Original Article

Psychiatric diagnosis as a political device

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Abstract Diagnosis in psychiatry is portrayed as the same type of activity as diagnosis in other areas of medicine. However, the notion that psychiatric conditions are equivalent to physical diseases has been contested for several decades. In this paper, I use the work of Jeff Coulter and David Ingelby to explore the role of diagnosis in routine psychiatric practice. Coulter examined the process of identification of mental disturbance and suggested that it was quite different from the process of identifying a physical disease, as it was dependent on social norms and circumstances. Ingelby pointed out that it was the apparent medical nature of the process that enabled it to act as a justification for the actions that followed. I describe the stories of two patients, which illustrate the themes Ingelby and Coulter identified. In particular they demonstrate that, in contrast to the idea that diagnosis should determine treatment, diagnoses in psychiatry are applied to justify predetermined social responses, designed to control and contain disturbed behaviour and provide care for dependents. Hence psychiatric diagnosis functions as a political device employed to legitimate activities that might otherwise be contested.
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Introduction

Modern diagnostic systems in psychiatry, like the Diagnostic and Statistical Manual (DSM), now in its fourth version and soon to be updated, have been enormously influential. Many formal concepts like 'clinical depression', attention deficit hyperactivity disorder (ADHD) and more recently bipolar disorder have been incorporated into lay language and understandings, helping to shape the way ordinary people view themselves and their situations (Healy, 2004; Rose, 2004). These systems also form the basis of a vast research effort aimed at mapping the prevalence, aetiology, outcome and treatment response of the entities defined. They are also used in pharmaceutical marketing, which often starts with raising awareness of a particular diagnostic category, before going on to promote a drug for its treatment (Koerner, 2002).

The basis of modern diagnostic systems, the idea that psychiatric disorders can be conceptualized in the same terms as medical diseases, has been challenged for decades now. Antipsychiatrists such as Laing and Szasz, and sociologists such as Conrad, stressed the differences between medical diseases and psychiatric conditions and pointed out the social control function served by dressing up normative judgements about behaviour as medical facts. Although their work provided an important conceptual analysis, it often relied on extreme and exceptional examples of the use of psychiatric diagnosis, such as the incarceration of dissidents in the old Soviet Union. Less attention has been paid to the nature of routine psychiatric practice. More recent analyses have highlighted the tautological and redundant nature of psychiatric diagnoses (Bentall, 1990). A diagnosis is applied on the basis of observations of an individual's behaviour, but diagnostic categories are defined by collections of typical behaviours.

Champions of the idea that psychiatric disorders are like other medical diseases have continued to assert their position (Craddock *et al*, 2008), but have not answered the basic arguments posed by their challengers. David Pilgrim recently argued that the debate had been rehearsed so many times that the question that remained was not about the validity of psychiatric diagnosis, but why it has survived, and what interests it serves (Pilgrim, 2007).

In this paper I examine the gulf between what psychiatric diagnosis purports to be and how it functions in everyday practice. I have returned to the analyses of Jeff Coulter, a sociologist with an ethnomethodological orientation, and David Ingelby, a psychologist and philosopher, whose work examines the differences between psychiatric diagnosis and diagnosis in the rest of medicine. In particular, it suggests that contrary to other areas of medicine, where diagnosis determines the appropriate treatment to be given, in psychiatry diagnosis is merely a 'signal' for the application of pre-existing institutional arrangements. I shall present the stories of two real psychiatric patients, who are reasonably typical of people with severe and long-standing psychiatric problems. These stories illustrate how psychiatric diagnosis can be understood as functioning as a political device, in the sense that it legitimates a particular social response to aberrant behaviour of various sorts, but protects that response from any democratic challenge.

What is Psychiatric Diagnosis?

First however, it is necessary to clarify the meaning of the term 'diagnosis'. Diagnosis is a medical concept which covers both the process of identifying a disease, and the designation of that disease. Reaching a 'diagnosis' involves

investigations and observations that help to identify the nature of the underlying disease that is thought to be causing the individual's symptoms. Having a diagnosis indicates that the nature of the underlying disease has been certainly or probably ascertained. Everyone with the same diagnosis is assumed to have the same disease, the same biological abnormality. This means that their outcomes are determined by the nature of the disease, within the range of outcomes associated with that disease. They can also be predicted to respond to a given set of treatments that are known or thought to modify the particular disease process. Indeed, establishing the correct treatment is the main practical function of diagnosis in medicine.

