

---

## CHAPTER 1

---

# Continuing madness

GUY HOLMES, CRAIG NEWNES AND CAILZIE DUNN

THIS BOOK FOLLOWS on from where *This is Madness* (Newnes, Holmes and Dunn, 1999) ended. In the concluding chapter of *This is Madness* we wrote about the future of mental health services: these ideas remain very much alive. The authors in *This is Madness Too* give even greater weight to the arguments for: a separation of the social policing and therapeutic roles of psychiatry; an abandonment of the medical model and a challenge to the power of the pharmaceutical industry; the need for informed consent and advocacy; the validation of the expertise of current and ex-users of services and the need for properly funded service user controlled services; and political effort and community work aimed at tackling the roots of experiences that subsequently become individualised and labelled mental illness (poverty, racism, abuse, sexism, lack of opportunity, and so on).

The energy around mental health that we referred to in *This is Madness* (see Newnes and Holmes, 1999) still sparkles. One of the strange things is that, perhaps more than at any other time in the history of psychiatry, it is not the clinicians that are fuelling or even guiding that energy. There appear to be two tracks, with ideas racing along on both. Although these ideas frequently conflict, they both appear to be gaining pace. For example, the concept of informed consent in medicine in general is almost constantly being aired in public debate. In the age of the Internet, people have access to information previously kept from them. Knowledge is power, and medical paternalism seems antiquated in the 21st century. But at the same time, the British Government's new Mental Health Act brings an even wider group of people under its remit — a remit which gives doctors and other professionals the power to take away basic human rights (to liberty, to refuse treatment, etc.) let alone the principle of informed consent. On the one hand the stigma of mental health seems to be reducing: people are more accepting that at times in their lives they might break down, have crises, and need help. People speak openly about being depressed, having counselling or psychotherapy and drugs such as Prozac have become de rigueur. On the other hand the stigma of a diagnosis of schizophrenia, with media and government propaganda about its links with violence, and the

## *2 This is Madness Too*

---

stigma of the psychiatric hospital have increased. Similarly, ideas that mental health problems are physical and genetic and need medical treatment seem, paradoxically, to be both challenged and accepted more in our society.

On the one track the government and mental health professionals are speaking a new language — of clinical governance, evidence-based practice and risk assessment — and are creating new ways of categorising people (through DSM and more general categories like ‘severe and enduring mental illness’, without defining what those categories mean). On the other track, the service user/survivor movement is returning to old language — breakdown, madness, crisis, recovery — language that brings fresh ways of thinking to the area of mental health, language that does not emphasise ‘otherness’, language which holds out hope (see Wallcraft and Michaelson, Chapter 16). Along with different language, there is a creativity and an openness to new ways of helping people. But while this flourishes and more and more mental health professionals adopt ideas from people in the user movement, the government is trying to stifle debate, through insisting mental health services follow a textbook, or recipe book — the National Service Framework — that defines what services must consist of. Similarly the pronouncements of NICE (the National Institute for Clinical Excellence) are meant to be an end to debate about the most effective ways of helping people. Mental health professionals are increasingly receiving training from psychiatric system survivors at the same time as training courses narrow down the debate about what helps people.

In a system that reifies evidence-based practice, who controls the evidence and what weight is given to different types of evidence are critical areas. Gourevitch (1998) stated that: ‘Power largely consists in the ability to make others inhabit your story of their reality, even if you have to kill a lot of them to make that happen’ (p. 181). The indoctrination that characterises compliance therapy and behavioural family therapy, the remits of assertive outreach teams, the emphasis on safety and dangerousness, the cabinet control not only of policy but of practice, the power being given to mental health professionals to decide who is a ‘risk’ and to be compulsorily treated, all point to a system where that power is being more brutally exercised. At the same time there has been an enormous growth in humanistic counselling, with over 26,000 members of the BACP (British Association for Counselling and Psychotherapy, formerly BAC), and counsellors are becoming commonplace in GP surgeries. Gourevitch’s quote is applicable to all mental health professionals, to anyone who describes themselves as a therapist, not just those who work in the areas of the mental health system that exert social control (see Chapter 14 by Sanders and Tudor), but the gulf between those who try to help people find their own ways of understanding and coping with their difficulties and those who argue with people until they accept the professional’s way of explaining things seems to be getting bigger. Britain is starting to resemble America, where the poor and socially deviant and devalued receive social control and biological psychiatry and the rich and conforming choose psychotherapy. We should applaud the National Service Framework for Mental Health in promoting the usefulness of humane psychological therapies for people with a diagnosis of psychosis, but it seems mad that the British Government proposes to employ a thousand graduates

