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Survival and its discontents: the case of British psychiatry

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Abstract Sub-divisions of labour in health settings are common and medical dominance and encroachment from competitors are well known. This article considers this general picture but in specific relation to mental health work in Britain and its particular features of recent contestation. British psychiatric orthodoxy has faced challenges to its legitimacy for over a century. However, since the 1980s, in the wake of de-institutionalisation and a new shared service commitment to 'recovery', these challenges have taken new shape. They are explored by considering: the current ambit of mental health care; the sub-division of labour in specialist mental services; recent governmental expectations of the mental health workforce; and the contested legacy of theory and practice in mental health work. The conclusion is that the profession is not under immediate threat of collapse but that its fate may now rest on whether a biomedical or a biopsychosocial model of practice predominates in routine service delivery.

Keywords: psychiatry, medical dominance, legitimation crisis

Introduction

This article examines the many problems British psychiatry has had in maintaining its legitimacy. These have been long standing and aggregating, but they have still to bring the profession to an evident point of collapse. At present, the profession survives organisationally, but it has internal factions and it remains hedged around by a range of external threats, including disaffected users, other professions making competing bids for legitimacy and recent governmental demands to work differently and evince evidence based practice.

These dynamics are not immediately evident if psychiatry is simply described by its outward appearance as a specialty, like others within medicine, which monitors and controls its own occupational boundaries. Beyond that surface appearance, a range of difficulties soon appears for and about the profession. Its outward organisational form, for now, survives and acts as a container for the points of vulnerability created by internal divisions and external threats.

Notably, to date, cumulatively those vulnerabilities and pressures have not fatally broken the container. Moreover, the plural identities within the profession represent cumulative adaptation and so may signal a force for survival, rather than decline, for the occupational group. However, the fate of the profession is not only determined by inner forces of adaptation or re-professionalisation. Competition from others and political demands from the State (psychiatry's main employer) can also shape its legitimacy and affect its sustainability.

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In relation to this contradictory picture, the current article will provide an updated elaboration of the analysis offered by Samson (1995), about British psychiatry, to examine whether what he called 'fracturing medical dominance' has persisted to a point of crisis in the profession in the past 20 years. The notion of a 'legitimation crisis' was used by Habermas (1975) in relation to the lost credibility and collapsing sustainability of systems of power and has heuristic value in this case. In this sense we are using it as a metaphor but will return to the general point about crises and discontent from Habermas later.

Prior to the recent past (our main focus), a number of longer historical features since the mid-Victorian period, when British psychiatry was professionalised, need to be kept in mind to test the legitimation crisis thesis. For reasons of space here, they will be simply noted briefly. We will, however, return to them later, when considering disputes about psychiatric theory and practice:

- The biodeterminism associated with the eugenic zeitgeist of the late 19th century, remains influential in practice (dubbed 'neo-Kraepelinian' psychiatry) but is now challenged from many directions.
- In the 20th century biomedical psychiatry faced competition from more holistic models, from within the profession, first from 'psychobiology' and then the 'biopsychosocial model'.
- The profession weathered attacks from high profile internal critics, at a particular point, when it was exposed to popular critiques, during the counter-cultural period of the 1960s and 1970s. 'Anti-psychiatry', argued for the pressing and radical reformation of the profession, to humanise it and make it more holistically sensible or to debate its political role and its taken-for-granted epistemological premises. Human-rights-based critiques and especially hostility from disaffected service users prolonged this pressure, even when the storm of 'anti-psychiatry' had apparently passed.

With this broad historical context setting the scene, we now turn to a drama that highlights the tensions in more recent times about British psychiatry.

'Wake up call for British psychiatry'

An article that appeared recently in the *British Journal of Psychiatry* (Craddock *et al*. 2008) will be used now to illuminate the profession's problems of legitimacy. It has the title cited above in our heading, which signals a sense of anxious foreboding about the status and survival of the profession. Although the article appears as an academic review, the content and list of authors make it resemble a petition, or even manifesto, in defence of the profession. The article has 37 (sic) authors; a large number even by the norms of authorship in medical journals. The petitioners came from both academic and clinical psychiatry.

