Anti-Psychiatry Perspective of Mental Illness

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Mental Illness, Anti-Psychiatry Perspective of

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The anti-psychiatry perspective of mental illness incorporates a range of viewpoints, with the most extreme advocates arguing that mental illness is not a real concept, but instead a powerful tool for demonizing those who refuse to conform to social norms. Most supporters typically share an antagonism to psychiatric standards of diagnosis, with varying ideas about the political or social implications of this stance. These general beliefs appear in the writings of several philosophers and social theorists prior to the 1960s, but it was during this turbulent decade that they fueled powerful social agitation, known as the anti-psychiatry movement, which challenged the power of mental health specialists, particularly in the United States, United Kingdom, Italy, and France. In these nations, the anti-psychiatry perspective resulted in legislative shifts and major policy changes, including the deinstitutionalization of patients. Both the social movement and the perspective are important because of their influence on contemporary mental health issues, including the expansion of community-based mental health services, the development of the mental health consumerism movement, and the growth of an urban, mentally ill, homeless population. In order to understand these contemporary developments and their history, it is important to consider how psychiatrists define and diagnose mental illness.

MENTAL ILLNESS AND PSYCHIATRY

Mental illness is a concept particular to the developed Western world. In many other parts of the globe, including indigenous communities and rural locations in developed nations, there are varying folk understandings of health and illness, and the extent of these differences have not been recognized by Western-trained physicians until fairly recently. Often, the mind–body divide is not as clearly separated in these folk taxonomies, with "curers" synchronously attending to physical, mental, and social phenomena, in contrast to psychiatrists, who have tended to deal with the mind, cognition, behavior, and the brain, in isolation from other bodily functions.

This style of medicine has considerable longevity in the United States, with the creation of the American Psychiatric Association (APA) in 1844, and the founding of the American Psychological Association (also, known as the APA) approximately 50 years later. This historic weight, combined with prestigious university programs, and a long-standing history of institutionalization of those deemed insane, provided mid-twentieth-century American psychiatrists with extensive powers over the lives of the "mentally ill." As the discipline expanded its authority over people's lives, clients' unusual ideas and behaviors became increasingly medicalized, and viewed as deviant, resulting in growing stigma and discrimination against this community.

Mid-twentieth-century patients were diagnosed with a mental illness by psychiatrists using the *Diagnostic and Statistical Manual of Mental Disorders*, or the DSM, first published

The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society, First Edition.
Edited by William C. Cockerham, Robert Dingwall, and Stella R. Quah.

in 1952. The method of linking DSM-described symptoms to patients, and their eventual diagnosis, relied on the skill of a mental health specialist in persuading them to disclose their symptoms, or in cases of non-communicative individuals, observing them, and linking these data to DSM-documented disorders. According to this template, a mental disorder is demonstrated by enacted behavior or expressed beliefs that lie outside the boundaries of psychiatric normalcy, and typically, individuals must exhibit a certain number of these characteristics, often over a certain time span, in order to be diagnosed with the disorder.

Since the 1950s, this technique has remained essentially unaltered, although with an updated description of disorders. The contemporary iteration is the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, or the DSM-5 (APA 2013). Despite the text-based logic of this system, the basic problem with psychiatric practice has been, and continues to be, the lack of external tests to validate the clinician's diagnosis. For example, with a physical injury, a tentative diagnosis of broken ribs can be substantiated with an X-ray, but no such confirmatory tests are available for most mental illnesses, especially personality disorders. This aspect of psychiatry means that the discipline is vulnerable to suggestions that it lacks the rigor and replicability of a physical science. These arguments may be especially powerful if patients are deemed to be suffering at the hands of psychiatrists, documented in several twentieth-century, socially isolated, "lunatic" asylums. Criticisms included institutional overcrowding, with incarcerated patients under the control of specialists in restraint, rather than treatment specialists, although when cures were applied, they were often barbaric. For example, lobotomies were approved for Americans with schizophrenia in the 1940s. These notorious practices and an increasingly rights-conscious community, along with public awareness of psychiatric specialist critiques, spurred developing antipathy toward the mental health system, which occurred in concert with other 1960s social activism.

