From Szasz to Foucault: On the Role of Critical Psychiatry

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Abstract: In this article, we examine the different ways in which Thomas Szasz and Michel Foucault have challenged dominant perspectives within psychiatry. We identify, analyze, and compare the central elements of their respective discourses on psychiatry and show that although they are often bracketed together, in fact there are certain fundamental differences between Szasz and Foucault. Of most importance is their contrasting ways of characterizing the nature and role of critical thought. Whereas Szasz's analysis is predicated on a number of binary distinctions, Foucault works to overcome such distinctions. In the past ten years, a new movement of critical psychiatry has emerged. Although this shares certain concerns with the critical psychiatry of the 1960s and 1970s, there are substantial differences. We argue that this discourse is more resonant with the Foucauldian approach.

Keywords: Antipsychiatry, binary distinctions, critical thinking, postpsychiatry, poststructuralism, psychotherapy

Because psychiatry deals specifically with 'mental' suffering, its efforts are always centrally involved with the meaningful world of human reality. As such, it sits at the interface of a number of discourses: genetics and neuroscience, psychology and sociology, anthropology, philosophy, and the humanities. Each of these provides frameworks, concepts, and examples that seek to assist our attempts to understand mental distress and how it might be helped. However, these discourses work with different assumptions, methodologies, values, and priorities. Some are in dispute with one another. At various times in the history of psychiatry, a particular form of understanding has become dominant and worked to marginalize the contributions of others.

These conceptual dynamics are related to changing external economic, cultural, and political conditions, to struggles between different professional groups and to changes in the relationships between professionals and those who are recipients of their interventions. As a result, psychiatry, and mental health work in general, is (by its very nature) a site of dispute, conflict, and agitation (Stastny & Lehmann, 2007). Although there have always been voices within psychiatry that have challenged the assumptions of the status quo, at certain times these have become more organized and coherent than others. In recent years, a new movement of critical psychiatry has emerged. In the United Kingdom, a group called the Critical Psychiatry Network has been in existence since 1999; both the authors belong to this group.[1]

This contemporary movement shares many concerns with the critical psychiatry of the 1960s, but there are important differences. As authors,

we do not speak for anyone but ourselves: this review is not a manifesto for the Critical Psychiatry Network. Instead, we simply aim to contrast the approaches of Thomas Szasz and Michel Foucault in relation to critical thought and to look at some of the implications of this analysis for the project of a critical psychiatry. Whereas most authors are aware that Foucault and Szasz approached psychiatry from very different angles, nevertheless, there has been a tendency to lump them together as representatives of 'anti-psychiatry.' A typical example is Edward Shorter's (1997) dismissive remark: "The works of Foucault, Szasz, and Goffman were influential among university elites, cultivating a rage against mental hospitals and the whole psychiatric enterprise" (p. 275). In this paper, we focus on the *differences* between Szasz and Foucault. In focusing on the work of these two writers, we are not suggesting that their work encompasses all of what might be regarded as critical thought about psychiatry, but rather we are using this as a device to help us tease out differences in how we might conceptualize critical thought and its role in relation to psychiatry.

We are particularly concerned with the implications of critical psychiatry for us as medical practitioners. Is there a legitimate role for doctors in relation to madness and distress? Does medicine have anything to contribute when pain and suffering involve thoughts, emotions, relationships and behavior? Is the term 'mental illness' valid? We use the term 'anti-psychiatry' to indicate those positions in which the answer to these questions is a simple 'no.' Although a number of people have articulated this view, the most sustained anti-psychiatry critique (in this sense of the term) has emerged from Thomas Szasz.[2]

Szasz (2007) writes that, since the 1950s, he has been involved in a "systematic scrutiny and refutation of the two fundamental claims of contemporary psychiatrists—namely, that mental illnesses are genuine diseases, and that psychiatry is a bona fide medical speciality" (p. 3). Szasz has challenged psychiatric orthodoxy on a number of issues, including the use of coercion, the insanity defense, and the medicalization of recreational drug use. However, at the heart of his work is a wish both to demarcate the boundary between scientific medicine and psychiatry and also to demonstrate a fundamental contradiction between the individual and the state. With regard to the latter, Szsaz's account is primarily focused on his own country, the United States, with some references to the situation in certain European societies. Szasz understands social progress in Enlightenment terms: increasing individual autonomy alongside a movement to understand the natural world (including the human body) in the language of science.