The number and the public reputation of many of the authors, for their biological approach to psychiatric research and practice, and the leitmotif of special pleading running through the piece, lead to the reasonable conclusion that this was a petition aimed at warding off the profession's terminal decline. It makes an assertive demand for a return to forms of inter-disciplinary relationships and organisational arrangements, when medical authority (personal, practical and epistemological) was pre-eminent. As will become clear, however, such a reactionary nostalgia for medical hegemony is contestable. Although a confidence in medical certainties has been asserted episodically and with much political success, from and for psychiatry, in the past 200 years, the same hegemony has also been under constant threat from a range of sources.

Craddock *et al.* begin with a concession that efforts to improve the psychosocial care of 'people with mental illness' in the NHS in the UK are welcomed and that psychological and social interventions, which are evidence-based, are extremely important in 'managing psychiatric illness' (conflating one form of social deviance with professional jurisdiction). However, they then go on to complain that this has led to medical expertise and medical leadership being displaced by this psychosocial emphasis, to the detriment of service quality. Only through the clear leadership of the psychiatric profession, the article argues, will service quality be optimised because specialist medical competence is required to diagnose mental illness, distinguish it from physical illness and prescribe specific effective treatments for specific conditions. Put plainly the authors complain that:

> This creeping devaluation of medicine disadvantages patients and is very damaging to both the standing and the understanding of psychiatry in the minds of the public, fellow professionals and the medical students who will be responsible for the specialty's future. On the 200th birthday of psychiatry, it is fitting to reconsider the specialty's core values and renew efforts to use psychiatric skills for the maximum benefit of patients (2008: 6).

The authors offer no evidence to justify this position about putative patient benefit and the piece is driven explicitly by a fear of loss of medical authority or power inside mental health services and by concern about a general loss of status in the wider public domain. The special pleading or cri de couer is consequently justified by concerns about a loss of service quality for patients and the sustainability of psychiatry as a medical specialty. The first of these assumes that medical input drives service excellence and the second assumes that madness and misery should continue to justify biomedical expertise.

The article immediately stimulated a range of views in correspondence. Some fellow psychiatrists wrote in grave sympathy but others did not, warning that the original viewpoint was narrow-minded, outmoded and offensive to the non-psychiatrists operating competently and effectively in the multi-disciplinary context of modern mental health care. Moreover, many non-psychiatrists in correspondence (nurses, clinical psychologists and social workers) confirmed that offence had indeed been taken in their reactions to the article. They argued that whereas psychosocial approaches were effective and user-friendly, the biomedical viewpoint, though now very well tested, had been found lacking both in terms of its credible effectiveness and in acceptability to service users. These voices of professional complaint were joined by irate service users:

> There is much talk of 'stigma' nowadays but little appreciation that stigma emanates from within the health services, particularly psychiatric diagnosis, which is never addressed in 'anti-stigma' campaigns. . . . Psychiatry is not a medical specialty that can be equally compared to orthopaedics because there are no diagnostic tests with clear demonstrable results. Psychiatry must broaden its knowledge base and include subjects it currently ignores otherwise it will continue to be part of the problem and not part of the solution. Psychiatric patients deserve what we actually want, not what psychiatrists are prepared to give from an ego-fragile position (Campbell *et al.* Correspondence in the *British Journal of Psychiatry 24th* July 2008).

The piece from Craddock and colleagues, and the extensive correspondence it provoked, which contained extremes of collegial solidarity and scorn from those inside and outside medical ranks, could be the basis of a book-length deconstruction. Within the limits of this

article, we will examine some sociological aspects of the discourse it triggered, of relevance to our core task of demonstrating the apparent paradox of the de-legitimation of psychiatry, alongside its continuing survival. The following will be considered: the changed ambit of mental health care; the new sub-division of mental health work; the relationship between the State and the mental health workforce; and the relationship between theory and practice in mental health work.

These four inter-weaving aspects of modern psychiatry, implicating sociological aspects of the professions, the State and knowledge, will now be explored further. The dispute evident about medical hegemony in the debate, triggered by Craddock and colleagues, will be alluded to under each heading and other relevant literature used where appropriate.

