# Critical Approaches to Psychiatry

Detail from Hieronymus Bosch ‘Extracting the Stone of Madness’

# Critical Approaches

1. Preliminaries: initial questions.
2. Some historical background.
3. Positives and negatives: alternatives and criticisms (Laing, Szasz, Moncrieff).
4. Discussion.

# Preliminaries

- ‘Anti-psychiatry’ coined by David Cooper: “…profound questioning has led some of us to propose conceptions and procedures… quite antithetic to… conventional [psychiatry]… a germinal anti-psychiatry.” (Cooper 1967, p. 9)
- What led psychiatrists like Cooper to feel that psychiatry was “…perpetually in danger of committing a well-intentioned act of betrayal” of patients?

# Preliminaries

- We ordinarily assume medical intervention is a matter of our (informed) choice, in contrast with criminal justice interventions.
- Unlike other physicians, psychiatrists are expected, in certain circumstances, to use compulsion (involuntary detention and treatment).
- This difference between psychiatric and non-psychiatric medical care is a source of tension (cf. Basaglia 1980).

# Preliminaries

- Two important sources of criticism of psychiatry:
  i. One is related to psychiatric theory: how objective or scientific are psychiatric disease categories? Are medical (i.e. surgical, pharmaceutical) – as against psycho-social interventions – appropriate?
  ii. The other is related to psychiatric practice: the use of compulsion (involuntary incarceration and treatment).

# Preliminaries

- Compulsory detention in asylums/hospitals *even of people not guilty of any crime* might seem normal now.
- Not always the case. Nor was it always the case that medical professionals were involved in the management or treatment of the mentally ill (cf. Scull 1993, Jones 1993).
- How, and why, did psychiatry end up playing the role it does today?

# Preliminaries

- A little history will give some support to my claim that:
  - It is the structure of modern society that makes mental disorders almost exclusively *medical* issues.
    - Breakdown of communities, demands of employment, medicalisation of the mental.
- … And provide some background to understand why psychiatrists themselves (e.g. Laing, Szasz) felt moved to publicly criticise the foundations of their profession.

Francisco Goya, The Madhouse (Casa de Locos), 1812-1819

# Historical Background

- Early Christian views of madness saw it in terms of a battle for the soul between God and the Devil (Porter 2002).
- Mental distress was often (but not always) seen as a consequence of sin, or possession (Porter 2002, Roffe and Roffe 1995).
- There is little evidence of the confinement of the insane in specialised institutions before the end of the Middle Ages (~1500), with Bethlem an exception (Porter 1992).

# Historical Background

- David and Christine Roffe (Roffe and Roffe 1995) draw the following picture of late medieval treatment of the insane, on the basis of a well-documented case from 1383:
- Care of the mentally ill was primarily the responsibility of the family, unless they were unable or unwilling to provide it, when (for those with property) provision was managed by the crown;

# Historical Background

- In such cases, an inquisition determined diagnosis and guardianship of person and property;
- Recourse to an inquisition was not restricted to the rich, but was a means for *any* mentally disturbed person with property to have their case examined;
- The verdict was determined by commissioners in consultation with all interested parties including the disturbed person, and was intended to be in the latter's best interests.

# Historical Background

- The case of Emma de Beston (Handout, 1).
- The case of George Trosse (Handout, 2).

There are notable differences in the decision-making process and the provision of care in the two cases, which are nearly three hundred years apart.

