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Ron Roberts

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References

1. Charter Mental Health 2000. Brighton Declarations on the Rights of Mentally Ill People and the Promotion of Mental Health, Presented to World Congress on Mental Health, Brighton, England, 14–19 July 1985.
2. See for example: 'Treated Well?' A Code of Practice for Psychiatric Hospitals by Good Practices in Mental Health and Camden Consortium, 1988 and 'The Reality Within' by Avon Mental Health Alliance, 1989.
3. In particular the 'He thinks he's Jesus . . .' poster and cinema advert campaign by SANE – Schizophrenia: A National Emergency in London and the South East.

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Psychiatry, science and mental health: arguments against medical tyranny

RON ROBERTS

So much has been written about the social role of psychiatry in recent years that one might think that there isn't anything new to be said about it. I disagree. Institutional psychiatry has survived against the onslaught of anti-psychiatry and deviance models of mental health over the past 20 to 30 years. The focus of this piece is to examine at what price, to the discipline, the scientific community and the public users of psychiatric services, its survival has been ensured.

The influence of psychiatry

Psychiatry has maintained its present status by means of three major influences.

- There has been a deliberate failure to engage in debate with those who don't share the assumptions and axioms of psychiatry.
- There has been a deliberate restriction of students' and doctors' access to other points of view during medical training which have possibly been misrepresented and distorted. Once basic medical training is completed one of the forms this takes is the denial of funding for non-biologically based interventions and treatment alternatives.

- Medicine in general and psychiatry in particular deal with the casualities of social oppression, yet treat them as medical casualties, thereby transforming any protest against the way people live into a condition in need of treatment.

Defenders of orthodox psychiatry would claim that modern psychiatry owes its position to the success of the scientific enterprise. Perhaps the most lucid and accessible attempt to present the case for scientific psychiatry is made by Clare.[1] In *Psychiatry in Dissent* Clare goes to some lengths to refute the arguments of Thomas Szasz, who is famous for his views that mental illness is a myth. The following extract is revealing in its betrayal of some of the *modus operandi* of western psychiatry in Britain.

> 'I once myself debated with Szasz over the existence or otherwise of mental illness . . . I enquired as to the conceptual status of diseases *before* their biological features are known. What was epilepsy before the EEG? What was tuberculosis before the discovery of the bacillus? What was amphetamine psychosis before the association between the mental symptoms and the drug were noted? What was the correct classification of the psychological symptoms of pellagra before the underlying vitamin deficiency was identified? Have all diseases been discovered? . . . Szasz maintained a steadfast silence' (1980 p. 362).

Clare, of course, seems to be implying that mental illness is best construed as disease because there are diseases yet to be discovered and that currently recognised diseases once lacked the firm evidence we now possess that they are best construed as diseases. This frankly is a ludicrous position. That Clare cannot see it, is indicative of the deep malaise from which psychiatry speaks. Until *evidence* justifies it, there are no scientific reasons for coneptualising anything as diseases. To behave otherwise is a recipe for labelling anything as disease – buying the newspaper, hitting people when drunk, craving a better world. Clare's comments can be interpreted as saying that what the medical profession assume are diseases will turn out to be diseases, and that previous diseases have had their status conferred in this ontological way. Whatever else this is, it is obviously not science.

Challenging the disease model

Marshall[2] points out that psychiatry has maintained belief in biological explanations of disordered behaviour, particularly schizophrenia, by treating what are hypotheses as axioms. The disease view of psychological

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difficulties is always the starting point and therefore beyond challenge. To those educated within the medical tradition it can be difficult to see outside this perspective. I shall discuss this by referring to some of the psychological literature on 'schizophrenia'.

Bentall *et al*[3] has argued that if the concept of schizophrenia is a valid syndrome then relatively few people should be suffering from symptoms of more than one mental illness (Kendall[4]); it should manifest as a series of traits that tend to go together (Wing[5]) and diagnoses should bear some relationship to aetiology. In fact none of these contentions are well supported. There is a poor correlation between symptoms and diagnoses – hallucinations for example are found in a wide range of conditions (Assaad and Shapiro[6]).

There is also considerable doubt about the existence of scientifically meaningful clusters of psychotic symptoms. Slade and Cooper[7] estimated what the observed correlations between symptoms would be, given a random distribution of symptoms and selection of a biased sample of subjects exhibiting more than one symptom (subjects were unlikely to be hospitalised unless they had several symptoms). The predicted correlations compared well to those found by Troughton and Maxwell[8] and adduced as viable evidence of a syndrome. Symptomatology is also a poor predictor of outcome. Social variables on the other hand appear to be relatively good predictors (Strauss and Carpenter[9]).

Psychiatrists' responses to these points have been both illuminating and disturbing. I have been met with several kinds of reaction:

- That I am making it up, and even when I have produced the evidence cited above, been told they do not exist *because* they *have never heard of them*.
- I myself am disordered and therefore anything else I have to say is irrelevant.
- It doesn't matter – in some mysterious way the symptoms still cluster together even if evidence doesn't support the fact that this is on anything other than a random basis. *In other words the evidence will be disregarded in favour of the prevailing system of belief.*
- No further discussion of this will take place.