The changed ambit of mental health care

A central argument from Craddock *et al.* is that medical leadership is warranted in the field of modern mental health care because of the profession's unique expertise about 'mental illness'. There is circularity in this argument; 'mental illness' was invented by psychiatry to codify madness and distress, so ipso facto it possesses a privileged authority. But notwithstanding this tautological rhetoric of justification, there is a basic empirical problem about using the concept of 'mental illness' to define pre-eminent jurisdiction in current mental health care. The focus on 'mental illness' by psychiatry was certainly evident up until the First World War. The Victorian asylum system existed in essence for the containment and management of the insane.

From the 1920s, however, 'the neuroses', 'the personality disorders' and 'substance misuse', versions of 'mental disorder' but not of 'severe mental illness', were all colonised by the profession. Moreover, a major structural change emerged during the 1980s: the widespread closure of large psychiatric institutions. This brought with it a shift back to a focus on psychosis for inpatient psychiatry. With fewer beds to control, in the reduced inpatient settings of District General Hospitals, there was a strict narrowing of psychiatric jurisdiction, based on *risk not diagnosis per se*. With most patients now controlled coercively using legal powers, or under threat of that coercion by the profession in those settings (Szmukler and Appelbaum 2001), it became commonplace for these risky patients to have more than one diagnosis ('co-morbidity' or 'dual diagnosis').

Thus, it is often psychotic patients posing acute risks to self or others and those displaying concurrent and ongoing forms of dysfunctional action leading to social crises that are now prioritised for admission. The days of truly voluntary admission to reverse distress and create mental health gain are now virtually gone; risk management now dominates the scene of inpatient mental health work. Accordingly, these sites are found to be 'non-therapeutic' and pregnant with risks to, not just from, patients (Warner *et al*. 2003, SCMH 1998, Stationery Office 2000).

With the inevitable non-therapeutic consequences of an emphasis on risk management in inpatient work in mind, mental health work has taken a different form in community settings, with psychiatrists working alongside nurses and psychologists and with the latter enjoying more daily autonomy than in the past. Also, because of the pressure to focus on risk, in the smaller inpatient facilities available, psychiatrists now find themselves taking fewer cases from primary care. 'Common mental health problems' have now become the main medical jurisdiction not of psychiatry (the case over 20 years ago and beyond) but of general practitioners. The latter also now manage community-based psychotic patients not displaying immediate signs of risk to self or others.

The impact of this mixed picture is that the jurisdiction for mental disorder in the community is now divided between primary care teams and mental health teams, which include, but are not restricted to, psychiatrists. Moreover, with de-institutionalisation, the emphasis has now shifted from the long-term containment of mental disorder to hopes about 'recovery' and a particular emphasis upon keeping as many patients as possible out of hospital, for as long as possible (Stein and Test 1980). That scenario is attractive to many communities of interest: service users with their preference for citizenship not coercive containment; practitioners with their emphasis on creating client improvement; and politicians and service managers concerned with efficiency and cost-containment.

Accordingly now, 'recovery' is the new broad consensus about mental health work for practitioners and service managers alike (Anthony 1993, Davidson and Roe 2007) and it is supported by national and international policy statements (Health Care Commission, 2007, World Health Organization 2001). These policy emphases are increasingly about a 'capabilities' or 'strengths' approach, rather than one focusing on deficits and pathology (Hopper 2007). Pilgrim (2008) has noted that 'recovery' has three connotations relevant to our discussion here:

1. Recovery as the successful *treatment* of mental disorders.
2. Recovery as the successful *rehabilitation* of those impaired by mental disorders.
3. Recovery as the successful *survival* of social invalidation.

Thus, the ambit of mental health work now contains those who approach it under the umbrella of a seeming consensus of recovery, even if it is constrained by the competing imperative of risk minimisation, which shapes daily decision making. The first version of recovery readily accommodates biomedical psychiatrists, such as Craddock *et al.*, by offering the prospect of an 'old wine in new bottles' approach to practice. The second version of recovery accommodates those approaching their work from a biopsychosocial perspective (some GPs, psychiatrists, nurses, psychologists and others) (Barker 2002, Mueser *et al.* 2002, Ranz and Mancini 2008).