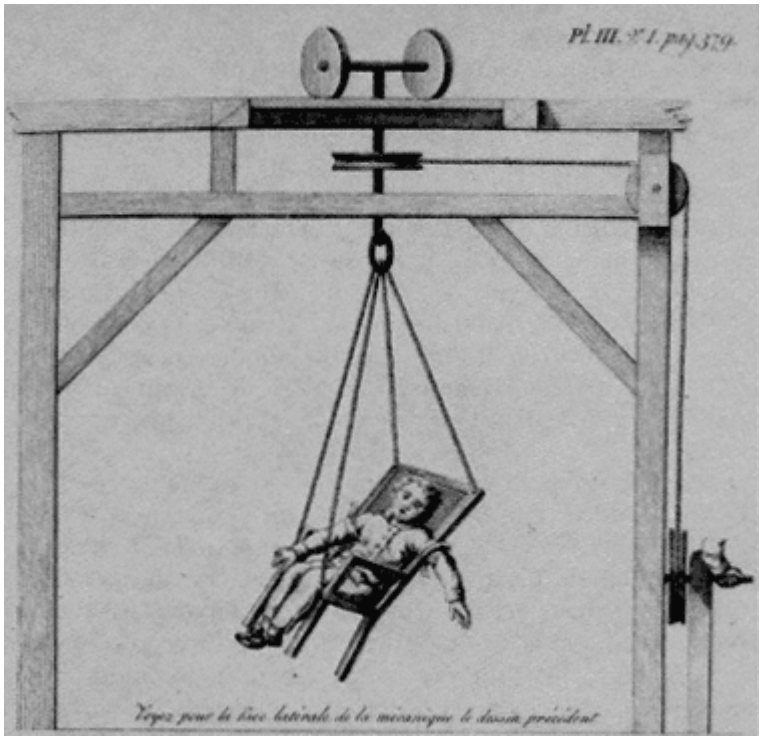
Both Emma and George were lucky. For the mentally ill (as for others) without means or support, especially the unruly, life was ‘nasty, brutish and short’. (Jones 1993, Scull 2011)

# Historical Background

- Before the 18th c. most mentally ill people whose families or communities were unwilling or unable to care for them became itinerant 'Tom o'Bedlams', who 'with roaring voices' begged to survive (Jones 1993, Scull 2011).
- Those who ended up in poorhouses or jails rarely got any care, and could "serve for sport to idle visitants" (John Howard, *The State of the Prisons* 1777, quoted in Jones 1993)

William Hogarth, A Rake's Progress Plate 8 (Bethlem), 1735

The confinement of James Norris in Bethlem for over 9 years, ~1800



A device based on Joseph Mason Cox's spinning chair, ~1800

# Historical Background

- Treatment for the mentally ill was, in common with humoral medicine of the time (Porter 1997), barbaric and gruesome:  bleeding and purging, as well as the 'betynge and correccyon' of the unruly (Thomas More on Bedlam, quoted in Scull 1993).
- The Old Poor Law (1601 Act) distinguished between the *impotent* and the *able-bodied poor*, and made parishes responsible for the care of their impotent poor in poorhouses.

# Historical Background

- Subsequent laws (Vagrancy Act of 1714) allowed for the confinement of ‘furiously and dangerously mad’ vagrants on the order of two magistrates, and (Criminal Lunatics Act 1800) the detention of the mentally ill who had committed significant offences (e.g. murder).
- During the 1700s, there was a growth in the ‘trade in lunacy’, with private madhouses catering for clients whose families could pay (Jones 1993, Scull 2011).

# Historical Background

- There was little regulation of private madhouses, and the sane could be admitted by family interested in getting rid of them, e.g. for inheritance purposes (Jones 1993).
- Some, such as Matthew Wright's White House in London "became a byword for cruelty and neglect", with patients sleeping naked amid their own excrement (Andrews & Scull 2003).
- Private madhouses provided a good income for 'mad-doctors' such as John Monro, physician of Bethlem, 1751 – 1791 (Andrews & Scull 2003).

# Historical Background

- The York Retreat was founded in 1792 by the Tuke family in direct response to the suspicious death of Quaker patient Hannah Mills in York Asylum. (Jones 1993, Scull 1993)
- The York Retreat was among the first to replace medical treatment (bleeding, purging) with ‘moral therapy’, i.e. psychological and occupational therapy, and to do without the use of chains or corporal punishment. (Jones 1993, Scull, 1993)

