

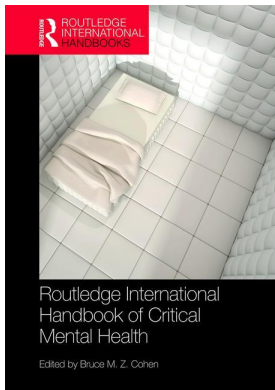
This article was downloaded by: 10.3.98.93

On: 18 Nov 2019

Access details: *subscription number*

Publisher: *Routledge*

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



Routledge International Handbook of Critical Mental Health

Bruce M. Z. Cohen

‘Mental health’ praxis – not the answer

Publication details

<https://www.routledgehandbooks.com/doi/10.4324/9781315399584.ch3>

Bonnie Burstow

Published online on: 28 Sep 2017

How to cite :- Bonnie Burstow. 28 Sep 2017, *‘Mental health’ praxis – not the answer from:* Routledge International Handbook of Critical Mental Health Routledge

Accessed on: 18 Nov 2019

<https://www.routledgehandbooks.com/doi/10.4324/9781315399584.ch3>

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: <https://www.routledgehandbooks.com/legal-notices/terms>

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

'Mental health' praxis – not the answer

A constructive antipsychiatry position

Bonnie Burstow

Upon being invited to pen a chapter for the *Routledge International Handbook of Critical Mental Health*, I was immediately beset by two opposing feelings – pleasure (I was delighted to be part of this important undertaking) and discomfort over the title. A clarification about the latter: I hold that terms like 'mental health' are misnomers – moreover, a form of colonisation. Herein lies a clue about the nature this chapter.

As evident in my title itself, the chapter is antipsychiatry. Now, as a descriptor, 'antipsychiatry' has had variable meanings. Introduced by the group that coalesced around R. D. Laing (see Cooper 1967), it initially referred to an existential and social reframing of the concept of 'mental health', along with a commitment to 'treatment' of an existential variety, as well as to social restructuring. When associated with Thomas Szasz (1961), it means rather a *total* rejection of psychiatric concepts. When employed by activists today, however (see, coalitionagainstpsychiatricassault.wordpress.com), it generally denotes a Szaszian critique combined with a commitment to abolition.

Uncompromisingly antipsychiatry in the latter sense, while also drawing on Laing, this chapter fundamentally problematises psychiatry's use of the concept 'mental illness' and, in line with that, psychiatry as a whole. What is demonstrated is that something is being depicted and treated as medical which is in no way medical and, largely as a consequence, people are being profoundly damaged. Psychiatry is likewise revealed as self-interested, reductionistic, a form of power-over. Moreover – what particularly distinguishes this piece – psychiatric reform itself emerges as problematic. The chapter culminates in an abolitionist call but also a call for a more fundamental shift – one effecting not only 'services' but, on a very basic level, how we live with one another.

Psychiatry as a regime of ruling

Irrespective of how credible or non-credible one finds psychiatry, it is blatantly a formidable regime of ruling (an institutional ethnography term; see Smith 2005). That is, it is a form of governance which creates 'official knowledge', which dictates how people are seen and what happens to them. One obvious example of the power wielded is that, via psychiatry's authority, people who have committed no crime are ripped from their lives and deprived of their freedom, despite their urgent wishes to the contrary. Pivotal players in this ruling are psychiatrists

themselves, their business partners (e.g. the multinational pharmaceutical corporations), the legal apparatus (which endows psychiatry with this power and facilitates it) and, not coincidentally, the state, which provides funding, legitimisation and the means by which psychiatry continues to grow. Institutionalisation itself occurs on the basis of ‘dangerousness’, albeit statistics do not indicate that the ‘mentally ill’ are any more dangerous than anyone else (see Burstow 2015). Psychiatry, correspondingly, is a growth industry with more and more falling under its auspices (for details on the exponential growth in both the number of ‘diagnoses’ and the numbers of people ‘diagnosed’ and ‘treated’, see, e.g. Whitaker 2002, 2010). All of which, in turn, increases the power and the profit of the industry.