The use of the concept of diagnosis in psychiatry implies an equivalence between psychiatric classification and the process of medical diagnosis with the implication that psychiatric problems are caused by a bodily dysfunction. Therefore diagnosis in psychiatry should determine the nature of treatment in the same way that it does in medicine.

Some early psychiatric classification systems used the term diagnosis loosely and metaphorically. The first versions of the DSM were influenced by psychoanalytical concepts of the nature and causation of psychiatric conditions. In contrast, the development of DSM III has been seen as a deliberate remedicalization of psychiatric classification. References to psychoanalytical concepts and sociological thinking were expunged, in favour of brief lists of supposedly objective empirical criteria for the application of different diagnoses. The manual is reported to have contained the statement that 'mental disorders are a subset of medical disorders' in an early draft, which was taken out after complaints by the American Psychological Association (Kutchins and Kirk, 1997). In addition a huge research effort was put into demonstrating the reliability, or reproduceability, of DSM III categories, with almost no attention paid to their validity. This was necessary so that the concepts outlined in the manual could legitimately be employed in medical research designs such as epidemiological studies and clinical trials.

The construction of medical-like diagnostic systems can be seen as one of a number of ways in which psychiatry increased its medical orientation from the 1970s onwards, in the face of attacks from the antipsychiatry movement and elsewhere (Wilson, 1993). The influence of psychoanalysis and sociological theories of mental illness were seen as making psychiatry vulnerable to competition and economic pressures and the reassertion of the 'psychiatry is like any other medical speciality' argument was the line taken to safeguard psychiatry's dominant role in the management of madness and mental distress (Wilson, 1993). As well as detailed diagnostic manuals like DSM III, the medical credentials of psychiatry were promoted through an increasing focus on high-tech biological research and greater links with the pharmaceutical industry.

Before I go any further it is necessary to assess whether the view of psychiatric disorders as manifestations of bodily diseases is justified. In contrast to most medical conditions like diabetes, tuberculosis and heart disease, no psychiatric condition can be traced to a specific dysfunctional bodily process, excepting dementia, and the occasional neurological conditions that present to psychiatrists. In other words, there is no agreed physical aetiology for psychiatric disorders, although there are numerous and ongoing speculations about physical processes that might be involved.

In addition, despite claims to the contrary, there is no evidence that psychiatric conditions respond to physical interventions in a specific manner, as would be expected on the basis of a disease model. The effects of psychiatric drugs can be explained by the fact that they are psychoactive substances, that produce altered, drug-induced states. These altered states may effectively suppress psychiatric 'symptoms'. There is no evidence that any class of psychiatric drug acts by reversing or partially reversing an underlying physical process that is responsible for producing symptoms (Moncrieff and Cohen, 2005). Therefore the idea that the behaviours seen by psychiatrists are indicative of an underlying disease is simply an assumption. Diagnostic labels embody this assumption, but also obscure the fact that it remains an assumption by glossing over the complex subjective judgements involved in the process of applying the label.

Coulter and Ingelby on the Nature of Psychiatric Diagnosis

Coulter's analysis, based on an ethnomethodological paradigm and strongly influenced by the later Wittgenstein, suggests that psychiatric diagnosis is a quite different sort of activity from the medical process of diagnosis (Coulter, 1979). 'Psychiatric practices are not poor cousins of physical diagnoses, for they do not belong to that family of practices, however medical are some of the consequences' (p. 149). In contrast to medical diagnoses, which result from the application of biological knowledge, Coulter argues that the designation of insanity or mental illness is not made on the basis of scientific methods, and cannot claim to be objective and independent of context, as scientific judgements are meant to be. Instead someone is said to be mad or mentally ill when their behaviour infringes social norms of intelligibility. What counts as intelligible, reasonable or rational is determined by unwritten rules of conduct that are constituted by social groups. In contrast to scientific laws, which are universal, judgements about conduct are always dependent on context. Different rules apply in different situations and what counts as infringement of those rules also varies: 'psychiatric diagnoses are predicated on social and

moral contingencies relating *both* to a person's conduct and to the context within which the diagnosis is being made' (p. 147).