Szasz's critique is heavily dependent on what we call 'binary oppositions.' Indeed, much of the strength of his analysis derives from the fact that he is prepared to 'draw lines in the sand' and to be very clear about where he stands on any particular issue. In this paper, we first provide a brief outline of how we understand Szasz's critique and then question whether such binary thinking is adequate to the lived reality of struggling and suffering human beings. We then go on to show how Foucault's analysis of psychiatry works in a very different manner and leads to different answers to the questions posed. We follow this by outlining some elements of contemporary critical psychiatry. We end by arguing that critical thought has a positive and constructive role to play within psychiatry.

Szasz on Medicine, Science, and Psychiatry

For Szasz, there are clear, definable limits to what it is legitimate to call 'illness.' Problems with our bodily functions are properly understood to be pathological, but difficulties with our thoughts, feelings, relationships, and behaviors are of a different order. They are not pathological, not diseases or illnesses; they are best characterized as 'moral' issues or simply 'problems in living.' His argument is based on a particular understanding of the nature of human reality. For Szasz (2007), human reality is like a television set that is transmitting a program: "I maintain that mental illness is a metaphorical disease: that bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television program" (p. 6). Two completely different discourses are needed to describe the quality of the set and

the quality of the programs that are transmitted through it. We cannot improve the quality of a television program by interfering with the wiring of the set. In the same way, according to Szasz, we cannot 'treat' or 'cure' psychological difficulties by interfering with the 'machine' (the body) of the individual who experiences these difficulties. If we do so, he says, "It is as if a television viewer were to send for a television engineer because he dislikes the program he sees on the screen" (p. 6). The content of a television program is related to things outside the set: scripts, acting, directing, and production values. These involve discourses that are very different to the technical logic of television manuals. So too, argues Szasz, we should not attempt to use the language and logic of medical pathology to frame psychological problems. When we do, he says, we end up fitting suffering individuals and their problems into a framework that causes confusion and further suffering and oppression.

This leads to a seemingly uncomplicated view of the world of medicine. To Szasz diseases are 'cellular pathology.' Medicine derives its authority and credibility from its basis in biological science. Proper medicine is applied science. But, he maintains that medicine is only properly scientific when it confines itself to the workings of the body. He says (2007) that, following the work of the nineteenth century German pathologist Rudolf Virchow, the "standard scientific measure—the 'gold standard'—of disease was bodily lesion, objectively identifiable by anatomical, physiological, or other physico-chemical observation or measurement" (p. 43). Szasz bemoans twentieth century moves away from this 'gold standard.' He argues that interpretive forms of the human and social sciences have no real role to play in relation to understanding and treating illness. For Szasz, if the patient's suffering can be matched with an abnormal scan or laboratory result, then it can be regarded as 'genuine'; if no such matching is possible, it is essentially malingering and the implication is that doctors should walk away. He sees no role for medical involvement in the messy world of madness and distress. In an interview with the *Psychiatric Bulletin* (Fannon 2005), he was asked (in relation to psychiatry): "How would you entice more medical students into the profession?" He answered: "I wouldn't" (p. 120).

Szasz proposes that the only legitimate professional response to states of madness and distress is a form of free-market psychoanalysis that he calls 'autonomous psychotherapy.' He defines this (2003) as a nonmedical process: "I have made it clear that I regard psychoanalysis (psychotherapy) as a special type of dialogue—listening and talking—that has nothing to do with doctors (medicine) or therapists (persons who treat diseases) or 'analyzing' (any object or person)" (p. 203). In *The Myth of Mental Illness* (Szasz 1972), he combines insights from Freud, Piaget, and others to develop his own approach to understanding the origins of madness and distress. He relies strongly on ideas about rule following and game theory. Mental illnesses do not exist, he says, only 'problems in living.' Autonomous psychotherapy should be purchased by the client as they would purchase a book in a bookshop. It should never be provided by the state.

