joanna Moncrieff at University College London (UCL) has persistently challenged the claims for efficacy of prophylactic drug treatments such as lithium and maintenance antipsychotics.[14] Derek Summerfield at the Institute of Psychiatry has written prolifically about the imposition of diagnoses such as post-traumatic stress disorder (PTSD) and depression on more diffuse human problems (and in particular the export of these 'Western' concepts).[15]

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The post-psychiatry movement draws on the ideas of postmodernism.[16] It emphasises the loss of faith in science as an effective solution for current problems and questions its status as a privileged discourse among others. It emphasises social and cultural contexts and places ethics before technology.

Both the radical psychiatry group and the post-psychiatrists differ fundamentally from the earlier anti-psychiatrists in that they are focused on 'improving' psychiatry and limiting its poor (damaging) practice. This is fundamentally more a technological than an ideological attack despite some of the language. Both have been fuelled by the one-sidedness of the evolving biomedical model within psychiatry and the disquieting growth in power of 'Big Pharma'. The muted response of orthodox psychiatry to these critics undoubtedly stems from similar shared concerns (albeit less extreme) being widespread throughout the profession. Psychiatry has learnt to coexist with its internal critical friends. This may reflect its need to pay urgent attention to a more cogent threat to its status growing alongside it in the multidisciplinary team.

Psychiatry and Psychology

Psychology and psychiatry relate to each other at three different levels. They are distinct conceptual and methodological disciplines, with border territories of abnormal and medical psychology. Psychologists and psychiatrists relate to each other as immediate clinical colleagues in day-to-day practice; and their professional bodies relate to each other in the context of their own competition for political influence and funding. The British Psychological Society (BPS) was founded in 1901, gained its Royal Charter in 1965 and represents all psychologists, both academic and applied. In most of these areas, there has been co-operation and mutual acknowledgement of each other's knowledge and skills – and there have been differences and mutual criticisms.

It is no surprise that the strongest advocates for psychological input to the new NHS were psychiatrists in the asylums and mental handicap hospitals. This built on pre-existing joint practice between psychiatrists and educational psychologists (and social workers) in the Child Guidance Clinics that were set up from the late 1920s and on the less well-known joint working in military settings during the Second World War, as colleagues in both military selection and training.

Psychiatrists initially wanted psychologists to bolster their search for a more measurable and scientific psychiatry. Consequently, the two main functions of the early psychologists were as psychometricians ('test-bashers') – mainly with ability, personality and projective tests – and to contribute to doctor-led research projects. Yet growth in numbers before 1960 was very slow; in that year, there were only around 180 clinical psychologists in England and Wales, with a few in Scotland.

Changes in Clinical Psychology, 1960–2010

The scope and nature of the work of clinical psychologists in Britain, and their numbers, have changed almost beyond recognition from that early period.[17] Many of those early clinical psychologists were former educational psychologists who had moved into the NHS. In 1957, there were only three formal training courses in Britain, and it was also possible to qualify simply by a three-year apprenticeship.

Involvement in anything that could be called treatment was forbidden – not least by Aubrey Lewis at the Maudsley – but if it could be called education or training that might be

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permitted. In the mental handicap field, clinical psychologists had an early innovative role, as shown by the work of Jack Tizard and Neil O'Connor at the Medical Research Council's Social Psychiatry Research Unit and of the Clarkes at the Manor Hospital at Epsom.[18]

The Todd Report on medical education led to the establishment of both new medical schools and new university departments of psychiatry from the 1960s. The new professors of psychiatry – many of them trained at the Maudsley – were keen to appoint clinical psychologists, and they were strong supporters of the new regional clinical psychology training courses that developed from that period.

Two factors then conspired to broaden the fields of activity of psychologists beyond psychiatry and so to loosen the control of psychiatrists over their work. In 1974, the creation of area health authorities meant that the management of clinical psychologists was often transferred to an area officer, and clinical psychologists began to be seen as a resource for other areas of clinical work, such as neurology and paediatrics. In 1977, the DHSS-sponsored report on the role of psychologists in the health services,[19] chaired by William Trethowan (then professor of psychiatry at Birmingham), recommended that clinical psychologists 'should have full professional status' in the NHS and should develop specialist services beyond psychiatry. Some psychiatrists resented and vehemently opposed these proposals; others felt the recommendations did not go far enough.