# Historical Background

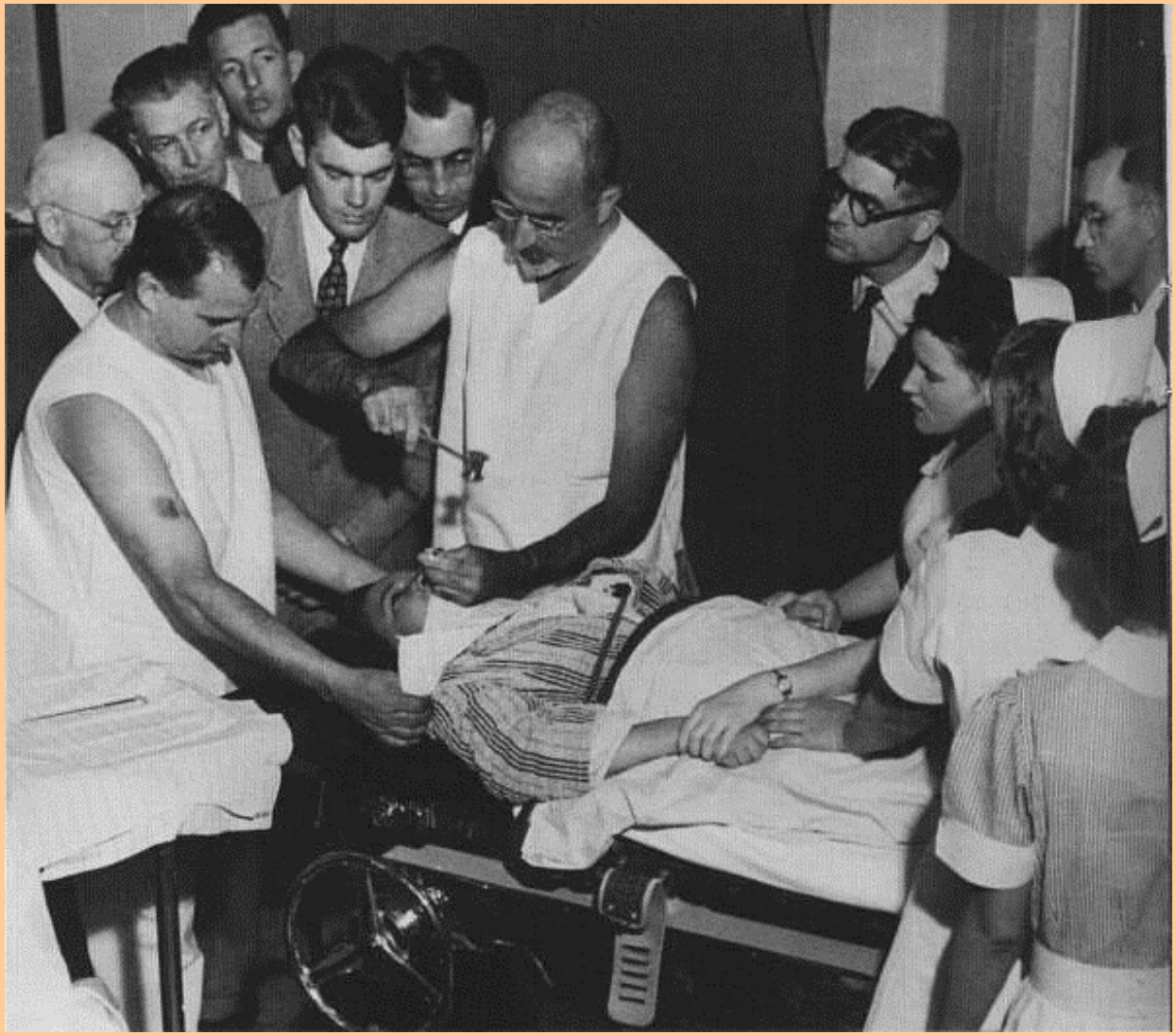
- Thomas Bakewell, a contemporary of Samuel Tuke wrote "… authority and order… are better maintained by kindness… than by any severities… Lunatics are not devoid of understanding… they should be treated as rational beings." (quoted in Scull 1993, p. 98)
- "… the statistics collected during the Retreat's first fifteen years… seemed to show that moral treatment could restore a large proportion of cases to sanity." (Scull 1993, p. 103)

# Lobotomies

- Procedure developed by Egas Moniz in 1935. Moniz won the Nobel prize for this work in 1949.
- Involved destruction of parts of the frontal lobes of patients' brains.
- The procedure spread throughout Europe and the USA, the latter principally through the efforts of Walter Freeman.
  - Radio program of Walter Dully, who was lobotomised by Freeman at the age of 12.