All of Szasz's work is informed by a philosophical belief in individualism, which he associates strongly with free-market forms of capitalism. In his writings, he speaks positively of capitalist social relations and argues in favor of a return to a situation where medical care was delivered on a purely private basis. He pits individualism against collectivism and regards any form of state provision (such as the UK National Health Service) as a form of socialism, something he despises. He writes (2004a) that "Capitalist acts imply and rest on a relationship of equality and mutual need: they satisfy the needs of both parties. For example, a person wants his pet cured, takes it to a veterinarian, and pays for his services. The veterinarian provides the service the client requests." On the other hand, "socialist acts imply and rest on a relationship of inequality and the absence of mutual need: satisfying the needs of one party frustrates the needs of the other party. The participants are adversaries" (p. 112).

Szasz sees the state as essentially evil, something that works to limit the individual's liberty and independence. He argues (2007) that: "undeniably, the state is primarily an apparatus of coercion with a monopoly of the legitimate use

of violence" (p. 151). The state stands against individual freedom.

In Table 1, we have summarized some of the important oppositions we have identified in our reading of Szasz. Although this kind of binary thinking can be attractive on account of its apparent clarity, what is called post-structuralist thought has exposed some of the ways in which distinctions like these conceal political, ethical, and conceptual complexities. In binaries such as those set up by Szasz, one part of the binary is considered to be correct, better, 'normal,' or in some other way foundational, and is thus privileged. Szasz's approach to critique is to identify these distinctions and to argue in favor of the superiority of the first part of the binary. His fundamental assumptions are that it is possible to make such distinctions and that progress involves moving toward a situation defined according to them.

Table 1. Binary Distinctions in Szasz's Work

Biology	Social science
Autonomous psychotherapy	Psychiatry
Freedom	Coercion
Individual	State/collective
Bodily illness	Mental illness
Free market	Socialism

Why Szasz's Binary Distinctions Are Problematic

We agree with Szasz that biomedicine (as currently understood) will always struggle to explain the meaningful human world of thoughts, feelings, and behaviors. Using the television analogy, wiring diagrams will never explain why the acting in one program is more convincing than in another. However, because we 'are' our bodies, we do not exist as an amalgam of separate 'mind stuff' and 'body stuff.' The television analogy breaks down quickly when we start to think of how interconnected our bodily and mental realities are. When it comes to human beings, the 'programs' do not transmit through an independent 'set.' Ours brain states are very much involved in the quality of our experiences and vice versa. Human reality is an embodied, 'en-cultured' reality, which is always linguistically and historically situated. All these elements merge to create the conditions whereby a world is experienced by us.

What is most evident to us as doctors is that we do not *suffer* in the world in two different modes: bodily and mental. The physical and mental anguish that occurs in bereavement is the response of the whole human being to a deeply felt loss. The fundamental question that faces psychiatry is: can a discourse be produced that is adequate to this reality, a discourse that is sensitive to the complexity of our embodied, encultured nature? Traditional psychiatry has responded by developing a *singular* biomedical approach, using the conceptual tools of physical medicine to organize its thinking and practice in its response to madness and distress. Although Szasz is not committed to 'substance dualism,' the *binary* logic of his arguments is very much underscored by a form of 'methodological dualism.' Szasz not only argues for methodological dualism, he argues for a very *strong* form of it. Put simply, he argues that we need two very different forms of knowledge when it comes to engaging with human suffering and we need to keep these separate. On the one hand, we need a medical science that is completely materialistic. On the other, we need a de-medicalized form of psychotherapy that is really a form of 'moral education.' But our experiences of pain, sorrow, despair, sleep disturbance, alienation, and ritual all involve the different dimensions of our human existence—biological and cultural. Many sicknesses involve some degree of cellular pathology, but not enough to explain all the pain experienced. Most patients and doctors accept this as a reality and are skeptical of attempts to divide experiences of pain and suffering by using dualistic concepts such as 'objective' and 'subjective.'[3]

