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IS PRIVATE (CONTRACT-BASED) PRACTICE AN ANSWER TO THE PROBLEMS OF PSYCHIATRY?

PAT BRACKEN AND PHILIP THOMAS



KEYWORDS: Anti-psychiatry, binary distinctions, critical thinking, postpsychiatry, poststructuralism, psychotherapy

WE ARE VERY grateful to both Matthew Ratcliffe and Thomas Szasz for taking the time to read and respond to our paper. Ratcliffe is broadly sympathetic to our efforts and provides a very convincing argument against mind–body dualisms by drawing on work from the phenomenological tradition. His comments extend rather than challenge our central thesis. Szasz, however, is dismissive of our position. As a result, most of our response is directed to his commentary.

Ratcliffe uses the work of van der Berg to make the case that any easy distinction between bodily and mental illness or suffering is false to our lived reality as human beings. Of course, in the day-to-day world of contemporary medical practice, the problems that we encounter can be separated broadly into those that emerge primarily from the psychological aspects of our lives and those that are more centrally somatic. But our position, and that of Ratcliffe and van der Berg, is that there

are no clear or easily defined boundaries between the two. Ratcliffe is right when he says that our aim is “not to ditch such language altogether but to awaken a sense of intellectual humility, a realization that categories which structure much of our current thinking are specific to contingent and easily overlooked sociocultural practices” (2010, 235).

One element of the sort of critical psychiatry we propose is an exploration of the categories we use in psychiatry: their historical and cultural origins and the role they play in shaping the practices of contemporary mental health work. To the extent that Thomas Szasz has contributed to this work, we are indebted to him. His efforts in this regard have made a huge contribution to the critical mental health literature. Where we part company is his insistence on a dualistic approach to medical practice, an approach that encounters binary thinking, not as something problematic to be overcome, but as emerging from the very nature of the world itself. Our thesis is not, as Szasz claims, “binary bad, non-binary good” (2010, 230). Rather, our argument is that the sort of dualistic categories we often use such as good/bad, normal/abnormal, and psychological/medical are not as simple or as

innocent as they sometimes seem to be. Nevertheless, we (perhaps particularly those of us raised in the Western world) seem drawn to them. Such distinctions often serve to give us a false sense of clarity. Furthermore, they can serve to obscure complexities and work to maintain a social and political order in which some people are silenced and excluded. For example, on one level, the binary ‘male/female’ seems simple enough. It seems, as Szasz puts it, “an attribute of the natural world” (2010, 230). The question is: what we do with this? Do we take this binary and rigidly order our personal and social worlds according to it? Do we insist that we work to distinguish male and female social spaces, social roles and personal identities? What happens to those of us whose sense of self is not so clear cut? If this binary is “an attribute of the natural world” where does that leave those whose gender is somehow ‘in-between’? Our point is that the dualism ‘male/female’: where it comes from, how it is conceived, used, the effects it has in our lives, and even how we see it operating in the natural world is not something simply ‘given.’ Rather, like other linguistic categories it emerges from our specifically human attempt to understand the world and to bring some order to it. As a result, it is bound up with all the other cultural and social dynamics involved in that struggle.

We are not suggesting that we should never think in binary terms; this would be ridiculous. Every day, we need to compare and contrast events, situations, and people (as we do in our article with Szasz and Foucault). Our point is that we should avoid reifying the distinctions we make. We agree with Ratcliffe that there are ways in which Foucault’s thought and that of Szasz can be seen as complementary rather than as being opposites. Indeed, Foucault has made very positive remarks about Szasz’s work (Foucault 1996, 200–201). What is at stake is the need to use binaries tentatively, carefully, and with a sensitivity to the various ways in which categories emerge in a culture and how they can serve a particular political order. When one uses binaries as though they were categories given to us by nature or derived from some sort of universal moral order, we can quickly end up contradicting ourselves, or worse, imposing a rigid system on others. Our

critique of Szasz emerges from the realization that a great deal of his thought is premised on the use of a heavily dualistic logic. In fact, much of the rhetorical appeal of his work rests on divisions and contrasts that seem initially to be simple and straightforward. However, many of the distinctions he makes carry strong moral undertones. Furthermore, some of these distinctions are mutually contradictory.