Both of these versions of recovery emphasise the technical achievements of professionals. The third version, by contrast, reflects a social-existential state of recovery 'in' rather than 'from' mental illness, achieved by patients themselves. Sometimes this is with the help of, and sometimes in spite of, professional action. This is a challenge to mental health work from radicalised mental health service recipients, who argue that they have survived the invalidation that was the source of their mental health problems, as well as the stigma and invalidation created by psychiatric services and wider forces of social exclusion (Coleman 2004, Burnett 2003, Faulkner and Layzell 2000). The term 'psychiatric survivor' implicates this mixture of invalidation from psychosocial forces, including, at times, psychiatry itself.

A consensus about 'recovery', despite the distinct connotations just noted, has only been evident since the 1980s, suggesting that mental health work and its broad aspirations have now been shaped by the major structural context of de-institutionalisation. We now say a little more about the implications of this for its recent sub-division.

The new sub-division of labour in mental health work

With de-institutionalisation came a fragmentation of the mental health system and shifts in the division of labour followed. It is at this juncture that the complaints from Craddock and colleagues become particularly intelligible. Psychiatric tradition was rooted strongly in

the Victorian arrangement of inpatient beds being the small empire of each Consultant Psychiatrist. An adjustment to, and even increased legitimacy of, that arrangement offered itself in the shift from large hospitals to the less stigmatised arena of District General Hospital work, which was near to other medical specialties, unlike the asylum system. This trend began in the 1970s, even before the large-scale run-down of the Victorian legacy (Baruch and Treacher 1978).

The threat to psychiatry came mainly then as mental health work, with or without Consultant leadership, expanded in non-residential settings after 1990: community mental health teams; primary care counselling; assertive outreach teams; early intervention teams. Without beds, the traditional division of labour, with the doctor diagnosing and prescribing treatment and the nurse monitoring patient behaviour and administering treatment, was no longer fixed and inevitable. For nurses in particular, moving to community-based work meant that that division of labour could also be challenged and new professional autonomy potentially achieved (Barker 2002).

As for clinical psychologists, they had created an autonomous space away from medical dominance by taking direct referrals of 'common mental disorders' from primary care. In line with this, during the 1980s, they temporarily abandoned secondary care in favour of primary care (Pilgrim and Treacher 1991) but latterly they are aspiring to even treat psychosis using psychological therapies (Bentall 2003). These shifts signalled an encroachment onto the core territory of psychiatry established in its Victorian roots. The recent government emphasis on improving access to psychological therapies for a range of mental health problems provides a new opportunity for more power and status for psychologists and non-medical psychological therapists (DoH 2007a).

These threats of encroachment were dealt with in various ways by psychiatrists, as is evident in the correspondence from medical colleagues in response to the Craddock *et al.* article. Some accepted and welcomed this new multi-sited, multi-disciplinarity. Some in residential settings (acute psychiatry, medium and high secure settings for mentally abnormal offenders) could expect the older traditional division of labour to be retained. In these settings the monitor-and-administer-treatment role of nursing in particular was feasible. So too was the rehabilitative role of occupational therapists and the expert psychometric assessment role of clinical psychologists.

The response to a changing set of structures, and the new sub-division of mental health work that flowed, was one determinant of medical resistance or adaptation. But other factors were relevant, to be picked up again below, about the ideological orientations within psychiatry. The position taken by Craddock and colleagues is very clear. It is based upon the assumed unambiguous legitimacy of a traditional biomedical approach to diagnosis, aetiology, treatment and prognosis.

In the context of general medicine, this logic of understanding and responding to morbidity is normal. However, in the context of mental health work it is not. Views about assessment, speculation about relevant antecedents, favoured interventions and predictions about outcome are highly variegated inside and outside psychiatry. For this reason, medical colleagues of Craddock *et al.*, coming from a psychodynamic tradition, are dismissive of their special pleading (see Holmes 17th July, correspondence *British Journal of Psychiatry*) as are psychiatrists who prefer a biopsychosocial approach to their work (see Kingdon, 2nd July, correspondence, *British Journal of Psychiatry*). Indeed the latter author, an academic psychiatrist, has gone as far as arguing that biological psychiatry, despite its long tradition, has delivered nothing of value to patients (Kingdon and Young 2007).