Although they are rarely explicit, rules of conduct are constituted and understood by most members of the social group they operate within. Again this contrasts with scientific laws which emanate from the physical world and require specialist scientific knowledge to be understood and applied. Coulter suggests that ascriptions of mental illness or insanity are first made by the individual themselves or by family members, social workers or general practitioners, before the prospective patient reaches a psychiatrist. The diagnosis is merely a formal sounding label given to behaviour that has already been identified as problematic. It is a 'response to mundane social and moral requirements, and not to the development of some esoteric branch of knowledge' (p. 147).

Rules of conduct are bound up with the practical arrangements that exist for enforcing the rules, such as arrangements or sanctions for dealing with people who do not abide by them. Implicit in Coulter's analysis is the idea that psychiatric diagnosis serves the pragmatic function of enabling the appropriate application of these arrangements. In Coulter's words diagnoses are 'devices for pragmatic use in ward or treatment allocation' (p. 149).

Ingelby accepts Coulter's emphasis on intelligibility and how it is understood with reference to rules of conduct (Ingelby, 1982). Ingelby's interest, however, is in the contradiction between the way Coulter demonstrates that psychiatric diagnosis is applied and the way it is portrayed. What Ingelby points out is that psychiatric diagnosis can only function in the way outlined by Coulter because it presents itself as an activity other than that which it actually consists of. In other words, it is only because psychiatry presents its activities as essentially medical in nature, that it is able to fulfil the function of social control that Coulter identifies, in the sense of enforcing certain rules of conduct. A psychiatric diagnosis brings with it consequences that follow directly from the implication that it designates a medical disease.

A psychiatric diagnosis therefore allows a situation to be construed within a medical framework and this framework obscures the values and judgements embedded in psychiatric activity. The framework allows interventions designed to curb or control unwanted behaviour to be conceptualized as medical treatments – in other words, as treatments that modify the underlying disease process and thereby help restore normal functioning. Psychiatric treatments are presented as capable of changing the course of the condition, not merely suppressing or ameliorating its symptoms or manifestations. From this it follows that the problem or disorder can be regarded as temporary in nature and can be expected to abate as soon as effective treatment is administered. If it does not, then a search for more effective treatments commences.

Mental health legislation is also premised on the notions of the treatability of mental disorders. Involuntary commitment to hospital is presented as serving the best interests of the patient because treatment will restore them to normal functioning. It is only their temporarily disordered state of mind that prevents them from perceiving their need for treatment. Mental Health legislation cannot be used simply to incarcerate someone whose behaviour is odd, antisocial, violent or dangerous. It has to be justified on the basis of providing 'treatment' that will benefit the individual by alleviating their illness or disorder. Although the 'treatability' criterion has arguably been weakened in the latest Mental Health Act of England and Wales passed in 2008, and this may reflect a desire in parts of government that the Act be used to detain people on the grounds of dangerousness alone, it remains the case that 'appropriate medical treatment' has to be available to justify the use of coercive measures (UK Parliament, 2007).

Apart from disguising control, psychiatric diagnosis also enables the provision of care for adults. In modern societies the presence of physical illness or disability entails an unquestioned entitlement to state-funded care and support, and other prerogatives of the sick role. The implication provided by a psychiatric diagnosis that disturbed behaviour originates from a bodily disease, enables these prerogatives to be extended to cover numerous situations in which people find it difficult to care for themselves. Temporary sick notes for people in distress can be justified by a diagnosis of 'depression' and long-term care can be provided for people with more severe behavioural problems. Psychiatric diagnosis therefore authorizes the allocation of state funds, but forecloses any debate about this area of policy. In addition, by eradicating culpability for the actions concerned, since these are the result of disease rather than intention, a psychiatric diagnosis can exempt people from the usual sanctions of the criminal justice system.

Coulter examines several empirical sociological investigations of the way in which psychiatric diagnoses are applied in practice. The most well-known is perhaps the Rosenhan experiment, which was published in 1973 in the leading scientific journal *Science* (Rosenhan, 1973). In this experiment eight volunteers contrived to be admitted to psychiatric hospitals by presenting at appointments saying they were hearing a voice saying 'empty', 'hollow' or 'thud'. After admission all behaved entirely normally and all were discharged with a diagnosis of 'schizophrenia in remission'. This is especially remarkable since the 'symptom' at presentation, that of hearing a voice speaking a single word, is quite unlike typical auditory hallucinations that occur in people with psychotic disorders like schizophrenia. Rosenhan concluded that the psychiatric system could not distinguish between the sane and the insane. What Coulter is interested in is the fact that the context of being in a mental hospital determined

the way a diagnosis was applied. In this context, the psychiatric system assumes that people are mentally ill, and observations of their behaviour are shaped to fit this assumption. In other contexts like the military, or assessments for welfare benefits, the assumption that operates is that people are well, unless proven otherwise (p. 146).