THE GROWTH OF A MOVEMENT

Indeed, the anti-psychiatry movement might not have developed any trajectory if all of these events had not developed in tandem during the 1960s, with the start of the civil rights movement, the women's movement, and protests against the Vietnam War (1955–75). This was a time when Americans were open to alternative ideas, and willing to criticize authoritarian government policies which denied equal rights for all citizens, including those under psychiatric care (Berlim, Fleck, and Shorter 2003). An additional link between Vietnam War activism and resentment of psychiatric powers was the fact that conscientious objectors were still being labeled as mentally ill, a practice which originated in the 1940s. While these activist groups all shared some key tenets during this turbulent decade, the founders of the anti-psychiatry movement had little in common, beyond a core belief in the inability of psychiatrists to diagnose or treat mental illness.

Internationally, this perspective was represented by Ronald D. Laing, a Scottish psychoanalyst, and Franco Basaglia, an Italian medical doctor, who each played a major role in fostering the relaxation of mental health legislation in their respective nations. This social critique was placed in a broader historical context by the French philosopher, Michel Foucault, who published the *History of Madness* in 1961, with an English translation available a decade later.

Meanwhile, back in the United States, a Hungarian psychoanalyst, Thomas Szasz, argued from the 1960s onward that mental health diagnoses did not reflect reality, and were used by members of the profession to

solidify their social status (Berlim, Fleck, and Shorter 2003). (An articulate presentation of Szasz's views appears in his 1997 publication.) This negative view of psychiatry was complemented by the Canadian-born sociologist, Erving Goffman (1961), who wrote *Asylums*, exposing American audiences to the hardship and despair of patients' lives inside an institution for the insane in Washington, DC.

Despite all these publications documenting a common philosophical trend, until 1967 there was no unifying term describing these developments; however, in that year, the South African psychiatrist David Cooper first published the term "anti-psychiatry." It should be noted that Cooper was referencing psychiatric insider critique of practice, rather than the growing public discontent with mental health specialists, which it now signifies (Crossley 1998).

In contrast to this critique of the discipline from disciplinary insiders, familiar with its practices, there were also two additional groups, which should be included in a history of the anti-psychiatric perspective. The most influential group consisted of psychiatric patients, the other major player in the treatment dyad. These individuals began to publish personal treatment histories, and suggestions for change, with increasing politicization, and adoption of the term "survivors" from the 1970s onward, eventually creating the mental health consumerism movement (Dain 1989; Nasser 1995; Rissmiller and Rissmiller 2006). Other critiques originated with the Church of Scientology, which was incorporated in 1953, and has become better known recently, with the involvement of popular movie actors. However, this cult was never a major player in philosophical discussions, or psychiatric reform, in contrast to the powerful combination of patient and insider critique.

ANTI-PSYCHIATRY MOVEMENT OUTCOMES

In the United States, decreased powers for psychiatrists resulted in the closure of many notorious "lunatic" asylums, liberating many patients. Certainly, this policy benefited some individuals, who were healthy enough to achieve social integration, with support from community-based mental health services. Other people, who lacked the various skills needed for successful independent living, ending up among homeless, urban populations. Many of these individuals experienced, and continue to experience, physical hardship, including hunger, and other harms, such as assault and harassment. It is too early to evaluate the long-term effects of the anti-psychiatry movement and perspective, although certainly the results have varied depending on the population under consideration.

SEE ALSO: Diagnostic and Statistical Manual of Mental Disorders (DSM); Health Care, Consumerism in; Homelessness and Health Care; Mental Illness, Diagnosis of; Mental Illness and Discrimination; Mental Illness, Medicalization of; Mental Illness, Social Construction of; Patient/User Associations; Physician–Patient Communication

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