This dualistic logic is seen very clearly in his response to our paper. This opens with a distinction between the *discourse* of psychiatry and the *deeds* of individual psychiatrists and a dismissal of our work for not focusing on the latter. This distinction is of course itself problematic because many contributions to the discourse of psychiatry (such as the development of the DSM categorization) provide the context and justification for the deeds of psychiatrists. We have written elsewhere about the use of coercion, but any form of critical psychiatry worthy of the name has to engage with the underlying logic that guides the practices of mental health professionals. Thus, we make no apology for writing a paper about the discourse of psychiatry! Szasz dismisses our paper because it is not centered on the question of coercion. Our position (echoing Foucault) is that the problem of psychiatry is wider and more complex than the question of coercion, and coercion itself is not as simple as Szasz would have it.

He maintains that “we relate to others in two opposite ways: by cooperation and by coercion. Some psychiatric relations are consensual, some are coercive. Contractual psychiatry, based on cooperation, is like mutually desired love-making. Coercive psychiatry, based on force, is like rape” (2010, 230). The fact is that human encounters are more complex than this. Coercion is very often not simply present or absent. Prostitution for economic motives is not simply rape, but is it plausible to describe it as ‘mutually desired love-making’? Likewise, in the field of mental health, many encounters between patients and professionals are not coercive (in the sense of being based on physical force), but neither are they completely based on ‘cooperation.’ In this field, the professionals know ‘the rules of the game’; they are masters of the discourse, they run the

institutions and the services and often control access to benefits and other non-medical services. Even though the patient might not be coerced by force, very often they are politically, socially, and economically disadvantaged compared with the professional and thus their ‘cooperation’ with ‘contractual psychiatry’ is at the very least problematic. This is the case whether they pay directly for the service or not.

In this response to our paper lies a good example of how Szasz contradicts himself by structuring his thinking around two binaries. On the one hand, the whole thrust of his argument against us here is that coercion is the only issue worth tackling. He condemns us because we do not focus on coercion in this particular paper. He seems to say that there would be no problems with psychiatry if psychiatrists acted ‘like other physicians’ and treated ‘only individuals who consent to receiving their services.’ In other words: coercive psychiatry bad, contractual psychiatry good, end of story! As long as the intervention is contractual, ‘what the customer/patient wants,’ it is good. But elsewhere, in fact in most of his other writings, Szasz has worked to establish another distinction: that between medicine and psychiatry. In these writings, Szasz has argued that *all psychiatry* (including traditional contractual psychiatry and psychoanalysis) is bad. In our paper, we quote him from 2007, making the statement that 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 specialty” (Szasz 2007, 3). This distinction between proper medicine and bogus psychiatry is echoed in his statement (in this response to us) concerning ‘stigmatizing psychiatric diagnoses’ and his denial that ‘mind-altering drugs’ can be of help. The fact is that diagnoses are made and drugs prescribed more often to consenting out-patients than to detained, non-consenting in-patients. Our position is that all psychiatry (whether it is contractual or non-contractual) is problematic and that the use of coercion and the question of consent are a lot more complicated than Szasz allows for in his statements here. In fact, we believe that psychiatry is often most destructive when it

is not acting coercively. Situations where patients freely and voluntarily agree to psychiatric formulations of their problems and begin to live their lives according to agendas that emerge from these can be often profoundly disempowering. Furthermore, Szasz seems to agree. In a recent article about Alan Turing, he writes: “psychiatric destruction often begins with psychiatric self-destruction, the denominated patient believing the psychiatrist’s self-deceptions about nonexistent diseases and their damaging treatments” (Szasz 2009).