What the Rosenhan experiment tells us, and why it caused the consternation it did, is that in ordinary practice, psychiatric diagnoses are applied to whoever presents themselves or is presented to psychiatric services, unless a good case can be made that they should be dealt with by another institution. Psychiatric services simply apply a diagnosis to whoever they are asked to deal with. The diagnosis signals that the situation can be re-interpreted according to a medical framework. This framework obliterates the memory that what psychiatric 'treatment' consists of is a particular social response to certain problematic behaviours. It conceals the fact that the response could be different. As Ingelby points out: 'If it were accepted that the meaning of the label were simply to signal a certain organisational response, then questions would immediately arise about the propriety of those responses' (Ingelby, 1982, p. 137).

Case Studies

The stories of two individual mental health patients are presented below. Both stories are fairly typical of people with more severe forms of psychiatric disorder. The patients are described using pseudonyms, and factual details have been changed to preserve their anonymity. Bill was chosen as he represents a group of patients whose behaviour clearly does not conform with the criteria for the diagnosis of any specific mental illness such as schizophrenia or manic depression. He appears to represent an example of people who end up in the psychiatric system because no other institution appears to be capable of, or willing to deal with them, but the sort of problems he presents are not uncommon. I could have chosen a number of other patients who raise similar issues. Tanya was chosen because her problems conform more nearly to the picture of a severe psychiatric disorder, namely schizophrenia, although, like many such patients, she does not exhibit the typical 'textbook' symptoms of the disorder.

Bill

Bill was first admitted to psychiatric hospital at the age of 29. Over the next few years he went in and out of hospital several times, and in his late 30s, when his elderly father could no longer cope with caring for him, he was admitted as a long-stay patient. He has spent the last 15 years in hospital. At school he was

described as a 'loner', he worked very little and was dependent on his parents until admission. The 'symptoms' that led to his admission to hospital, and that he continued to display intermittently over the following years, consisted of periodic outbursts of violence, lack of activity, little communication, rigidity and resistance to change. He usually became violent or abusive if he was asked to do something he did not want to do, or if his wishes were challenged in some way. Throughout the early years of his stay in hospital he was diagnosed with schizophrenia and treated with injectable and oral antipsychotic medication. He spent most of his time sitting in the same chair smoking cigarettes. He engaged in little conversation and gave mostly one word answers in response to questions. He rarely took part in any organized activities provided, nor did he engage in informal contact with staff. He did communicate with some of the other patients, among whom he had great authority and he was able to make them lend him money and run errands for him.

A few years ago a new psychiatric team took over Bill's care and decided that there was no basis for the diagnosis of schizophrenia. The team started to reduce his considerable dose of antipsychotic medications, at which point he became more talkative and animated. However, his violent outbursts also became more frequent, and so his medication was increased again. About a year later he made a violent and premeditated attack on another patient, which resulted in serious injuries. Although he was arrested for this attack, no charges have been pressed and the police have shown no further interest in the case, despite repeated requests from the psychiatric team and hospital management. Shortly after this incident, Bill attacked a member of staff in a similar fashion, but resulting in less severe injuries on this occasion. At this point he was transferred to a locked ward, for which he needed to be under a section of the Mental Health Act 1983 (although he would have gone quite willingly). In the section papers he was given a diagnosis of psychopathic disorder and he was detained on the legal grounds that treatment may alleviate his condition or prevent deterioration. The Mental Health Trust management were unhappy about the use of the clause for psychopathic disorder and queried the section. In the locked ward environment he was again labelled as having schizophrenia and his drug treatment was increased in response to further violent attacks. The discharge summary from this unit refers to him as having a 'well documented diagnosis of paranoid schizophrenia' (discharge summary, dated 17 May 2007). His refusal to take outside exercise and his concerns about being harmed by local 'yardie' gangs were interpreted as evidence of psychotic symptoms and he was referred to as having 'persistent persecutory thoughts' (*ibid*). However, he was never known to take much exercise, and had long expressed racist views. His concerns about 'yardie gangs' are also understandable as a reaction to being moved from a hospital situated in a largely white middle class area, in which he

had resided for over 10 years, to a unit located in an inner city area with an ethnically more diverse population. At this stage an application was made for a placement in a long-term secure unit, but funding for this was turned down on the grounds that there was a lack of consensus about his diagnosis.