in primary care to 'treat people with anxiety and depression' at a time when it is obvious that individual therapy cannot possibly meet the needs of the people and in no way addresses the social causes of distress. As Hillman and Ventura (1992) said: 'We've had a hundred years of psychotherapy and things are getting worse'.

### **Why *This is Madness Too*?**

The first volume was incomplete. We did not mention children, informed consent was only discussed in relation to adults being given ECT and medication, and the world of learning disabilities was nowhere to be seen. Issues about women and eating distress were only briefly touched upon. *This is Madness* also failed to include critical psychiatrists amongst the authors prepared to speak out. In this volume there are chapters on children (Chapter 5 by Peter Breggin and Chapter 10 by Steve Baldwin), people with learning disabilities (Chapter 4 by Mark Rapley and Chapter 7 by Biza Stenfert Kroese and Guy Holmes) and eating distress (Chapter 11 by Vivien Lewis and Sara Cureton). Several of the authors are psychiatrists — Duncan Double writes about psychiatric training (Chapter 3), Peter Breggin about the drug treatment of children (Chapter 5), David Healy about SSRIs (Chapter 6) and Susan Hallwright on community mental health. These authors join an array of people from the service user/survivor movement in an attempt to recreate the mix that made *This is Madness* so successful. But another reason for re-entering the fray is our continuing frustration with the psychiatric system and our confusion at the paradoxes to be found at every turn: the decent psychiatrist who sees little reason to stop using ECT; the general practitioners who wouldn't dream of taking drugs (any drugs) themselves but who willingly give out repeat prescriptions of major tranquillisers; the psychologists who claim publicly to work as evidence-based scientist practitioners, but in private admit that they have little evidence for anything; the people who espouse the benefits of multi-disciplinary teams but protect their clients from team members they do not trust; the government that consults with service users then ignores their human rights in its proposals for a new mental health act. We meet mental health workers who are far more mixed up and needy than their patients, and system survivors with more wisdom than a room full of NHS planners. We wanted to be involved in a project that published that wisdom, hence the contributors to this volume include Peter Beresford and Suzy Croft (Chapter 2), Peter Lehmann (Chapter 8), Peter Campbell (Chapter 9), Sara Cureton (Chapter 11), Olive Bucknall (Chapter 12), Vivien Lindow (Chapter 13) and Jan Wallcraft (Chapter 16) — people whose ideas come from a wide range of sources, but who share the experience of having been recipients of psychiatric services.

### **The evidence game**

Evidence is all the rage in mental health services. It is as if professionals have never received any training, never read journals and spend their time randomly pulling treatments off their shelves. But it is more complicated than that. What one person calls evidence another calls prejudice. Earlier this year (2001) newspapers carried stories from the USA about how the eugenic practice of sterilisation was based on science and scientific evidence

#### 4 *This is Madness Too*

---

(see Stenfert Kroese and Holmes, Chapter 7, for more on this), and how the recent banning of Darwinian theories has been justified by educationalists on the basis that 'evolution is not good science' (*Independent*, 16.2.01). All interest groups are claiming that their policies are evidence based (see Beresford and Croft, Chapter 2, for a discussion of SANE's evidence base), and the field of ethics is not getting a look in. People who claim to be evidence-based practitioners need to ask major questions about the ways in which research is funded and the ways in which results are disseminated. The research reported is frequently only a fraction of that carried out, and it is invariably only the results which suit the vested interests of researchers or funders that appear (see Healy, Chapter 6).

