

Psychiatric power: A personal view

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Introduction

One of the most important questions facing psychiatry today concerns its relationship to the emerging international service user movement. I believe that this movement presents not only the greatest challenge to psychiatry, but also the greatest opportunity. As it becomes more organised and influential this movement is starting to play a major role in shaping the sort of questions that are being asked about mental health services and their priorities. Yet there is limited reflection in our profession about how we, as doctors, might engage positively with it. It seems that while we are comfortable working with individuals and organisations who accept the medical framing of mental problems, we are less willing to contemplate working with critical service users. These are people who reject the medical model because they feel harmed by a system that describes their problems using the language of psychopathology. If we are serious about having an inclusive debate on mental health we will have to overcome this impasse. We need to entertain the idea that people who reject the medical framing of their problems are nevertheless legitimate stakeholders. It is time that we learned how to talk to them and to listen to their ideas. The user movement, with its substantial critical component, is not going to go away.

One of the most important elements of the relationship between psychiatric services and the people who use them is the reality of psychiatric power. Many critical service users accept that legally sanctioned interventions may be necessary when individuals lose capacity to care for themselves and perhaps put themselves or others at risk. However they do not accept the fact that the Mental Health Act in Ireland gives sole authority to doctors to take decisions on such interventions without any obligation to consult other interested parties.

Under the terms of the 2001 Act in Ireland, while an application for involuntary detention may be made by a relative or other named individual and a GP is required to support this with a recommendation order, once a patient is detained all power is put into the hands of the consultant psychiatrist. As a result the Act effectively privileges the voice of psychiatry. When an individual is detained, the psychiatrist is endowed with the authority to determine the nature of his or her problems and the vocabulary that will be used to describe them. Moreover, the psychiatrist has the power to determine what treatment will be used, how it will be used and for how long. It is also within the power of the psychiatrist to decide what side-effects of medication will be taken into account and what risks to the patient's health will be tolerated and to order ECT for a patient even if the patient and his/her family refuse it. The patient is seen for a second opinion shortly after

admission, but this is also carried out by a psychiatrist. The three-person tribunal team that reviews the admission order always includes a psychiatrist.

There is evidence that many people who have undergone involuntary admission and treatment continue to feel hurt and even violated by this process.¹ Stefan Priebe and his colleagues reported on a study in which they were able to follow up more than half of a cohort of patients who were detained under the Mental Health Act in England.² After one year they asked these patients if their involuntary detention was justified. Only 40% said that it was. The authors comment that 'this percentage might have been even smaller if all patients had been re-interviewed'. This would indicate that a majority of patients are currently unhappy with the process of involuntary detention.

A review of the 2001 Irish Mental Health Act will be taking place shortly. In my opinion, this presents us with an opportunity to engage creatively with the user movement in all its diversity, something that many psychiatrists genuinely welcome. However, in order to do so we will have to reflect critically on the 'micro-politics' of our current clinical encounters. In this paper I will argue that the decision-making powers that are currently given to psychiatry cannot be justified on either scientific or moral grounds. I will go on to argue that shedding these powers (and subsequent responsibilities) would be a positive move for our profession.

Justifying Psychiatric Power

It is usual to justify psychiatric power by asserting that we have an expertise about mental illness that allows us to diagnose accurately, classify logically and treat efficiently. The assumption is that no other group in society has such knowledge and therefore can be trusted to make decisions about people who are mentally deranged for one reason or another.

The logic for psychiatric power would appear to be:

- States of madness and distress are the result of episodes of mental illness.
- Mental illness can be fully grasped in the logic of medicine and thus doctors are uniquely positioned to explain and to predict the outcome of such episodes.
- Psychiatry possesses a range of treatments that are uncontroversially of benefit to its patients.
- It is therefore justified to give psychiatrists the power to both detain and to treat patients without their consent.

The assertion here is that *psychiatric science leads to psychiatric power*.

Thomas Szasz has challenged this position for over half a century.³ He argues that it is actually the other way round. In his opinion the history of psychiatry is very different from the history of medicine. Western medicine traces its origins back to the Greeks, and has always been primarily concerned with the suffering caused by diseased organs, and the various interventions that can be made to ease or cure this suffering. Until the 19th century most mental and emotional problems were not treated by physicians. Disturbances of thinking and emotion were understood mainly as spiritual or moral problems. When people were detained on account of such disturbances, this was the domain of clerics rather than doctors.

In the 19th century a new sort of physician was born: the 'mad-doctor', the 'alienist', and in the end, the psychiatrist. What characterised all these doctors was not their knowledge but the location of their work. Psychiatrists were simply doctors who worked in asylums. There is general agreement amongst historians that the enormous asylums were not the creation of the medical profession, less still of psychiatry.