As doctors who have been involved with states of madness, distress, and alienation for many years, we have come to share Szasz's refusal of a

purely medical framing of such states; however, we also find his insistence on a dualistic logic both forced and limited. Experiences such as hearing voices and fearfulness demand a more complex understanding than simply being seen as symptoms of an, as yet unidentified, abnormal brain process. However, often such experiences are phenomena that cannot be controlled by a simple act of will. We find the following statement from Szasz (2004b) unconvincing: "I do not regard hallucinations and delusions as 'symptoms' requiring 'treatment.' I view hallucinations as disowned self-conversations and delusions as stubborn errors or lies. Both are created by 'patients,' and could be stopped by them" (p. 234). This implies that such patients simply have to make a decision in relation to these phenomena for them to go away. Our encounters with many people who experience voices and/or delusions has convinced us that often these individuals are profoundly 'stuck' in a way of feeling, thinking, or behaving that involves all the dimensions of their being. Suggesting that their problems can be solved by a simple act of will is to seriously misrepresent the reality of their suffering. Recognizing this does not commit us to a simplistic medical understanding of their experiences. A great deal of human suffering demands that we think beyond binaries. Contrary to Szasz, we believe that it is possible to imagine forms of collective political organization that are not state bureaucracies. Likewise, we believe that it is possible to imagine a medical discourse of madness and distress that takes the issue of meaning seriously. This presents a radical challenge to psychiatry. In fact, we have argued elsewhere that such a development would require a move to 'postpsychiatry' (Bracken and Thomas 2005). To establish this we need closer links between biology, anthropology, philosophy, and the humanities. This would be to move in the opposite direction to Szasz, who insists on the need to police the boundaries.

Foucault's Challenge

Unlike Szasz, Foucault does not start with a philosophical or conceptual challenge, from which he develops a prescription for how things should be (Table 2). Instead, his work involves what he calls 'archaeology': an historical examination of how certain ideas came to be accepted as true, how certain practices came to be accepted as normal, how a certain understanding of the world came to be accepted as common sense. Foucault uses history in a particular way. He is not seeking to convince us of the truth of his arguments, or to impress us with his scholarship. In an interview with Duccio Trombadori (Foucault 1991) he said:

> If . . . I had wanted to write the history of psychiatric institutions in Europe between the seventeenth and nineteenth centuries, I'd certainly never have written a book like *The History of Madness*. But the problem isn't that of humouring the professional historians. Rather, I aim at having an experience myself—by passing through a determinate historical content—an experience of what we are today, of what is not only our past but also our present. And I invite others to share the experience. That is, an experience of our modernity that might permit us to emerge from it transformed. Which means that at the conclusion of the book we can establish new relationships with what was at issue; for instance, madness, its constitution, its history in the modern world. (pp. 33–34)

Unlike Szasz, Foucault is not telling us how we should understand madness or whether there is a legitimate medical dimension to madness and distress. He wants us, as a *society*, as a *culture*, to engage with the way in which madness is encountered in all our lives. He is seeking a different *sensibility* toward madness.

Like other post-structuralists, Foucault is skeptical of binary distinctions. He does not position psychiatry as something bad, or wrong, but instead shows that its history is not a *necessary* one, that is, something that simply had to develop the way it did, according to a logic that is independent of particular human interests. Foucault demonstrates how perceptions and representations of madness changed in Europe during the time of the Enlightenment and in its aftermath, in relation to other social developments. The outcome of his work is that we start to see that our approach to madness and distress could have developed along other paths and that in future we could perceive and conceptualize madness quite differently.