So where might we find information about the human condition which appealed to people's sense of what it is to be human rather than the psychology and psychiatry of diagnosis, drug trials and involuntary treatment? How can we find out about the lived experience of service users, what they want and what they don't? Vivien Lindow (Chapter 13) suggests a move towards research controlled and directed by service users and survivors themselves. A further challenge for the pseudo-scientific community of psychiatry would be embrace the common place wisdom of philosophy, literature and poetry.

There are good text-books on the human condition (Judith Shklar's *Ordinary Vices* or Dorothy Rowe's *Wanting Everything* spring to mind) but if psychiatry is to take its subject-matter seriously then Dickens and Zola (in particular *Hard Times* and *Germinal*, respectively) cover class oppression pretty exhaustively and should be compulsory reading. Psychiatry treats the mind/body divide as if it is unproblematic, but how many mental health professionals have read Descartes or Ryle? The angst, desperation and anxieties of the middle classes are described throughout Balzac's *Comedie Humaine*. Catholicism and the power of faith is to be found in Burgess (*Earthly Powers*) and Greene (*The Power and the Glory*) while murderous hate is no better explained than in Mailer's *The Executioner's Song* and *The Collector* by John Fowles. Grief weeps off the final pages of Byatt's *Still Life* and madness permeates *Titus Alone* by Mervyn Peake. A brilliant exposition of hallucinatory paranoia is at the centre of Terry Gilliam's film *The Fisher King*, while the drug-induced variety saturates Waugh's *The Ordeal of Gilbert Pinfold* and *Fear and Loathing in Las Vegas* by Thompson. Hypocrisy is laid bare in Miller's *The Crucible* and love is no better explored than in *Birthday Letters* by Ted Hughes.

None of this counts for much in psychiatry or psychology. Nor is the criticism new. In the late nineteenth century the wholly subjective introspection of William James epitomized psychology. Jung broke from Freud, in part, because Freud saw his respect for spirituality, an essential human concern, as pandering to neurosis. Freud himself had considerable respect for the power of mythology. Duncan Double (Chapter 3) refers to the psychiatrist Meyer's project to bring a philosophical approach back into the domain of an overwhelmingly biological psychiatry, and Forsyth (1988) has argued:

*Psychologists do not study the mind, they do experiments. If psychologists were genuinely interested in the mind they would use every scrap of evidence they could lay their hands on; novels, poems, films, folklore,*

*introspection, dreams.* (p. 23)

It is, however, as if the eternal truths explored by philosophers, novelists and other artists are of no concern to mental health professionals who continue to absorb a diet of drug company propaganda and Government dictats. Indeed, Double (2001) has noted that many psychiatrists and junior medical staff actually receive their so-called training in psychopharmacology from drug company salespeople. A recent Government publication, *Effective Health Care*, in reviewing the newest so-called anti-psychotic medication concluded, 'Most relevant trials are undertaken by those with clear pecuniary interest in the results' (December, 1999). Strikingly, a review by Jorm (2000) remarks: 'The public's view of psychotropic medication is almost uniformly negative, contrary to the views of clinicians and to evidence from RCTs [Randomized Controlled Trials]'. The reading lists of counselling and psychology courses contain very little on pharmacology, let alone the iniquities of research funding, and don't even pay lip service to the world of literature. So much for evidence. All we can hope is that, as with a good novel, the reader of this volume will get a more colourful view of the area of mental health than the black and white orthodoxy that tends to characterise the field.