As Roy Porter says: 'It would be wrong to regard this drive over the last three centuries towards institutionalizing insanity fundamentally as the brainchild of "psychiatry"'. In the first instance the sequestration of 'lunatics' was primarily an expression of civil policy: rather an initiative from magistrates, philanthropists and families than the achievement (for good or ill) of the doctors. Indeed, the rise of psychological medicine was more the consequence than the cause of the rise of the insane asylum. Psychiatry could flourish once, but not before, large numbers of inmates were crowded into asylums'.⁴

Szasz argues that 'as the clergyman's power diminished, the mad-doctor's increased, and theological coercion was replaced by psychiatric coercion'.³ Furthermore, according to Porter, the emergence of a psychiatric science only took place once individuals had already been separated from society and brought together in the asylums of the early 19th century. In other words, according to Szasz and historians like Roy Porter, *psychiatric power led to psychiatric science*.

This analysis has major implications for the situation in which we find ourselves today. Historically, there was no real science of psychiatry that could justify the power that was given to the profession. In the early 19th century, there were disparate, contradictory theories of madness; there were no clear classification systems and the treatments used were often akin to torture. Porter gives us an account of Johann Christian Reil's approach to treatment (Reil is credited with being the first person to coin the term 'psychiatry'). Reil, says Porter:

'proposed an idiosyncratic variant on moral treatment: the charismatic alienist would master the delinquent mind; a staff trained in play-acting would further the alienist's efforts to break the patient's fixed ideas – and all would be combined with salutary doses of therapeutic terror (sealing-wax dropped onto the palms, immersion in a tub of eels, etc.)'.⁵

Psychiatry did not have any answers. In fact, the one regime that genuinely seemed to possess therapeutic efficacy, the moral treatment practiced at the Quaker York Retreat, was devised by the Tuke family who were tea merchants, not doctors. Yet, psychiatry was invested with the power to detain, to explain and to treat.

In our own era, the powers of psychiatry have been refined but not lessened. The question still faces us: is the science of psychiatric treatment robust enough to justify psychiatric power?

In their defense of involuntary commitment, in *The Reality of Mental Illness*, Martin Roth and Jerome Kroll make an important point:

'Since most people agree that civil commitment, i.e. involuntary incarceration of a person who has not committed a crime, and involuntary treatment (based upon what others believe is best for a person) represent *massive* [their emphasis] infringements of that person's civil liberties and personal integrity, it follows that the factual basis and the ethico-legal justification for such a course must be suitably strong and unambiguous'.⁶

According to Roth and Kroll, if psychiatrists are ever going to be able to justify their role in such 'massive infringements' of civil liberty we will need to be very confident that our science is disinterested and robust and that our treatments are transparently effective. We will need to be confident that we can predict outcomes, and happy that we understand how our treatments work and for whom. Furthermore, we will need to be very clear that the benefit of these treatments completely outweighs their negative effects. Remember, no other branch of medicine has the power that psychiatry possesses. We will need to be at least as confident as the rest of medicine about the veracity of our science if we are to justify this power. Do we have such a science? Let us briefly look at a couple of issues.

Is the science of psychiatric treatment 'strong and unambiguous'?

While mainstream psychiatry still holds to the idea that antidepressants work through their pharmacological effects on specific neurotransmitters in the CNS, critical psychiatrists like Joanna Moncrieff and David Healy have been pointing out for many years that most of the therapeutic effect of anti-depressants can be explained by the placebo effect. In the past two years the evidence for this has become indisputable. Two major meta-analyses of US Federal Drug Administration (FDA) data by Turner et al⁷ and Kirsch et al⁸ concluded that over 80% of the improvement seen in the drug groups was duplicated in the placebo groups. Irving Kirsch published a book based upon this research in 2009. He concludes:

'The belief that antidepressants can cure depression chemically is simply wrong'.⁹

The placebo phenomenon is not peculiar to psychiatry.¹⁰ However, a great deal of theoretical reflection in psychiatry, such as the monoamine theory of affective disorders, has been based upon the

supposed biological effects of these drugs. Thus these recent meta-analyses represent not only a challenge to our prescribing but also question the foundations of contemporary psychiatric science itself. Rather than embrace the therapeutic reality and the theoretical implications of the placebo phenomenon and explore ways of incorporating these positively and transparently, a number of prominent psychiatrists have sought to justify current prescribing practices by dismissing the results of these meta-analyses. Some of them have done so by arguing that we should abandon the evidence-based medicine (EBM) approach. They say something like: 'actually science isn't that important in debates about psychopharmacology, what is really important is the experience of the doctor'. So we hear one prominent psychopharmacologist, MacAllister Williams, insisting that:

'it matters little whether the patient responds due to the placebo effect or the specific pharmacological actions of the drug, as long as they get better'.¹¹

But the whole logic of EBM, of double blind controlled trials, is to identify what part of therapeutic improvement is due to the placebo response. MacAllister Williams is telling us that this is not important: we know how to get our patients better with antidepressants and that is all that matters.