# Lobotomies

"… the story of lobotomy involves many factors: opposing theories of mental dysfunction; a long political struggle within medicine between psychiatrists and neurologists; a desperate human need and a procedure that offered to cure it; immediate enthusiasm in the popular press; uncritical acceptance by the medical profession… and determined and ambitious doctors."
(Valenstein, Great and Desperate Cures, p.6)



Walter Freeman operating in Western State Hospital, 1949

# Imaging and Diagnosis

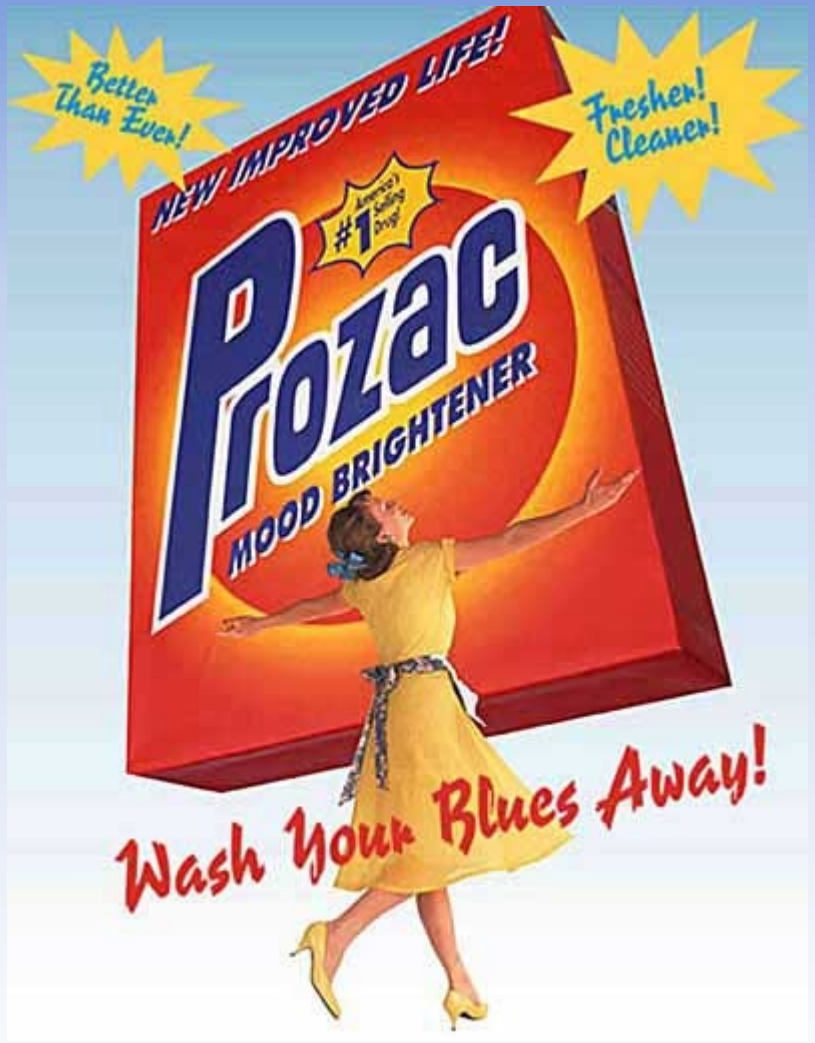
- Most neuroimaging studies aggregate data from many test subjects. In contrast, a diagnosis is relevant to just one person. Problematically, “the distribution of healthy and ill subjects generally overlap” (Farah & Gillihan 2013 p. 136)
- Studying brain activation requires a baseline (no activation) and a relevant task. Aggregated data must be from comparable tasks (ibid. p. 137).
- Activation may cut across diagnostic criteria, which may themselves not be valid (ibid. pp. 137-8).

# A Critical Look at *Explanation*

- Explanation in diagnosis:
  - As the psychologist Martha Farah points out, "Diagnoses in psychiatry are based entirely on behavioural, not biological, criteria." (Farah & Gillihan 2013 p. 128)
  - Yet most treatments for psychiatric disorders target the patient's *brain* (e.g. drugs, ECT, surgery), not his/her *behaviour* (psychotherapy is an exception).
  - Are psychiatric disorders primarily *brain disorders*, or primarily *behavioural disorders*? The brain might help with diagnosis, but is the brain the whole story?

# Diagnosis and Treatment

- If psychiatric disorders are primarily *brain disorders*, why do psychological (e.g. trauma) and social factors (e.g. poverty, social isolation) affect their prevalence?
- If psychiatric disorders are primarily *behavioural disorders*, shouldn't we be looking at multifaceted approaches to treatment?
- What are the dangers of relying (almost) exclusively on drug treatment?


Better Than Ever!
NEW IMPROVED LIFE!
Fresher! Cleaner!
#1
Prozac
MOOD BRIGHTENER
Wash Your Blues Away!