Like all regimes of ruling, psychiatry rules by texts. If a psychiatrist activates a particular section of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), for example, the person is officially ‘schizophrenic’. Correspondingly, if s/he signs a particular form (in Ontario, Canada, a *Form One*; see Hiltz and Szigeti 2011), a person *by law* is involuntarily committed. In this respect, the words spoken or written by a psychiatrist have the power of law, they make certain processes happen. This in itself is a problem of epic proportions, as is the transparently carceral and punitive nature of the psychiatric project, so brilliantly articulated by Foucault (1980, 1988). That said, a whole new problematic level surfaces as we consider psychiatry’s pivotal concept.

The concept of mental illness: the foundations of psychiatry

While mental illness as a concept has become so hegemonic that most people use it without hesitation, stop to reflect on it and it begins to look strange, perhaps even suspect. Significantly, as Szasz (1961) points out, illnesses are conditions of the body and, as such, *only a body or one of its organs* can have an illness. The mind (thinking) is neither a body nor an organ. It is rather *an activity* of the body much like running and jumping and, as such, it can no more have a disease than running or jumping can – hence Szasz’s (1961) identification of ‘mental illness’ as a metaphor. This much the early psychiatric pioneers were well aware of, with the Austrian physician von Feuchtersleben (1955: 412, emphasis original), for example, stating that, ‘[t]he maladies of the spirit... can be called diseases of the mind only per *analogiam*’ – though we almost never see such admissions today. Now, to be clear, it is not in itself problematic to employ health-based metaphors. We habitually do with no untoward consequences. We refer, for instance, to ‘sick jokes’. The difference is we do not bring in a doctor to cure the sick joke. By contrast, we do call in a doctor to attend to these putative ‘mental illnesses’.

What has happened here? What is a figurative truth only is being taken as literal fact. In short, what we have here is the literalising of a metaphor – hardly a credible scientific foundation. The problems evident here are multiplied exponentially when you examine the ‘diagnoses’ themselves. Integral to the DSM is language manipulation, arbitrary criteria, reductionism, a de-contextualising of people’s problems, the transformation of people’s reactions to their world into inner ‘symptoms’ (see Woolfolk 2001) and, correspondingly, the projection of a disease entity which is subsequently treated as causal despite the DSM’s claim to be aetiology-free (for elucidation of this claim, see Burstow 2015). A response which I gave in an interview recently (see Spring and Burstow 2015) further elucidates the phenomenon:

[The DSM] sets practitioners up to look at distressed and/or distressing people in certain ways. So, if they go into a psychiatric interview, they’re going to be honing on questions that follow the logic of the DSM, or to use their vocabulary, the ‘symptoms’ for any given ‘disease’ they’re considering. In the process it rips people out of their lives. And so now

there's no explanation for the things people do, no way to see their words or actions as meaningful because the context has been removed. In essence, the DSM de-contextualizes people's problems, then re-contextualizes them in terms of an invented concept called a 'disorder.' Let me give you an example. 'Selective Mutism' is a diagnosis given to people who elect not to speak in certain situations. So, if I were... trying to get a handle on what's going on with somebody – I would try to figure out what situations they aren't speaking in, try to find out if there's some kind of common denominator, to ascertain whether there's something in their background or their current context that would help explain what they are doing. You know, as in: Is it safe to speak? Is this, for example, a person of color going silent at times when racists might be present? Alternatively, is this a childhood sexual abuse survivor who is being triggered? Whatever it is, I would need to do that. But this is not what the DSM, as it were, prompts. In the DSM, 'Selective Mutism' is a discrete disease. So, *according to psychiatry*, what causes these 'symptoms' of not speaking? Well, 'Selective Mutism' does.

What we have here is the invention/projection of invalidating labels which function so as to cover up the real problems that people face. Correspondingly, in what is blatantly an exercise in ideological circularity, these labels are attributed with causality. Now, to be clear, it is not that any of us who are antipsychiatry would deny that the people so diagnosed *may be* enormously confused or beset with horrendous problems and *may* indeed be in need of assistance – only that we see these as social and psychological in origin, rather than as products of a disease process, and we regard the people themselves as agential. Herein lies a paradigm difference of colossal significance.