One of Foucault's great contributions to late twentieth century thought was his challenge to traditional ways of thinking about power. In

Table 2. Contrasting Szasz and Foucault

	Szasz	Foucault
Attitude toward the Enlightenment	Szasz is a staunch modernist. He asserts the fundamental truth and authority of biological science. His views about the illegitimacy of psychiatry are rooted in this view.	Foucault's work involves a critique, not a rejection, of the Enlightenment. Promoting scientific rationality as a singular authority involves, for Foucault, a betrayal of the original questioning that gave rise to the Enlightenment.
Individualism	Szasz pits the individual against the collective. The individual self is the bedrock of truth and legitimacy.	Discourses of the self are recent productions of Western culture. Putting 'the self' at the heart of how we think about people and their problems involves a particular 'take' on the world and our place in it.
Psychotherapy	Szasz works with a form of 'autonomous psychotherapy'. This is a sort of educational encounter in which the therapist attempts to help the client through practices such as 'decoding symptoms and dreams.'	Foucault sees psychotherapy as emerging from, and contributing to, psychiatry. In *The History of Madness*, he presents Freud as inheriting the power of the doctor, a power that was consolidated in the regimes of asylum life.
Biomedicine	Szasz is reverential. He regards biomedical science as a value-free detached objective account of the human body and its diseases.	Foucault sees the scientific approach to the human body as having developed over time and as having thus incorporated particular assumptions, values, and priorities. The science and practice of medicine involve particular perspectives on the body and how it works.
Truth and power	Truth works in opposition to ideology. Truth and ideology can be separated by rational, scientific thought. Truth speaks against power. Psychiatry is a form of ideology.	Foucault speaks about 'regimes of truth,' background discourses that orient our thinking and that allow certain things to be said. For Foucault, there is no ultimate guarantor of truth. For him, truth is also an effect of power.
Role of critical thought	Critical thought is about establishing and patrolling limits, demarcations and boundaries. The medical profession should not be involved with 'mental' problems.	Critical thought is about 'problematizing' the distinctions upon which our current thinking and practice is built. For Foucault, there is a legitimate role for practitioners of a profession to engage in critical analyses of that profession while continuing to work to change it 'from within.'

established political discourses, such as those of Marxism and liberalism, power was usually regarded as negative. Power suppressed, conquered, limited, silenced. When it came to knowledge, power worked in opposition to the truth. Powerful groups created ideologies, distorted versions of ourselves, our histories, and our worlds. These distorted accounts blocked the truth. Foucault worked with a broadly similar understanding of truth in his very early works, including *The History of Madness* (2006a). However, by the early 1970s, he started to write about power in a different way. Power was not always negative, but often positive or productive. In fact, in modern societies, power is probably more commonly productive. Moreover, power does not simply suppress 'the truth.' Instead, Foucault began to understand power as something that produced 'regimes of truth'; background discourses and practices that made it possible to speak of one statement being true or another false.

Through his analysis of the organization of asylums and prisons, he developed the concept of 'disciplinary power.' In modernity, according to Foucault, power came to be exercised less through the application of brute force, and more through efforts to discipline the bodies and behaviors and, ultimately, the selves of those who are subject to power. Disciplinary power operates more diffusely than other forms of power. It is seen most clearly in the various technologies that have emerged to shape and guide our behaviors and subjectivity. Indeed, Foucault, like Heidegger (1977), sees modernity as the emergence of a technological culture: a culture where the difficulties and contradictions of human life show up as technical problems to be solved rationally. Thus, the medicalization of madness and distress is not for Foucault a conceptual problem as it is for Szasz, but part of a deeper, more far-reaching cultural change. It is one manifestation of the 'technicalization' of our way of life. It also relates to changes in the way our societies are organized economically and politically, and how we exist as ordered, governed, and eagerly consuming populations. Ironically perhaps, power in modern societies sometimes works to maximize freedom and choice. It promotes a discourse of the psychological, an almost tangible arena where our desires are identified and matched to services, objects, and opportunities in the context of consumer capitalism. For Foucault, power is not something that, of necessity, is opposed to the self and its aspirations, against the individual and his/her sense of identity. On the contrary, he sees our preoccupation with the individual emerging in the context of the development of disciplinary powers such as psychiatry. In *Psychiatric Power* (2006b), he writes:

> There is no point in wanting to dismantle hierarchies, constraints, and prohibitions so that the individual can appear, as if the individual was something existing beneath all relationships of power, pre-existing relationships of power, and unduly weighed down by them. In fact, the individual is the result of something that is prior to it: this mechanism, these procedures, which pin political power on the body. It is because the body has been "subjectified", that is to say, that the subject-function has been fixed on it, because it has been psychologised and normalized, it is because of all this that something like the individual appeared, about which one can speak, hold discourse, and attempt to found sciences. (p. 56)

When it comes to madness and distress, psychiatry is now only one element of what Nikolas Rose (1985) calls 'the psychological complex.' A Foucauldian perspective does not see nonmedical forms of psychotherapy (as promoted by Szasz) as the alternative to psychiatry. Instead, these practices are, themselves, seen to wield different forms of disciplinary power. Rose (1989) writes:

> Psychotherapeutics is linked at a profound level to the socio-political obligations of the modern self. The self it seeks to liberate or restore is the entity able to steer its individual path through life by means of the act of personal decision and the assumption of personal responsibility. . . . The codes and vocabularies of psychotherapeutics thus can bring into alignment the techniques for the regulation of subjectivity and the technologies of government elaborated within contemporary political rationales. (p. 254)

Foucault, and those who take inspiration from him, present us with an historical perspective in which we see the incarceration of madness in the classical age, not as a matter of medical practice but an act of social exclusion. In the world of the asylum, the doctor was granted control, and from this position of power emerged the knowledge

and practice we now call psychiatry. In turn, from this disciplinary world, a discourse of individual subjectivity emerged. According to Foucault, this is where the therapeutic enterprise originated. Thus, a Foucauldian perspective links the social exclusion of the mad, the asylum, psychiatric practice, and the world of psychotherapy together. All are the products of the operation of power/knowledge. All involve authority, goals, and discipline, and are linked to the development of our modern economy and culture. In this culture, problems with our behaviors, relationships, beliefs, and sexualities show up not as religious, spiritual, or moral issues, but as technical problems that are open to examination, classification, analysis, and intervention by suitably trained experts. Although this has brought benefits, there are also losses and losers in this process. In recent years, many users and survivors of mental health services have documented these losses and have worked to challenge the authority of the various forms of technical mental health expertise.

Foucault's work highlights the complexity of power and sensitizes us to the destructive impact of ordering the human world in terms of simple binary distinctions such as good/bad, right/wrong, truth/ideology, illness/non-illness. A critical psychiatry that resonates with Foucault's analysis does not oppose the asylum with a form of expertise called 'community psychiatry' centered on new technologies of diagnosis, risk assessment and clinical effectiveness. Neither does it oppose psychiatric power with a nonmedical expertise called psychotherapy. Critical thought in this school is not about defining what is or is not illness. It does not seek to oppose power with the banner of truth. It is more about challenging the legitimacy of *any* group that claims to speak with exclusive authority about the truth of madness and distress.

Conclusion: The Role of Contemporary Critical Psychiatry

Earlier, we asked, "Does medicine have a legitimate role to play in relation to madness and distress?" Whereas Szasz and those who take inspiration from him answer no, contemporary critical psychiatry proposes a more positive, if more complex, response. We reiterate that, in this paper, we are putting forward our own views, not attempting to speak for a 'movement.' Not all current critical psychiatrists are influenced by, or even aware of, Foucault's work, but in our analysis, their efforts offer a form of engagement with psychiatry that resonates more with his thought than with that of Szasz. Crucially, this movement has largely sought to work inside the profession to create an atmosphere where critical thought becomes a valued element in professional practice. Foucault (1988) says:

> One of the essential sociological features of the recent evolution of our societies is the development of what might variously be called technology, white-collar workers, the service sector, etc. Within these different forms of activity, I believe that it is quite possible, on the one hand, to get to know how it works and to work within it, that is to say, to do one's job as a psychiatrist, lawyer, engineer, or technician, and, on the other hand, to carry out in that specific area work that might properly be called intellectual, an essentially critical work'.