A third factor was the explosive growth of behaviour therapy, soon expanded to cognitive behavioural therapy (CBT) and which changed the core role of clinical psychologists in all clinical fields.[20] From the early 1960s, the increasing evidence for the effectiveness of behaviour therapy, initially for anxiety-related conditions, led to high levels of demand for psychological services – not least from GPs. From the 1980s, the major expectation of clinical psychologists was a contribution to psychologically informed treatments and to psychiatric rehabilitation, with increasing demand in outpatient and Community Mental Health Team (CMHT) settings and significant developments in work with older adults, for example.

Hans Eysenck, the deliberately provocative and now controversial professor of psychology at the Institute of Psychiatry up to 1983, has often been seen as the representative leading clinical psychologist in Britain. While he was a prodigiously productive researcher, he did not himself see patients and his influence on clinical and professional practice has been overstated,[21] with Monte Shapiro and Jack Rachman instead having been central to developments in training and CBT at the Maudsley during the early part of this period.

Away from the London and the Maudsley, David Smail in Nottinghamshire and Dorothy Rowe in Lincolnshire, for example, promoted more reflective and critical stances,[22] with other firebrands such as Don Bannister at Bexley Hospital. Other centres developed their own highly productive research programmes, such as at Birmingham, Edinburgh, Manchester and Oxford.

A number of effective professional and academic leaders worked closely with the Department of Health, and with the Royal College, to influence policy and improve practice. These included the three clinical psychologist members of the Trethowan Committee – Alan Clarke, Gwynne Jones and May Davidson. In a later generation, psychologists such as Glenys Parry and Anne Richardson worked very effectively within the Department of Health.

Fifty years on, in 2010, this led to there being 8,800 clinical psychologists in England and Wales who had trained at one of the thirty-five 3-year highly selective university doctoral programmes throughout the UK that adopted a 'scientist-practitioner' model of training. In

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2010, the lead psychologist within a service was likely to be as experienced as the consultant psychiatrist. Psychologist-led research programmes mushroomed, and the BPS is now an equal partner with the Royal College in contributing to mental health–related NICE guidelines. With the advent of general management, clinical psychologists can be clinical directors or Trust CEOs and, with the 2007 Mental Health Act, could be responsible clinicians (RCs) in their own right.

In 1960, there would typically be one relatively inexperienced psychologist in a mental hospital, working essentially as a subordinate scientific technician, when psychiatric services were emerging from the hierarchical systems that existed before the 1959 Mental health Act. So the crucial underlying factor in the changing relationships between the two professions over the period is the shift from a marked imbalance in power and experience to a position of equivalence in expertise within their own fields and of equality in experience and numbers.

So What *Is* Distinctive about Clinical Psychologists?

The distinctive characteristic of psychologists is their felt primary identity as psychologists, acquired during their initial education and training and sustained by their ongoing professional relationships and exercise of distinctive skills and perspective. First degrees in psychology are not vocational. Although the curriculum has to cover core issues required by the BPS, degrees vary significantly in their content and orientation. Many potential clinical psychologists choose to take courses in abnormal psychology that often adopt a critical approach to psychiatry.

Psychology has become one of the most popular undergraduate subjects in Britain, so entry to clinical psychology is highly competitive, with trainees already high academic achievers. They are in effect required to have several years' 'relevant' experience before beginning their clinical training. One significant consequence of this is that most trainees are several years older than most medical students when they begin medical school.

Simon Sinclair, himself a psychiatrist, explored from a social anthropological perspective the socialisation process which medical students undergo, forming what he considered a distinctive 'embodied disposition' or 'medical habitus'.[23] Clinical psychologists are undoubtedly socialised into their roles, but they have gone through a different intellectual and social journey to doctors. They have much in common with other psychological colleagues also working in mental health – health, child, counselling and forensic psychologists as well as clinical neuropsychologists.