Psychiatry's biological claims

Psychiatry's way around the 'metaphor problem' has been to be more biologically specific and name the diseased organ. The psychiatric claim, as articulated by Andreasen (1984), is that 'mental illnesses' are illnesses of the brain – moreover, that they have been conclusively proven to be such. Here, once again, we enter the realm of assertion, not fact. Note that, as demonstrated by Breggin (2008) and Burstow (2015) (despite assertions to the contrary), not a single brain illness – not any oedema, not one lesion – has ever been established for a solitary 'mental illness'.

That said, proceeding as if the brain disease hypothesis were proven has long been psychiatry's way. This modus operandi stems from a gambit made by pioneer Emil Kraepelin (1962: 151) over a century ago, who recommended that psychiatrists act *as if* these putative 'conditions' were bone fide diseases, adding:

The nature of most mental illnesses is now obscured. But no one can deny that further research will uncover new facts in so young a science as ours... It is logical to assume that many other types of insanity can be prevented even cured – though at present we haven't the slightest clue.

Psychiatrists proceeded as recommended. In the fullness of time they additionally 'progressed' from acting *as if* the brain disease hypothesis were 'established' to insisting that the hypothesis *had in fact been proven*, this despite the total lack of evidence. Herein lies the basis for psychiatric treatment of 'mental illness' – something transparently fraudulent. Correspondingly, the very fact that attempts to prove the brain disease hypothesis persist

despite the fact that over a century of trying has led only to reasons to see it as mistaken in itself an indicator that the agenda is inherently political (for a detailed discussion of such attempts, see Burstow 2015, chapter 1).

A related claim, also without merit, is that the success of the psychopharmaceuticals proves that ‘mentally ill’ people have chemical imbalances, which, in turn, constitutes proof of brain disease. Again such claims will not hold. To put aside the dubious claim of the ‘success’ of the psychopharmaceuticals for a moment, chemical imbalances in themselves do not constitute proof of a disease. In this regard, according to the Virchow criterion (the medical gold standard), to qualify as a disease there must be real lesions, real cellular abnormality observable directly or by tests (see Ackerknecht 1953; Szasz 1988). And note, chemical imbalances do not constitute lesions or cellular abnormality. What is equally fundamental, contrary to the impression created by psychiatry, as demonstrated by numerous authors (see, e.g. Breggin 2008; Whitaker 2010) and despite the abundance of research and research funding in this area, there is not an iota of proof that a single chemical imbalance underlies even one of these putative disorders. In this regard, the so-called proof of the chemical imbalance theory of schizophrenia serves as exemplum.

For years it was *claimed* that people labelled schizophrenic had chemical imbalances. Then proof began to materialise, all based on incorrect premises, all subsequently disproved, only to be rapidly replaced by others equally problematic. A well-known example is the proof predicated on the prevalence of extra dopamine receptors. To wit, having found that neuroleptics (‘anti-psychotics’) impeded the transmission of the neurotransmitter dopamine, psychiatric researchers hypothesised that ‘schizophrenia’ is caused by excess dopamine. Searching for ‘evidence’, they soon claimed to have discovered that ‘schizophrenics’ have extra dopamine receptors – from which they concluded that ‘schizophrenics’ indeed suffer from a chemical imbalance. What was subsequently discovered? Being labelled schizophrenic was not the relevant variable but *the taking of the drug*. The point is, it is not ‘schizophrenics’ but *people ‘after treatment with the neuroleptics’* who have extra receptors – a development itself traceable to the brain’s attempt to compensate for the dopamine deficiency created by the drugs. The point? No chemical imbalance exists *until the ‘treatment’ creates one*. A similar story could be told about all the other psychiatric drugs (for details and substantiation, see Burstow 2015; Whitaker 2002). Whatever additionally follows, the treatments per se are lacking in medical validity.