### **The impact of speaking out**

Publishing *This is Madness*, this volume and numerous related articles can be seen as a form of speaking out. It can often feel that speaking out changes nothing. On a small scale, however, saying clearly what is seen as wrong with a system or process can change hearts, minds and conduct. In psychiatry, for example, concerted efforts by service users and their allies have resulted in the establishment of better information for recipients of psycho-active medication (although Chapter 8 by Peter Lehmann on withdrawal from neuroleptics is one of the first articles published in English that counters the argument that these drugs are not addictive and gives advice about how to come off these drugs). There has been a shift in the attitudes of mental health professionals to issues of race, gender and (to a lesser extent) poverty and deprivation. All these changes are, of course, part of a wider cultural change. Speaking out in advance of these cultural changes can be deemed premature, to be hailed as visionary or dismissed as unrealistic. When Survivors Speak Out first claimed, over ten years ago, a place for service users on mental health planning committees, the idea was seen to be preposterous, a classic case of the inmates taking over the asylum. At the beginning of the 21st century, the question is not whether to include services users, but how, and how much to pay them (see Chapter 9 by Peter Campbell). Changes of this type are seeded by those brave enough to speak out, seeds which will grow and bear fruit when the conditions are right. Equally major shifts can be made in clinical regimes. Peter Breggin's successful campaigning almost single-handedly prevented lobotomy being carried out in the USA in the 1970s (Isaac and Armat, 1990). Similarly, ECT has been banned in Holland, Italy and Germany through campaigning pressure groups (Arscott, 1999).

Speaking out can have detrimental effects on the critic including threats to personal safety, which result from an identification of the advocate with

## 6 *This is Madness Too*

---

devalued and marginalised people. Bender and Wood (1994) discuss the likely impact on whistle-blowers' careers — leaving a current employer is likely. In one case, that of Moira Potier, Consultant Clinical Psychologist, her departure during the first Ashworth inquiry was followed by the award of an MBE in recognition of her services to the public good and a return to Ashworth Special Hospital as head of the clinical psychology service. As less high profile people speaking out, we have noticed other effects, both negative and positive. These include a recurring sense of self-doubt — perhaps madness really is only the result of faulty brain biochemistry, perhaps clinical psychology is not just another profession, perhaps management really is concerned, first and foremost, about patients. Being shot as the messenger is commonplace. Remarking, for the umpteenth time, that a management process is flawed or a clinical procedure dubious eventually pushes the speaker into a corner, to be marginalised as the (unheard) voice of reason, or marked as politically motivated and a trouble-maker. The process is tiring, not least due to the energy taken up in defending against feeling disliked and waking in the middle of the night overwhelmed with paranoid anxiety. The effects on colleagues, so often the only support to a person who speaks out, can be considerable. In our department clinical psychologists are routinely branded trouble makers because it is assumed they share our own critical stance. A certain amount of verbal abuse goes with the territory. We have been called mad and dangerous, people have simply walked out on us during what we considered conversations and, memorably, a consultant once threw a copy of Breggin's *Toxic Psychiatry* at the second author before storming off. We would not want to claim that these effects are comparable to the emotional consequences for system survivors, nor even with the utterly isolating and rejecting experience of some professionals (e.g. Johnstone, 1993). One outcome of speaking out is, however, exhaustion.

Other effects are more personally idiosyncratic — drinking more alcohol, driving faster, becoming arrogant, even getting bored with the same arguments. It is difficult to keep in mind that just as every new cohort of mental health trainees is exposed to the rhetoric of organic psychiatry and the unsurpassed excellence of psychiatry, clinical psychology and counselling, each cohort will need a dissenting, more critically reflexive voice. Keeping that voice from going hoarse is a strain. So why do it?

Speaking out in the world of mental health is part of a much larger resistance movement; to glibness, to oppression, to the sheer smugness of the psy-complex (Breggin's term for the vested interests of the pharmaceutical industry and the mental health professions). It protects the person from a position of bad faith: if some things considered bad are inevitable, then at least we can say they are bad, if others can be changed through voicing concern, then to do otherwise would be cowardly. This is not to say that the courage in speaking out should be taken for granted. For some people, such action is not realistically possible; for many others, speaking out is only possible with a considerable amount of support from friends, colleagues, unions or local and national networks. The response from people, often strangers across the other side of the world, is immensely heartening. To receive a postcard from someone thousands of miles away saying they have been inspired by your stance compensates for many of the voices speaking against you. In the psychiatric field, speaking out as a

professional can be enormous fun; inevitably a patients' council meeting is more interesting and diverting than most management meetings. Sitting alongside a psychiatric service user at a rally or on the platform of a conference is at least as satisfying as offering that person psychotherapy. To speak out in psychiatry is ultimately to side with less powerful people against powerful industries and elites, even if one is considered to be part of that elite. We are grateful to all of the authors in this volume for speaking out, for taking a stand against the maddening orthodoxy of the psy-complex.