However, what gives some confidence to the conservative position of biodeterminism adopted by Craddock *et al.* and their allies, evident in their supportive correspondence, is

that by the time of the Presidential-announced 'decade of the brain' at the turn of the 21st century, psychiatrists could ask themselves the self-confident and rhetorical question 'biological psychiatry – is there any other kind?' (Guze 1989). This biological triumphalism led to publicly expressed fears within the biopsychosocial camp of psychiatry (see below), not of the breakdown of biological hegemony, but of its enduring confidence at the start of the 21st century (Clare 1999, Moncrieff and Crawford 2001). As we later note in conclusion much now hinges on which of these two lobbies within the profession prevails.

The State and the current mental health workforce

Since psychiatry emerged in the middle of the 19th century, the State has relied on it to lawfully control mental disorder and in exchange has often privileged a medical viewpoint about mental health policy. But this relationship has been ambivalent (Bean 1986). For example, no asylum doctor was invited on to the Macmillan Committee (1924–1926), which advised about the *1930 Mental Treatment Act*. In addition State-delegated power has moved between a reliance on medical authority on the one hand, and legal authority on the other. This tension between legal and medical authority was also evident in episodic debates immediately preceding legislation (1930, 1959, 1983, 2007). These periods were particular points of adaptation for psychiatry, as well as sites of opportunity for new bids for legitimacy from competing professions.

At the centre of the special pleading about a return to traditional medical authority by Craddock and colleagues was the recognition of encroachment from other professions and a fear that government policies about workforce development, called 'New Ways of Working' (NWW) (DoH 2007b), are now amplifying that encroachment. Nurses may now train to become prescribers alongside psychiatrists. Consultant psychologists and others may now become Responsible Clinicians (the role displacing that of Responsible Medical Officer under the *Mental Health Act* (2007)).

NWW is evidence that government has taken charge of professional working and has not left it to chance as an outcome of professional turf wars. This deliberate 'system re-engineering' has been a motif of government health policy in recent years. Although NWW is written in a language that does not explicitly require any change from psychiatry, implicitly the interests and traditional hegemony in mental health services of the latter are certainly under threat. That actual or perceived threat was reacted to strongly by Craddock and colleagues.

Several conferences and publications came out of this work on NWW (DoH 2007), highlighting a principle of collaborative work between disciplines, users and carers. Although formally committed to recovery principles, the discussion focused on organisational efficacy and securing the continuation of professional integrity. The unspoken assumption was that no occupational group needed to change their knowledge or skills base to provide an improved practice, and that only organisational tweaking, flexibility and a collaborative stance towards a common goal of client recovery was required to secure their effectiveness. Thus, NWW proceeded cautiously by demanding reasonable change without directly threatening the interests of the professions, including psychiatry.

A change in the traditionally medically dominated and fixed hierarchy workforce has also been encouraged by accumulating shortages. By 2000 mental health services faced problems with unfilled vacancies in all the professions. This crisis in recruitment at the turn of the century prompted the government to set up the Workforce Action Team (WAT), which was charged with developing solutions in tune with the National Service Framework

for mental health (DoH 1998). The latter placed organisational reform at the centre of changes to mental health services and the government was only interested in the professions co-operating with, rather than defining, these reforms.

WAT has focused on: staff recruitment and retention; national occupational standards; a single agreed skill set for the mental health workforce; skill-mix solutions; the recruitment of more trained support staff; primary care staff development; tackling the stigma of working in mental health services; and engagement with professional bodies to examine the educational implications of this scoping exercise (Workforce Action Team 2001). Despite this WAT initiative, the Department of Health conceded considerable remaining workforce problems when reviewing the NSF after five years, despite increases in psychiatry (25%), nurses (13%) and clinical psychology (42%) (DoH 2004). Thus, uncertainty about a sustainable mental health workforce had provoked central government into a controlling role. Government played its part in removing traditional professional control from psychiatry.