The ‘treatments’ as ‘help’

It might be argued that, irrespective of medical validity, the treatments are helpful – so, minimally, they should be prescribed to those who want them. To argue this, however, is to misunderstand the coercive nature of the environment in which they are promoted and also the habitual lies told about the treatments. It is, likewise, to misunderstand the nature of the substances and processes involved.

As demonstrated by researchers like Breggin (2008), all quintessentially ‘psychiatric treatments’, whether they be electroconvulsive therapy (ECT) or one of the drugs, work by impeding and damaging the brain. Indeed, demonstrates Breggin, there is a one-to-one ratio between the ‘effectiveness’ and the degree of damage done. Correspondingly, albeit individuals may feel they have been helped by the drugs and, indeed, *on the face of it* may well fare better for a time, longitudinal studies reveal a truly bleak picture: those who come off the drugs within a few years fare better than those who stay on them. Correspondingly – and this is the ‘killer discovery’ – those who fare best in the long run are those who were *never on them in the first place*. By the same token, so-called schizophrenics living in allegedly ‘underdeveloped’ countries with

no access to the drugs fare better than those in ‘developed’ countries with access (for further details, see, respectively, Harrow 2007; Rappaport *et al.* 1978; Hopper 2000). In short, even when appearances seem to suggest otherwise, we are not helping, we are harming. Moreover, via the power of the state, we are not only authorising but paying for such harm. In the process – and as demonstrated by Whitaker (2010) – I would add, as a society, we have created a drug problem of epidemic proportions, all in the name of care.

How did we, as a society, get here?

It is beyond the scope of this chapter to articulate in any detail exactly how we arrived where we are. However, for us to make better decisions it is critical that we have some understanding of the factors involved. To begin with the most obvious: we have been routinely misled both intentionally and otherwise by an industry whose interests lie precisely in making what is not medical appear medical. What is apropos here (not just recently, but throughout the vast majority of psychiatry’s history) is that its practitioners have ever more systematically used medical trappings to bolster the claim that ‘madness’ is medical and hence the proper province of doctors, in the process driving out or marginalising all competitors for control over this turf – witness the routing of the women healers in the nineteenth century (see Burstow 2015).

Along with this, there has long been an exceptional level of manipulation both in how psychiatric research is conducted and in the reporting of it (see Whitaker and Cosgrove 2015). Other factors which come together to bring us where we are include:

- medicine proper reaching the scientific threshold and the huge credibility concomitantly given to everything considered a branch of medicine, including psychiatry (see Burstow 2015);
- mad doctors becoming agents of the state, complete with dictatorial powers;
- the state’s progressive attempts to control;
- the enormous money and power involved;
- people’s fear of those who strike them as different, and hence their willingness to entertain solutions that promise to keep the ‘othered’ person under control (see Foucault 1988);
- our tendency to see anything labelled ‘help’ as benign, even when it is blatantly incarceral (see Lewis 1970).

What is, likewise, a factor: the more our lives are in the hands of ‘expert others’, the more ‘normal’ and reasonable arrangements of this ilk seem.

What should we do about psychiatry?

On a very simple level, insofar as substances and processes such as electroshock and psychiatric drugs are not medical and, beyond that, by their very nature harmful, over time doctors should not be allowed to prescribe them – to be clear, this is not to say that I am advocating a ban on psychopharmaceuticals, any more than I would ban any other mind-altering drug which people use to cope. Correspondingly, on a more fundamental level, I am suggesting that we, as a society, admit that psychiatry has been a colossal misstep and begin moving towards abolition, preferably of the attrition (gradual erosion) variety (for elaboration on the attrition model, see Burstow 2014). A good beginning is, bit by bit, severing the relationship between psychiatry and the state.