Psychiatrists appear to have lost the ability to appraise evidence or engage in debate with those from outside the medical profession. I have witnessed consultants and professors of psychiatry argue that phenothiazines *cure* schizophrenia, and that schizophrenia is a brain disease because 20–30% of people diagnosed as such show evidence of minimal brain dysfunction. The textbooks of psychiatry also contain some

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uniquely one-sided presentations of existing data. Cancro,[10] for example, in reviewing some of the evidence purporting to favour the genetic hypothesis of schizophrenia reports that studies have not found differences in concordance rates between like and unlike sex twins. In fact a great many studies have found significant differences in this area. Again the evidence is simply disregarded when it conflicts with the prevailing system of belief.

The recent hullabaloo over the genetic linkage studies also illustrates the inability of the psychiatric profession to draw appropriate conclusions from evidence. Sherrington *et al*[12] purported to show that schizophrenia is coinherited with a particular region of chromosome 5. Although other investigations have failed to confirm this, eg. Kennedy *et al*,[13] the absence of a positive finding was taken as confirmation for the existence of a different positive finding, ie. that schizophrenia is polygenetic. Bentall[14] notes that the serious limitations inherent in these studies have simply not been aired, and that while the original results were first announced in the press prior to scientific publication, media discussion of the discrepancy between Sherrington *et al*'s results and other subsequent studies has been kept to a minimum.

The wealth of psychological knowledge contrary to the medical model is being suppressed in the hope it will go away or that critics will miss the evidence of fraud, statistical juggling, fabricated interviews, methodological sloppiness, and inappropriate conclusions drawn in the course of the quest to confirm the genetic hypothesis.[2,11,15–19]

A spirit of enquiry

The evidence will not go away. The medical model of schizophrenia is under renewed attack. Many are sceptical how much longer schizophrenia can exist as a viable scientific concept.[2,3,14,18–24] It would be interesting to survey the medical schools of the UK to ascertain how many of them will be putting this material at their students' disposal for their own appraisal.

As Szasz[25] points out, psychiatry occupies a unique position in being simultaneously an academic discipline and a social institution with vested interest in the control and 'treatment' of 'deviant' individuals. As such it is confused as to whether its primary aim is to understand behaviour or to control it. To those on the receiving end of psychiatric practice things are equally obscure. It is precisely this scenario which bodes ill for a spirit of free enquiry – and it must be recognised that at the present time within psychiatry there is no such thing as free enquiry. Prospective students of medicine would do well to realise this, as would

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those who currently look to psychiatry for salvation from the traumas encountered in living.

Oppression and blame

The psychiatric hospitals and out-patient psychiatric treatment facilities are full of the casualties of oppression, socially promulgated and installed through class discrimination, racism, sexism and sexual abuse.[26,27] Psychiatry explains this all away by having us believe that faulty genes (in what must be the most remarkable coincidence in the history of biology) reside in the oppressed. Neither are the faulty genes of those oppressed confined to upsetting their psyches. A recent report states that the higher rates of heart disease in Belfast citizens compared to their counterparts in Brussels could only be explained on the basis of genetics. That the people of Belfast have lived for the past 20 years in the midst of a Guerilla war and growing deindustrialisation while Brussels is one of the richest cities in Europe was never entertained. What happens to members of the medical profession to produce this kind of thinking?

The new psychiatric genetics offers no way out from the orthodoxy. Nor does it offer any new evidence. As before replications fail. Faulty conclusions ride on the winds of change and corporations controlling the new genetic engineering technologies reaffirm the eugenic ideal, ready to sell the delusion that we can live in a future society free of mental disorder. None of the treatments psychiatry has offered for distressed human behaviour have ever been derived by normal scientific practice – from first principles, testable propositions or refutable theories. Nor is there any change on the cards for the future. Behavioural and cognitive treatments for 'psychoses' though full of potential for success (Slade,[28] Tarrier[29]) offer no rich pickings for big business. No wonder orthodox medical thinking considers schizophrenia an intractable condition best treated by means of the chemical cosh.

The public health importance of this debate is obvious – as the social organisation of our society continues to crumble – those who fall by the wayside stand an ever increasing prospect of being blamed for their fate. Psychiatry has never been on the side of the oppressed in the battle to resist this. We, however, have a choice. There is the opportunity now – as there was in the 1960s and 1970s, but on much firmer footing, to reject the unscientific and dangerous nonsense that is pedalled as psychiatric treatment. We can ask to whom psychiatrists owe their allegiance if we don't like that answer then without delay we should start dismantling the power base of organised psychiatry before it is too late.