### **The future of mental health services**

When we look to the future, we are again struck by the paradoxes. Whilst NICE has approved the use of Ritalin in children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), it acknowledges that the condition itself is 'controversial'. This is something of an understatement. All psychiatric diagnoses are hopelessly flawed (Boyle, 1999; Kutchins and Kirk, 1999). Further, the diagnosis of ADHD is frequently made at the request of, or even by, teachers and relatives in order to get hold of Ritalin, even when all of the child's behaviour is normal and understandable (see Breggin, Chapter 5). The fact that Ritalin is an amphetamine-like stimulant which would be illegal if taken under other circumstances and is dangerous to the brain of the child receiving it seems not to feature when considering the issue of informed consent (see Baldwin, Chapter 10), yet another paradox for a government committed to informed consent of patients and their carers. If the future treatment of children is to embrace informed consent then NICE may need to think again.

The information revolution holds out some promise for mental health service users and survivors. Imagine sitting with a therapist who says that your difficulties will respond to a cognitive-behavioural approach. Via your voice-activated Internet ear-piece you ask, 'Cognitive-behaviourism; please advise'. Information is power. Unfortunately, your ear-piece informs you there are 17,500 sites listed under this heading. Where do you start? Most clients are likely to fall back on the expertise of the therapist. Although people who access information through the Internet are not likely to be very different from the people who have traditionally accessed information from books, the speed with which it is possible to get a wide range of information that challenges psychiatric orthodoxy does hold out promise. Having terminals in GP practices and mental health service premises should help service users and mental health workers alike.

Change in the aged bureaucracies of health and social services is inevitably slow; there remain entrenched policies and attitudes and an addiction to form-filling both for its own sake and because of a constant fear of litigation (a still remarkably rare event in real life, though not in the imaginations of mental health professionals and their managers). Organisational change is a disruptive inevitability in mental health services. The government's plan for the English mental health system to be largely subsumed into GP led primary care seems strange; not only will it further medicalise mental health care but it places the power of decision-making in the hands of the same GPs that the government has at times branded arrogant and unaccountable.

It is tempting to suggest that mental health services should be scrapped

## 8 *This is Madness Too*

---

altogether and that we should start again with a user-led agenda (see Pembroke, quoted in Lewis and Cureton, Chapter 11). Survivor groups would be instrumental in starting fresh initiatives and not paralysed by managerialism and the fear of things going wrong and being sued. People offering help would come from a position of feeling they have a responsibility to distressed people seeking help, rather than act like (and be made to feel that) they are responsible for the other person. It may be naïve to think that this could possibly happen in a social world which requires the controlling features of psychiatry just as much as it craves the healing promise of mental health services. It is unlikely that any professionals, including ourselves, could be so radical as to support their own ultimate unemployment, but at the very least professionals could speak out more about the inadequacies of services. Mental health nurses have a particular role here: it is nurses who spend most time with patients, do most of the form-filling, have to restrain violent people on wards and are tasked with the unrewarding job of tracking and engaging unwilling service recipients via assertive outreach teams. It is nurses who inject patients and nurses who find themselves on the receiving end of criticism when things go wrong. They should be well placed to empathise with those abused by services and, of course, are the closest professional group to patients in socio-economic terms. Survivors and radical professionals seem to have little power to change things from the inside. The vast numbers of mental health nurses in the system could make all the difference.

There remains a difficulty recruiting psychiatrists and all the psychiatrists we know are planning early retirement. So who is going to make all the judgements about whether paedophiles and violent sadistic men who haven't been convicted of a crime should be free? There is a myth that behaviour is easily predictable and mental health professionals are better at this than anyone else, a myth some are happy to exploit in a culture demanding certainty from experts and the control of frightening conduct. In the absence of psychiatrists taking on the mantle of being able to treat the untreatable (those diagnosed with personality disorders) clinical psychology shows every sign of stepping into the breach, a paradox indeed and hardly commensurate with a stance of either true science or clinical humility.