Herein my stance differs from the reformer, who opts for tempering psychiatry only. The question is: does such an arbitrary and coercive state power really serve us? And why would we want even a reformed psychiatry, given that psychiatry is a medical discipline and the problem being ‘treated’ *is not medical*? Correspondingly, there are lessons from history here that we can ill afford to ignore. Significantly, on two previous occasions, institutional psychiatry embraced reformism, moving seemingly decisively in a non-biological, comparatively humanistic direction. The first was called ‘moral management’ and it was dominant from the late eighteenth to the mid-nineteenth century; the second was psychoanalysis – the mainstay of mid-twentieth-century psychiatry. In both cases, these revolutions seemed irreversible yet proved to be detours only, leading to a return of biological psychiatry with a vengeance. Why? In both cases, non-medical helpers were better at it, which threatened the dominance/continuation of psychiatry. All of which culminated in a new revolution. In each case, moreover, it is not just that the ground gained was lost. The situation which materialised was far worse than what predated reform, for everything became grist for the biologising agenda (for details, see Burstow 2015) – a predictable reaction by psychiatrists, this being the one way to stop what would otherwise be an unstoppable erosion of their power. The point being made here is that a system which *includes* psychiatry but *precludes or minimises* the medical (read: pseudo-medical) will not last long precisely because psychiatry cannot afford it to, with the result being re-biologisation with a vengeance. As reasonable and promising as a non-abolitionist reform agenda may look, in the long run it is set to backfire and, in the short run – what is hardly a minor issue – it squanders the momentum for benign and lasting change.

In concluding: so where do we go in the long run?

This chapter has demonstrated that psychiatry’s tenets are unfounded, that psychiatry inherently and inevitably harms, and it calls for phased-in abolition. While it is beyond the purview of this chapter to articulate in any detail a more encompassing societal approach, I end by conveying, however scantily, a general direction: obviously disentangling ourselves from psychiatry, however necessary, hardly suffices – people will still be beset by massive problems and be in need of help. Nor, I would suggest, will providing more decent services (i.e. ones connected to the actual nature of people’s problems in living, ones provided on a voluntary basis and in line with recipients’ preferences), vital though these are. Insofar as the majority of us dwell in societies which are alienated and alienating and, as such, ones that necessarily give rise to humungous personal troubles, we need a more fundamental societal transformation.

With disempowerment and the relentless erosion of community clearly a factor in our current plight, an obvious direction would be predicated on smaller communities wherein everyone had a place, where we see ourselves as connected to every other being and where we grapple with problems together. Critical aspects could include:

- participatory environmentalism;
- participatory (not simply representative) governing;
- expansion of the commons (joint owning, co-creating, being co-responsible for; for a discussion of the commons, see Hardt and Negri 2004);
- equality/egalitarianism, with rigorous attention to systemic oppression such as racism and sexism;
- allowing everyone to contribute in their own unique way;
- respect for both collectivity and individuality;
- cherishing – not pathologising or trying to control – difference.

How children are raised is pivotal. Caring – not correction – would need to be prioritised. Correspondingly, it would be important that schools be places of freedom and creativity, while introducing children to the skills needed for life generally and community engagement in particular. Learning about feelings – one’s own and others – would be crucial. In such schooling, moreover, learners should be helped to appreciate the wisdom in states once dismissed as ‘mental illness’; skills such as conflict mediation should be prioritised; everyone should learn how to ‘befriend’ others in distress, including how to engage in active listening; moreover, everyone should acquire the skill needed to follow thinking processes radically different from their own (including acquiring what I call ‘mad literacy’ – that is, being able to follow thought that might initially seem irrational; for details, see Burstow 2015).

What would services look like in such a society? They would be diverse, manifold, tailored to both individual and collective needs and they would be vested in the community as a whole – as opposed to experts. People would contribute as their talents/inclinations lead them, whether it be counselling, assisting in emergencies, providing others with healthy food, witnessing, lending a supportive presence as folk retreat into themselves or any other act of befriending. Some basics would be: forced help is *not* help, people’s welfare is everyone’s concern and everyone befriends. Specifics would vary according to the particularity of a community’s needs and inclinations – in an apartment complex, for example, on a rotational basis, resident befrienders might be on-call who could be turned to should any resident find themselves in distress or should conflict arise. By the same token, everyone would be involved in conflict mediation, with the well-being of everyone affected actively grappled with and with respect demonstrated for everyone’s rights, everyone’s wisdom (for a fuller articulation of this ‘commoning’ of services, including how *extreme* situations might be handled – for, to be clear, such will inevitably arise – see Burstow 2015, chapter 9).