Bill's story illustrates some of the functions of psychiatric diagnosis. Firstly, his long-term hospitalization and drugging was justified by giving him a diagnosis of schizophrenia. No one questioned this diagnosis for many years, despite the fact that he never displayed any characteristic symptoms of schizophrenia. Secondly, the changing of his diagnosis from schizophrenia to psychopathic disorder caused discomfort within the system and it was soon changed back to schizophrenia by the staff of the psychiatric secure unit. In the secure unit, actions and utterances that appear quite understandable were interpreted as psychotic symptoms. Concerns about these symptoms were used to justify increasing the amount of medication he was prescribed, but his medication was also clearly increased in response to his continued violent outbursts, and unpredictable behaviour. Thirdly the police and criminal justice system took the fact of Bill's status as a psychiatric patient as a cue not to pursue criminal charges against him for a serious offence which could have sustained a charge of grievous bodily harm. The police indicated that they were unlikely to persuade the office of the Director of Prosecutions to take the case up, because the likelihood of obtaining a conviction in someone with a history of long-term contact with psychiatric services was so low. Lastly, the local funding body used the lack of consensus over Bill's diagnosis to justify refusing to fund an expensive placement. The implication was that if the diagnosis had been maintained as schizophrenia, the funding would have been awarded, although it is likely that the funding body was looking for reasons to make savings.

Tanya

Tanya is a 19-year-old girl who has been under the care of psychiatric services since she was 12. She has also been diagnosed as having schizophrenia. She has been an inpatient in various psychiatric facilities continuously for 3 years now, since her mother could no longer cope with her at home. She spends most of her time alone and talks little to staff or other patients. Occasionally she listens to music but she shows little interest in anything else. She does ask to spend time at home with her mother, but when she does, she spends most of her time in bed. Occasionally her speech is bizarre and she speaks about childhood friends and experiences in a disjointed way that is difficult to follow. Sometimes she expresses fears that people are trying to harm her, and this fear prevents her from going out alone, she says. She has never said that she hears voices, but it is

inferred that she does because she laughs and sometimes talks to herself when she is alone.

There is no doubt that something unusual is occurring in Tanya's inner mental world, which she cannot share with other people and that prevents her from communicating and otherwise functioning in a normal way. The nature of her inner experiences is unclear, as is often the case. Since she has been in hospital she has been treated with five different 'antipsychotic' drugs. These have been changed because of adverse effects and because of a lack of improvement. She has just started taking clozapine, a drug that is thought to produce some improvement when other drugs have failed. She also periodically receives other sedative drugs when she is agitated or distressed and she has a 'rehabilitation' programme consisting of occupational therapy and other supervised activities to try and help her function more independently. So far she has made little progress.

In contrast to Bill, Tanya had problems that could be more closely identified with the pattern of behaviour characterized as schizophrenia, but even in her case she did not explicitly describe the typical symptoms, such as auditory hallucinations. These were instead inferred from her bizarre behaviour and all that was directly observable was that she seemed preoccupied with a largely inaccessible internal world. In common with around 30 per cent or more of people given this diagnosis, she did not recover, but has continued to be severely impaired for many years now. The diagnosis firstly enabled her to be removed from her mother, who was finding it difficult to cope with her, and admitted to hospital. Tanya was detained using the Mental Health Act on several occasions during her adolescence, in which she was classified as having a 'mental illness'. Again the diagnosis also entails that she is cared for in a state-funded institution, without any questions asked about her ability to work or provide for herself.

In terms of her day-to-day care, the diagnosis of schizophrenia allows interventions such as the provision of medication and support to be presented not simply as sedative agents that may help suppress her mental preoccupations, but as treatments for a specific disease designed to produce a recovery. This has the advantage that if she does not show any improvement with the medications, as she clearly has not, different medications can be tried, doses can be increased, or additional drugs added. There is always something that can be done and staff involved in her day-to-day care can feel that they are able to make a fundamental difference to her outcome, through their specialist training in the application of medical treatments. When it was recently decided to start prescribing clozapine, one staff member commented 'isn't it exciting'. The alternative position is to admit that the most that can be achieved is a modest improvement in her functioning and that this could be done by anyone

who could provide a modicum of containment and encouragement. What is in reality, a difficult task of trying to help someone whose focus is an internal world that she will not reveal, whose ability to relate to others is severely compromised, and who is likely to remain in this state for many years to come, can be presented instead as a series of specific medical interventions, each bringing with it expectancy of a breakthrough. When the time comes for her to be discharged from hospital– when the list of drugs and other interventions has been exhausted – then the state will fund her ongoing care in a staffed care home.