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References

1. Clare A. *Psychiatry in Dissent.* 2nd edition. Routledge, 1980.
2. Marshall R. The genetics of schizophrenia: axiom or hypothesis. In Bentall R (ed) *Reconstructing Schizophrenia.* Routledge, 1990.
3. Bentall R P, Jackson H F and Pilgrim D. Abandoning the concept of schizophrenia: some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology* 27, 303–324, 1988.
4. Kendell R E. *The Role of Diagnosis in Psychiatry.* Oxford: Blackwell, 1975.
5. Wing J K. *Reasoning about Madness.* Oxford University Press, 1978.
6. Asaad G and Shapiro M D. Hallucinations: Theoretical and clinical overview. *American Journal of Psychiatry* 143, 1088–1097, 1986.
7. Slade P D and Cooper R. Some conceptual difficulties with the term 'schizophrenia': an alternative model. *British Journal of Social and Clinical Psychology* 18, 309–317, 1979.
8. Troughton D S and Maxwell A E. The relation between neurosis and psychosis. An analysis of symptoms and past history of 819 psychotics and neurotics. *Journal of Mental Science* 102, 1–21, 1956.
9. Strauss J S and Carpenter W T. Prediction of outcome in schizophrenia III. Five year outcome and its predictions. *Archives of General Psychiatry* 34, 159–163. 1977.
10. Cancro R. Etiologic concepts in the schizophrenic disorders. In F Flach (ed.) *The Schizophrenias.* New York: W W Norton, 1988.
11. Rose S, Lewontin R C and Kamin L. *Not in our Genes.* Penguin, 1984.
12. Sherrington R, Brynjolfsson J, Pertusson H, Potter M, Dudleston K, Barraclough B, Wasmuch J, Dobbs M and Gurling H. Localisation of a susceptibility locus for schizophrenia on chromosome 5. *Nature* 336, 164–1267, 1988.
13. Kennedy J L, Giufra L A, Moises H W, Cavalli-Sforza L L, Pakstis A J, Kidd J R, Castiglione C M, Sjogren B, Weterberg L and Kidd K K. Evidence against linkage of schizophrenia to markers on chromosome 5 in a northern Swedish Pedigree. *Nature* 336, 167–170, 1988.
14. Bentall R (ed.) *Reconstructing Schizophrenia.* Routledge.,1990.
15. Laing R D. Critique of Kallman and Slater's genetic theory of schizophrenia. In R I Evans: *R D Laing: The Man and his Ideas.* New York: E P Dutton, 1976.
16. Lidz T and Blatt S. Critique of the Danish-American studies of the biological and adoptive relatives of adoptees who became schizophrenic. *American Journal of Psychiatry* 140, 426–431, 1983.
17. Marshall J R and Pettitt A N. Discordant concordant rates. *Bulletin of the British Psychological Society* 38, 6–9, 1985.
18. Marshall J R. The genetics of schizophrenia revisited. *Bulletin of the British Psychological Society* 37, 177–181, 1984.
19. Marshall R. The role of ideology in the individualisation of distress. *The Psychologist* 2, 67–69. 1988.
20. Boyle M. *Schizophrenia: A Scientific Delusion.* Routledge, 1990a.
21. Boyle M. The non-discovery of schizophrenia. In Bentall R (ed.) *Reconstructing Schizophrenia.* Routledge 1990b.

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22. Claridge G. Can disease model of schizophrenia survive? In Bentall R (ed.) *Reconstructing Schizophrenia*. Routledge, 1990.
23. Pilgrim D. Competing theories of madness. In Bentall R (ed.) *Reconstructing Schizophrenia*. Routledge, 1990.
24. Barnham P and Hayward R. Schizophrenia as a life process. In Bentall R (ed.) *Reconstructing Schizophrenia*. Routledge, 1990.
25. Szasz T. *Ideology and Insanity. Essays on the Psychiatric Dehumanisation of Man*. Marion Boyars, 1973.
26. Albee G W. Towards a just society. *American Psychologist* 41, 8, 891–898, 1986.
27. Ellensen G S. Disturbances of perception in adult female incest survivors. *Journal of Contemporary Social Work* March, 149–159, 1986.
28. Slade P D. The behavioural and cognitive treatment of psychotic symptoms. In Bentall R (ed.) *Reconstructing Schizophrenia*. Routledge, 1990.
29. Tarrier N. The family management of schizophrenia. In Bentall R (ed.) *Reconstructing Schizophrenia*. Routledge, 1990.

Department of Psychological Medicine
St Bartholomews Medical College

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'I hear voices and I am glad to!'

PAUL BAKER

Hearing voices is regarded by clinical phsychiatry as an auditory hallucination, a symptom of a mental disorder and is most commonly thought of as a symptom of a 'schizophrenic disorder'. The usual treatment is to prescribe major tranquillisers which are given to reduce the delusions and hallucinations. However, it is known that not everyone's 'symptoms' are reduced through taking medication.

Seeking other explanations

In November 1988, I attended the conference *People Who Hear Voices* held in Maastricht, Netherlands. It was organised jointly by Foundation Resonance (a self-help organisation of people who hear voices) and the Department of Social Psychiatry at Limburg University. The conference was an opportunity for professionals to hear the direct experiences