In ending, two questions and some tentative answers: 1) can we integrate aspects of such services in society as it exists now? and 2) is there *any place* for ‘professionals’? For the first, my sense is, yes. Correspondingly, my invitation would be for readers, as interested, to be on the alert for openings in their current lives where such ‘commoning’ might be introduced. For example, does your current apartment building have residents on-call? If not, how would you feel about initiating a conversation about this? For the second, while arguably there is indeed room for ‘professionals’ (e.g. to provide training as needed), a cautionary note: the last thing needed is yet more armies of experts – a component, alas, implicit in the solutions of most reformers. Correspondingly, given how frighteningly easy it is for slippage to occur, care should be taken that decision-making remains in the hands of the community as a whole and its members, and not in the hands of the ‘experts’.

Bibliography

- Ackerknecht, E. (1953) *Rudolf Virchow*. Madison: University of Wisconsin Press.
- Andreasen, N. (1984) *The Broken Brain*. New York: Harper and Row.
- Breggin, P. (2008) *Brain-Disabling Treatments in Psychiatry*. New York: Springer.
- Burstow, B. (2014) ‘The Withering of Psychiatry’, in Burstow, B., LeFrançois, B. and Diamond, S. (eds), *Psychiatry Disrupted*. Montreal: McGill-Queen’s University Press, pp. 34–51.
- Burstow, B. (2015) *Psychiatry and the Business of Madness*. New York: Palgrave Macmillan.
- Cooper, D. (1967) *Psychiatry and Anti-Psychiatry*. London: Paladin.
- Foucault, M. (1980) *Power/Knowledge*. New York: Pantheon.
- Foucault, M. (1988) *Madness and Civilization*. New York: Random House.
- Hardt, M. and Negri, A. (2004) *Multitude*. New York: Penguin.
- Harrow, M. (2007) ‘Factors in Outcome and Recovery in Schizophrenic Patients not on Antipsychotic Medications’, *The Journal of Mental and Nervous Disease*, 195(5): 406–14.
- Hiltz, D. and Szigeti, A. (2011) *A Guide to Consent and Capacity Law in Ontario*. Markham, ON: LexisNexis.

- Hopper, K. (2000) 'Revisiting the Developed Versus Developing Country Distinction in Course and Outcome in Schizophrenia', *Schizophrenia Bulletin*, 26(4): 835–46.
- Kraepelin, E. (1962) *One Hundred Years of Psychiatry*. New York: Philadelphia Library.
- Lewis, C. S. (1970) *God in the Dock*. Grand Rapids, MI: Eerdmans.
- Rappaport, M., Hopkins, H., Hall, K., Belleza, T. and Silverman, J. (1978) 'Are there Schizophrenics for Whom Drugs may be Unnecessary or Contraindicated?', *International Pharmacopsychiatry*, 13(2): 100–11.
- Smith, D. (2005) *Institutional Ethnography*. Lanham, MD: Altamira Press.
- Spring, L. and Burstow, B. (2015) 'Probing Psychiatry and the Business of Madness', *rabble.ca*, <http://rabble.ca/books/reviews/2015/07/probing-psychiatry-and-business-madness> (retrieved on 5 January 2016).
- Szasz, T. (1961) *The Myth of Mental Illness*. New York: Paul B. Hoeber.
- Szasz, T. (1988) *Schizophrenia*. Syracuse, NY: Syracuse University Press.
- von Feuchtersleben, E. (1955) 'Medical Psychology', in Schreber, D., *Memoires of My Nervous Illness*. London: Dawson, p. 412.
- Whitaker, R. (2002) *Mad in America*. New York: Perseus.
- Whitaker, R. (2010) *Anatomy of an Epidemic*. New York: Broadway Paperbacks.
- Whitaker, R. and Cosgrove, L. (2015) *Psychiatry under the Influence*. New York: Palgrave Macmillan.
- Woolfolk, R. L. (2001) 'The Concept of Mental Illness: An Analysis of Four Pivotal Issues', *The Journal of Mind and Behavior*, 22: 161–78.