Discussion

The idea that psychiatry is an institution of social control is of course a familiar one (Foucault, 1965; Szasz, 1994; Conrad, 2009). However, there has been little examination of the actual mechanisms whereby the conceptual basis of psychiatry enables this control to be exercised. There has also been little attention paid to the other social function of psychiatry: the provision of care. Coulter and Ingelby took up the theme by examining the role of diagnosis in facilitating social control, and particularly the implications of its medical nature. Rosenhan's experiment revealed the process of initial application of a psychiatric label, but few people have yet examined the way that a psychiatric diagnosis functions once applied over the course of patients' lives in actual psychiatric settings.

The patients' stories presented here demonstrate how psychiatric diagnosis facilitates the control of people who exhibit violent and antisocial behaviours, whom the criminal justice system does not want to entertain. It is also employed to legitimate the provision of long-term care and to motivate and sustain the morale of the professionals who provide this care. There is no doubt that the behaviour of both the individuals described was, by most standards, highly abnormal and dysfunctional, but this is not in itself evidence of a specific physical disease. In both cases, the diagnosis they were given served clear social rather than medical functions.

Therefore, as Coulter and Ingelby suggest, psychiatric diagnosis appears to act as a political device to enable the application of various social arrangements for the care and control of people whose behaviour presents problems to themselves or to the people around them. Far from determining what sort of 'treatment' will be given, the diagnosis is invoked *post hoc* because the irreducible medical meaning of a diagnosis allows for those responses to be construed in a certain light. It allows behavioural control to be presented

as treatment and it sanctions the release of state funds for support, the desirability of which might otherwise be challenged. It conceals the coercive aspects of psychiatric care but it also maintains hope and morale among staff, by encouraging the belief that the interventions that they are specially trained to apply make a fundamental difference to the outcome of psychiatric problems.

Over recent decades, western society has accepted the mass use of prescribed psychotropic drugs for everyday problems. This phenomenon is presented as the treatment of previously unrecognized psychiatric disorders, which clinicians are now encouraged to diagnose as depression, anxiety, attention deficit disorder or bipolar disorder. Another interpretation is that diagnostic fashions follow marketing imperatives. David Healy has shown how everyday nerves were transformed from anxiety to depression in order to market SSRI antidepressants and that the diagnosis of bipolar disorder was promoted to sell antipsychotics (Healy, 2004; Healy, 2006). These examples illustrate how the concept of psychiatric diagnosis can be exploited for profit and how particular diagnoses are employed by leading drug companies to expand their markets.

Pilgrim rightly concludes that the interests of the psychiatric profession and the pharmaceutical industry have helped to sustain the practice of psychiatric diagnosis (Pilgrim, 2007). However, the current analysis suggests there are more fundamental reasons for its survival, as highlighted by theories of medicalization and social control (Conrad, 2009). Psychiatric diagnosis forms a key part of the framework that supports the existing social response to certain problematic behaviours. It is a vital step in the medicalization of social problems. By purporting to indicate the presence of an objectively identifiable bodily disease, psychiatric diagnosis is able to re-designate social problems as medical ones, and the social responses to those problems as medical treatment.

By concealing the political nature of the responses to the situations that are labelled as 'mental illness', psychiatric diagnosis prevents these responses from being questioned and scrutinized. It allows the state to delegate a difficult area of social policy to supposed technical experts, and thus to remove it from the political and democratic arena. An effective challenge to the concept of diagnosis would entail a challenge to an entire body of flexible institutional arrangements designed to deal with those who infringe certain social norms. It would open up complex and thorny questions about how society should respond to those whose behaviour is disruptive or dangerous to other people, and under what circumstances the state should provide ongoing care and financial support. Psychiatry would be revealed, as Coulter suggests it should be, as a 'practical moral enterprise' (Coulter, 1979, p. 151), that requires democratic participation and control.

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