The psychiatric discourse around antidepressants is far from the 'strong and unambiguous science' demanded by Roth and Kroll.

Is the science of anti-psychotics any more robust? The development of second generation antipsychotics was heralded as one of the great achievements of modern psychopharmacology. For many years after their introduction, psychiatrists told patients and relatives how safe and effective these drugs were. There was talk about a 'breakthrough' in the treatment of schizophrenia. Several years on, and the picture does not look so rosy. We now know that these drugs are possibly more toxic than the earlier ones and there is no evidence that they are more effective. Furthermore, in a major paper in the *Lancet* last year, evidence was presented to show that even the notion that these drugs represented a significantly different *grouping* was false.¹² In an editorial comment on this paper, Peter Tyrer and Tim Kendall wrote:

'The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed. But how is it that for nearly two decades we have, as some have put it, "been beguiled" into thinking they were superior?'.¹³

Antidepressants and antipsychotics are cornerstones of psychopharmacology. These are the drugs that are administered to patients when they are detained. Psychopharmacology is the usual form of treatment given to patients on an involuntary basis.

My argument is that the science we have available to us now, with its explanations and treatments, is simply not of the standard set by Roth and Kroll to justify the power that psychiatrists have been given.

Conclusion

As in most other countries, the Mental Health Act in Ireland puts a great deal of power and responsibility into the hands of psychiatrists. Advance directives, advocates, carers, other professionals and other interested parties play little if any part in the decision-making process regarding detention and treatment. In other words, the current legal framework governing these interventions endorses the singular authority of psychiatric science. In this paper, I have argued that psychiatric power did not develop logically from the explanatory and therapeutic abilities of psychiatric science in the 19th century. Indeed, historians suggest that this science was given energy and direction from the *prior* incarceration of thousands of patients across the western world. Furthermore, I have argued that, in our own time, we simply do not possess the sort of medical science with explanatory, predictive and therapeutic powers that might justify the legal authority invested in us. Our knowledge does not pass the test set by Roth and Kroll. Indeed, I believe that because psychiatry is tasked to deal specifically with problems of beliefs, feelings, behaviours and relationships, its knowledge has to be qualitatively different to that upon which a medicine of the tissues is built.¹⁴

But even if we did have such a knowledge, the current privileged position given to psychiatry in the Mental Health Act directly contradicts the fundamental ethic of the 'recovery approach' to mental health which is promoted by '*A Vision for Change*' and by the Mental Health Commission. One of the Commission's most recent documents contains the statement: 'the recovery approach challenges the privileging of one theoretical perspective as the primary explanation for and the treatment of mental distress and the privileging of professional interpretations and expertise over expertise by experience and personal meaning. The biomedical model and medical treatments may have an important place for some people in the recovery process, but as an invited guest, rather than the overarching paradigm'.¹⁵ A key element of the recovery approach is the promotion of 'empowerment'.¹⁶ This includes the power to define the nature of one's problems and to be involved in decisions about treatment.

Some psychiatrists have yet to embrace the 'recovery approach' and continue to think and act as though the psychopathological framework was the only legitimate and valid way of understanding states of madness and distress.¹⁷ But many are now responding to the calls of service users to create a different sort of psychiatry. A key element of any mental health service involves the management of risk. But there is clearly room to rethink how we do this. The EUNOMIA study has demonstrated 'huge variation' in the rates of involuntary admissions across Europe.¹⁸ Differences in 'socio-cultural contexts' appear to be responsible for this variation rather than rates of mental illness. I am not arguing that there should be no mechanisms in place to intervene when individuals are mentally disturbed. I am not denying that medical practitioners have an important role to play. However, I am suggesting that the current powers and responsibilities of psychiatry are not warranted on either empirical or philosophical grounds.

In their recent qualitative study of the impact of coercive interventions, Sibitz et al¹⁹ found that while some service users, who had received such interventions in the past, felt that involuntary treatment was sometimes needed; many felt that their crises could have been managed differently. They found that 'the ways that problems were formulated by mental health staff as psychiatric issues were sometimes contrary to the ways patients saw their problems and what was needed to solve them'. As a result, participants in this study reported that the experience of involuntary treatment had left them with a 'general distrust of others, particularly of medical professionals'. They reported living their lives as if 'on probation' in the aftermath.

This has implications for the personal relationships between individual psychiatrists and their patients but also for the profession and the society it serves. At present, psychiatry continues to be feared. In spite of all the anti-stigma campaigns, as long as the profession is bestowed with powers to incarcerate and to treat on an involuntary basis, this fear will continue. The forthcoming review of the Mental Health Act provides an opportunity for psychiatrists to shed some of these powers and to engage with service-users in a positive debate about how and when force should be used in mental health crises.

Conflict of interest

None.

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