Ultimately, although Szasz’s binaries often initially seem plausible, on further examination they are found to be of limited use. We see this happening here in his response to our paper, but it is a phenomenon that runs throughout his work. One particular contrast informs a great deal of his thought. This is the contradiction he discerns between the individual and the collective. Szasz characterizes himself as a ‘libertarian’ and his championing of individual liberty is laudable. Many of his arguments are sound. However, to our way of thinking, there is a fundamental problem with the opposition he proposes between the interests of the individual and the interests of the collective. In many of his writings, Szasz links liberty with things such as ‘free enterprise,’ the promotion of unregulated ‘free market capitalism’ and a defense of private property. There is no analysis of how the promotion of freedom in this idiom really means the promotion of freedom for some. There is no analysis of how the accumulation of wealth in the hands of a few individuals comes at a cost to the rest of the community. For us, individual freedom and collective egalitarianism are not opposites. We see freedom as happening when people have some control over their lives and destinies. We do not see a contradiction between this and limitations on the rights of private property. In Szasz’s writings, we have found no analysis of how poverty serves to limit freedom. Throughout his writings, Szasz is vehemently anti-socialist. To him, any form of collective control of economic and social life is to be abhorred. There is no recognition that human beings exercise a form of freedom when they join together in trade unions to challenge the rights of private property, or vote and campaign for left-wing parties that promote an egalitarian agenda.

The British National Health Service (NHS) was constructed after the Second World War by a Labour government in recognition of the severe limitations of a ‘free-market’ approach to health care. For all its faults, the NHS is now seen by most British people as an achievement in the struggle for a more egalitarian society. Not having to pay for health interventions effectively grants those with less money a measure of control over their lives that they would not have without the NHS. Just as the binary distinction—contractual psychiatry and coercive psychiatry—is faulty, so too is Szasz’s opposition of the individual and the collective.

Szasz contrasts his own ‘plain-speaking approach’ to writing with that of Foucault, which he dismisses as ‘opaque’ and ‘oracular.’ We maintain that this is unfair. Foucault understood the limitations of an ‘either/or’ approach to philosophy, politics, and history. For us, his work represents a genuine attempt to unpack some of the complexities of concepts such as progress, freedom, and normality. He did not always get things right. His work, like that of all philosophers, is not to be followed uncritically. We agree with Szasz that Foucault’s support for the pro-Khomeini faction in the Iranian revolution was a profound error. However, his work has been used positively by many users and survivors of psychiatry in their attempts to understand the world of mental health and the discourses and deeds of the psychiatric establishment (see, for example, a number of the contributions to the recent volume edited by Sweeney et al. [2009]).

We have learned a great deal from the works of Szasz, but ultimately his approach is limited by his adherence to an ‘either/or,’ ‘right/wrong’ form of analysis and an insistence that one cannot promote an egalitarian agenda and also support the rights of individuals. For us, the rights of private property are not sacrosanct and private practice is not a solution to the problems and contradictions of psychiatry. Foucault’s work does not offer simple solutions and he does not prescribe what types of social organization are to be created. He does not tell us what to put in place of psychiatry. However, his work is helping service users, survivors, professionals, and academics to critique the authority of traditional psychiatry and to

challenge the power of the current establishment. Szasz says that he does not know what ‘critical psychiatry’ is. He asks if there is another kind of psychiatry that could be properly called ‘uncritical.’ We believe that there is. Critical thinking is not taught in medical schools and is certainly not on the curricula of university departments of psychiatry around the world. Mainstream psychiatry is properly characterized as ‘uncritical.’ However, there has always been a substantial body of work that has critiqued some of the central assumptions of psychiatry. These critiques have emerged from inside as well as outside the profession. There have always been those who have been subjected to psychiatry who have argued against its ideas and its practices. All these voices contribute to what we call ‘critical psychiatry.’ Crucially, because these voices emerge from different sources, they do not always ‘sing from the same hymn sheet.’ For us, this is something to be celebrated. We will not agree on everything. In a nutshell: let us avoid another binary—‘good critical psychiatry and bad critical psychiatry.’ We do not accept the idea that simply working in a private practice (fee-paying, contract-based) situation allows one to avoid the contradictions, complexities, and moral difficulties that face those of us who work in the public sector. We leave the last word to Foucault:

I don’t believe that power is only the state or that the non-state is therefore liberty. It’s true (here Szasz is right) that the circuits of psychiatricizing and psychologizing, even if they pass through the parents, the peer group and the immediate surroundings, are finally supported by a vast medico-administrative complex. But the “free” medicine of the “liberal” doctor, the private psychiatrist or home psychologist are not an alternative to institutional medicine. They are part of the network, even in the case where they are poles apart from the institution. Between the therapeutic state Szasz talks about and “liberated” medicine there is a whole play of support and complex cross-reference. (Foucault 1996, 202)

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