So, what do we suggest? Well, *This is Madness* and *This is Madness Too* are full of terrific ideas. To pick up on a few, we would like to see people with learning disabilities defined and honoured for their abilities as much as their disabilities. We would like a coherent model of mental health care for children that does not involve giving them damaging — and in other contexts illegal — drugs. The language of recovery and health ought to be incorporated into all government plans for mental health services (see Sylvestri and Hallwright, Chapter 15). The national lottery as well as the Mental Health Foundation could allocate more funds to more radical projects, for example service-survivor-run crisis houses. We would like mental health professionals to simply ask people what they need in order to recover and then help them get it. When researching the effectiveness of treatments, we could start by asking people where they want to be and later asking them if they got there (Booth, Goodwin, Newnes and Dawson, 1997). This research would be user-led. Advocacy would be freely available and mental health professionals would support advocacy

schemes while respecting their independence (Newnes, 2001).

Psychiatric, psychological and other mental health training ought to honour the wisdom of philosophy, literature and the experience of those in the service user movement: such wisdom would be respected as the real evidence base. People in training should not just be exposed to a myriad of ideas about mental health, they should come away with a degree of humility and an open-minded curiosity about how much they have yet to learn, rather than an arrogance based on the fear of being found out about how little they know. Drug company sponsorship of journals, conferences and other media should be banned. The vested interests of funding bodies ought to be more explicitly stated in the published papers of psychiatric researchers. Counselling should be explicit about the value base of the practitioner and the best kinds of counselling and psychotherapy would be recognised as those placing the individual in a cultural context rather than those implying a quick-fix of the internal worlds of deranged individuals (see Sanders and Tudor, Chapter 14). We would like to see a government that really did consult. Service users would be respected and properly paid for their expertise on planning committees and in case conferences, and for the work that they do in helping others. If this sounds familiar it is because much of it can be traced to the first manifesto of Survivors Speak Out, published in 1987. It is time to enact that manifesto.

## References

- Arcsott, K. (1999) ECT: The facts psychiatry forgot to mention. In: C. Newnes, G. Holmes and C. Dunn (eds) *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books
- Bender, M., and Wood, R. (1994) When the nightmares come home: maintaining one's integrity in unacceptable places. *Clinical Psychology Forum*, 63, 5-9
- Booth, H., Goodwin, I., Newnes, C., and Dawson, O. (1997) Process and outcome of counselling in general practice. *Clinical Psychology Forum*, 99, 32-40
- Boyle, M. (1999) Diagnosis. In: C. Newnes, G. Holmes and C. Dunn (eds) *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books
- Double, D.B. (2001) Can psychiatry be retrieved from a biological approach? *The Journal of Critical Psychology, Counselling and Psychotherapy*, 1, 1, 27-30
- Forsyth, R. (1988) *From here to humanity: a manifesto for survival*. Nottingham: Pathway Publishers
- Gourevitch, P. (1998) *We wish to inform you that tomorrow we will be killed with our families: stories from Rwanda*. London: Picador
- Hillman, J. and Ventura, M. (1992) *We've had a hundred years of psychotherapy and the world's getting worse*. San Francisco: Harper
- Isaac, R.J. and Armat, V. (1990) *Madness in the streets*. New York: Free Press
- Johnstone, L. (1993) Psychiatry: are we allowed to disagree? *Clinical Psychology Forum*, 56, 30-34
- Jorm, A.F. (2000) Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, 177, 396-401
- Kutchins, H. and Kirk, S.A. (1999) *Making us crazy, DSM — the psychiatric bible and the creation of mental disorders*. London: Constable and Company
- Newnes, C. (2001) The commitments? Advocacy and clinical psychology. *Openmind*, 107, 14-15

## ***10 This is Madness Too***

---

- Newnes, C. and Holmes, G. (1999) The future of mental health services. In: C. Newnes, G. Holmes and C. Dunn (eds) *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books
- Newnes, C., Holmes, G., and Dunn, C. (1999) *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books