Foucault goes on to define what he means by 'critical' work:

> 'When I say "critical", I don't mean a demolition job, one of rejection or refusal, but a work of examination that consists of suspending as far as possible the system of values to which one refers when testing and assessing it. (p. 107)

At present, there are broadly three strands to the project of critical psychiatry: the development of a critique of the influence of the pharmaceutical industry on the theory and practice of psychiatry, the establishment of a medical discourse about mental suffering that is sensitive to the issue of meaning, and the promotion of a partnership with the emerging user/survivor movement. Examples of these include Moncrieff's (2008) challenge to the notion that psychiatric drugs work by 'correcting' underlying chemical imbalances that are assumed to be responsible for distress and madness. She argues that the emergence of this idea suited the interests of a section of the psychiatric profession and the pharmaceutical industry. She points out that greater openness on the part of the profession about the real nature of psychiatric drugs would lead to a more democratic form of psychiatric

practice. Timimi (2005) has developed a cultural critique of the concept of attention deficit hyperactivity disorder that understands the phenomenon in terms of the medicalization of childhood in the West. He has also developed a wider critique of the whole direction of contemporary child psychiatry (2002). Elsewhere, we have developed detailed cultural critiques of the concept of posttraumatic stress disorder and particularly its use in people from non-Western cultures (Bracken, 2002), and historical analyses of the experience of verbal auditory hallucinations that question contemporary biological accounts of the experience (Leudar and Thomas, 2000). Two recent collections of essays, edited by Double (2006) and Cohen and Timimi (2008), are good introductions to the various elements of current critical thought. None of these works is opposed to the involvement of medicine in the lives of those who experience states of madness, alienation, and distress. But by critiquing current ideas and practices they open the field to different ways of understanding, framing and responding to such experiences.

Critical psychiatry is a process, not a fixed set of ideas. Contemporary critical psychiatry is aware of how easily critical ideas can be incorporated, neutralized and absorbed into the mainstream. Peter Miller (1986) writes:

> The history of psychiatry is a history of fundamental transformations of its institutional, theoretical, professional and juridical existence. The critiques mounted against psychiatry, both from inside and outside, are a significant element in this process of modernization and transformation. (p. 13)

This is an issue that has much wider relevance. Throughout his career, Foucault sought to avoid becoming a new 'guru.' He was very aware of the power of knowledge (including critical discourses), and he struggled to avoid his own works being used to guide where, when and how resistance to power should come about. He spoke (Foucault 1988) of himself as a 'specific intellectual,' someone who did not have a 'theory of the world' and he was very clear that he did not want to lead a revolution or to be the spokesman for a social movement (p. 108). Likewise, contemporary critical psychiatry is a much more humble project than the critical psychiatry of the sixties and seventies (Thomas and Bracken 2008), which sought liberation on a grand scale (Cooper 1968). By critiquing the status quo, by revealing the constructed nature of psychiatric theory and practice, the aim is to create spaces in which excluded voices can be heard. In other words, the aim is not to replace one psychiatric authority with another but to weaken the notion of authority in the field of mental health altogether. The most important 'excluded voices' have been those of service users and survivors. At the heart of critical psychiatry is an attempt to promote the conditions whereby real dialogue can take place between medical professionals and the user/survivor movement in all its diversity.

Notes

1. See: http://www.critpsynet.freeuk.com/.

2. Schaler (2004) points out that Szasz himself rejects the label 'anti-psychiatrist' because of its links to the ideas of Laing and Cooper, ideas that Szasz 'detests,' We are using the term here in a specific way and do not imply any connection between Szasz and these other thinkers.

3. There is a strong tradition of phenomenological thought that has sought to overcome such binary modes of thinking about the body. The Swiss psychiatrist Medard Boss used insights from the work of Heidegger in an attempt to ground a non-dualistic approach to both medicine and psychiatry. See Bracken (2002) for a further discussion of this tradition.

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