The legacy of contested theory and practice in current mental health work

In this section, a brief commentary is offered about the relationship between theory and practice in current mental health work and the aggregating legacy of contestation it contains (Crossley 2006). Specialist mental health work is not unique in witnessing adjustments to, or the 're-engineering' of, the division of labour in health settings. For example, role substitution is becoming increasingly common now in primary care teams in relation to the management of both minor ailments and chronic disease (Sibbald, Laurent and Reeves 2006). Studies of the management of mental health problems in primary care show similar system adjustments and tensions about new roles (Bower, Jerrim and Gask 2004).

These studies of primary care suggest that whilst some epistemological tensions are thrown into relief, for example in relation to biomedical versus biographical medicine in general practice (Charles-Jones, Latimer and May 2003), it is the challenge of a new division of labour that is most salient. When we turn to secondary care, where psychiatry is the key player, *both* are important and at times the disputes over theory and practice, rather than the division of labour per se, predominate. This point can be outlined with reference to five main co-existing strands in psychiatry, which other professions have supported or opposed:

- The first is derived from *eugenic biodeterminism* typified in the later Victorian period and adopted from German psychiatry. The latter, championed by Kraepelin, argued that mental illnesses are genetically determined deteriorating brain conditions which are naturally occurring categories (Kraepelin 1858). The latter emphasis on categories has been retained in nosological systems, such as the Diagnostic and Statistical Manual of the American Psychiatric Association, but which no longer assumes aetiological certainty (hence it is now dubbed as 'neo-Kraepelinian'). The Kraepelinian tradition, celebrated in the entreaty of Craddock and colleagues, has also been called 'medical naturalism' (Hoff 1995). It implies a straight medical approach: diagnose; speculate about aetiology and prognosis; treat and monitor.
- The second strand was triggered by the work of Adolf Meyer, a Swiss psychiatrist who developed his career in the USA and was highly influential in laying the ground for what was to become the *biopsychosocial model* in psychiatry (Engel 1980, Double 1990, Clare 1999). This asks, 'why does this patient present with their particular problems at this point in their life and what can we do to help them recover?'

- The third strand has been *orthodox psychoanalysis*. Its cultural relevance for British psychiatry is that whilst London hosted the major international debates about psychoanalysis just after the Second World War, it remained marginalised in the profession, within the sub-specialty of medical psychotherapy and in a few psychodynamic therapeutic community hospital experiments and the Tavistock Clinic in north London. By contrast, psychoanalysis became a substantial lobby within the American Psychiatric Association, leading to aetiological claims being dropped in DSM III, to resolve the stand-off with biological psychiatry (Bayer and Spitzer 1985, Wilson 1993).
- The fourth strand of relevance in psychiatry is *radicalised psychoanalysis*. In its libertarian form psychoanalysis has challenged the coercive norms of institutional psychiatry (Laing 1967). It has also argued that mental illness is a category error, used as a political rationalisation to justify the social control of residual deviance, and that all coercive 'mental health law' should be abolished (Szasz 1961). Laing and Szasz, were derided or held in contempt by their orthodox colleagues. Neither actually argued for the abolition of their profession but their expectations of reform were depicted as both utopian and treacherous by professional leaders reacting to 'anti-psychiatry' (Hamilton 1973, Wing 1978). After its upsurge and subsequent containment in the 1960s and 1970s, British 'anti-psychiatry' influenced the ideas of the users' movement (Rogers and Pilgrim 1991) and acted as a source of provocation for the next strand.
- The fifth and most recent development within the profession is that of *critical psychiatry*. This is a network of British psychiatrists who debate the reform or abolition of their own profession and adopt a critical stance derived from Foucauldian analysis or from a demand to adopt, in a more thoroughgoing manner, the Meyerian position above of the biopsychosocial model (Double 2002, Moncrieff 2008, Bracken and Thomas 2006). The common thread in the network is the willingness of its participants to concede the limits of their profession and to open up debates for us all about mental health problems. Scepticism and curiosity are emphasised in the face of the social and existential complexities of psychological difference in society.