Psychologists are, however, now also entering the mental health field in other guises. Completely unexpectedly, the Labour government elected in 1997 gave priority to mental health. The 1999 Adult Mental Health National Service Framework (NSF) identified the need to improve staffing and uncovered serious difficulties in recruitment.[24] In 2000, a commitment was made to train a thousand 'graduate primary care mental health workers' – in practice, nearly all psychology graduates – to administer brief psychological therapy techniques in GP settings, and the 2007 Improving Access to Psychological Therapies (IAPT) programme brought in even more psychologists to NHS mental health services. Add in the psychology graduates who are now training as mental health nurses and occupational therapists, for example, and psychologists are now embedded in the NHS mental health services at every level.

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Inter-professional Co-operation, Competition and Criticism

What psychologists in health care and psychiatrists share is their concern for their patients – or clients or service users, as you will – and their families. When working well as a team, or as immediate colleagues, their concerns lead to a fuller understanding of the needs of their patient and to a wider range of available interventions. With experience, the assumption by mental health workers from all professions of origin of key worker roles and with the cross-professional take-up of post-basic training in new therapeutic modalities, there has been a softening of professional differences. When workers from different disciplinary backgrounds have worked together for thirty years or more, coping with very demanding and distressing circumstances, mutual confidence and trust deepen.

The professional bodies collaborate in a number of areas: the 1995 joint Royal College and BPS policy on psychological therapies in the NHS is an early example.[25] Yet there remain tensions within the BPS, earlier primarily a learned society with an open membership, with it recognising only in 1966 that it needed to also become a professional body and it now fighting to represent academic and research psychologists in a highly competitive funding environment.

There is competition between differing biomedical, psychological and social perspectives: applied psychologists do not privilege biomedical explanations for the myriad range of distress, disability and dysfunction they encounter. R. E. Kendell, in his 2000 Royal College presidential lecture,[26] explicitly saw clinical psychologists as direct professional competitors; he could 'visualise a scenario in which clinical psychology might seem . . . to both general practitioners and to the Health Departments . . . to be both the most important source of therapeutic skills and professional advice in the mental health field'. An important example of such challenges to conventional psychiatric thinking is Richard Bentall's book on the nature of psychosis.[27]

There is direct financial competition in the mental health private practice marketplace with the increased numbers of psychologists and other psychological therapists and counsellors. More psychologists engage in the lucrative business of court work and in the sound bite media comments that influence public attitudes to mental health.

There can still be strains to relationships, usually when one or another person plays power games or holds rigidly to a particular position and is unwilling to compromise; but for every rigid controlling psychiatrist encountering bumptious young psychologists, there have been supportive psychiatrists mentoring their new colleagues.

Just as there is critical and radical psychiatry, so there is critical and radical psychology. There has been no shortage of clinical psychologists challenging their own profession, with David Pilgrim, for example, being a trenchant critic for thirty years.[28] The sociologist Nikolas Rose has similarly been a trenchant critique of the 'psy' professions.[29]

Conclusion

The world of mental health has changed markedly over the past sixty years. Boundaries between normality and abnormality, sickness and health, are complicated by different ideas of distress and dysfunction. The voice of patients (experts by experience) now challenges our authority and mental health policy is firmly in the public and political arena.

To pretend that all is now well in the world of professional mental health practice is dangerous. Psychiatrists and clinical psychologists can be good clinical colleagues and

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conceptual sparring partners; however, both psychiatrists and clinical psychologists must be open to criticism, whether friendly or unfriendly.

Key Summary Points

- Psychiatry has never been without vociferous critics.
- Anti-psychiatry raised legitimate, albeit irritating, concerns about psychiatric practice.
- Clinical psychologists in Britain now outnumber psychiatrists, with an enormously expanded clinical remit.
- Lead psychologists are now as experienced as consultant psychiatrists and vie for leadership.
- To pretend that all is well in the world of professional mental health practice and relationship is dangerous.

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