Discussion

This overview of British psychiatry in 2008 has many resonances with that provided by Samson (1995), which can now be considered in the light of the above. Any sociological account of professional life can draw confidently, albeit selectively, on Marxian and Weberian traditions, and empirical case studies soon encourage some sort of syncretism. In particular, Samson highlighted a key insight from each in relation to British psychiatry in the 1990s: medical dominance and proletarianisation.

In the first regard, he noted that, for a variety of reasons to do with the growth of managerialism, marketisation of the NHS and its attendant consumerism and competing bids for legitimacy from non-psychiatrists, a stable enjoyment of dominance in the field of mental health care was fragmenting. He noted, with appropriate caution though, that the prospect of true proletarianisation was not likely.

It is true that psychiatry, like all medical specialties and other health care professions, was being subordinated to the pincer movement of marketisation and bureaucratisation in the NHS. At the same time, the profession was adapting to these demands as well – by adopting the logic of managerial surveillance; for example by embracing evidence-based practice and evaluation. Moreover, de-skilling (a feature of proletarianisation) at the time of Samson's analysis was not on the horizon in relation to a central, if often disavowed role

of psychiatry, that of parens patrie. The latter refers to the delegation of State paternalism to trusted occupational groups to protect or control those in the population who lack the capacity for self-care or self-control (children, those with learning disabilities and those deemed to have lost their reason).

The arguments evident about the 'Wake Up Call for Psychiatry' reflected many of the elements highlighted by Samson but re-visited in 2008. However, new developments intensified the forces threatening medical dominance and risking de-skilling. In particular during the 'New Labour' years, a new Mental Health Act introduced ambiguity about the professional identities involved in parens patrie by removing the medical monopoly of the Responsible Medical Officer. In addition, the New Ways of Working initiative has been an explicit threat to medical dominance. Not surprisingly, it was at the centre of the complaints issued by Craddock and colleagues, which were echoed by loyal conservative allies in supportive correspondence.

Thus, since Samson's analysis, there has been a continuation of the neo-liberal reform of the welfare state under Labour governments. This has entailed more marketisation and consumerism on the one hand and more bureaucratisation of the workforce on the other. These have provided both threats and opportunities for the psychiatric profession and others. But, in addition, the changing roles noted in the wake of legal and workforce policy shifts have undermined the confidence of some in the psychiatric profession about retaining a dominant role. An example of a shift from a biomedical focus, even in relation to those with 'severe and enduring mental illness', can be found in the National Service Framework (DoH 1999) and the recent conclusions about its success and implications by a multi-disciplinary expert review group (Care Services Improvement Partnership 2008).

The latter group highlighted: the need to continue with specialist community-based teams; the expansion of psychosocial interventions and specialist psychological therapies; the importance of social factors in mental health; the continued need to improve the quality of inpatient care; housing; rehabilitation pathways across communities, not just between primary and secondary care; and the continuing importance of user and carer views to improve services. In conclusion, the question was posed: 'Is it time to revisit the values and principles framework for mental health service provision, to include such issues as recovery, inclusion and wellbeing?' (CSIP 2008: 12). This checklist, with its psychosocial emphasis, gives comfort and confidence to the very interest groups which Craddock *et al.* fear now dominate the discourse about 'mental illness'.

The survival of the profession may rely then on its capacity to accept some loss of dominance in exchange for a tolerance, or even respect, for a medical contribution to mental health care, from its State employers and from colleagues in the wider psy complex. In its favour, is inertia about medicinal treatments and a continuing tendency for a range of interest groups to accept reified psychiatric diagnoses, rather than context-specific formulations (Pilgrim 2007). Also, medical psychotherapists, social psychiatrists and critical psychiatrists can retain an acceptable leadership role in a multi-disciplinary context. Against these trends of adaptation and survival we can also now identify a range of ongoing threats to the profession.

Medical dominance in mental health services has been progressively eroded in a number of ways. Dominance over patients has been undermined both by the weakening of coercive powers about detention and treatment (after 2007 to be shared with other professions) and by the disdain evident from disaffected service users. The first of these has been encouraged specifically by recent government policy, whereas the second reflects a continuing emphasis since the 1990s on consumerism in public services. The latter is reinforced by the long-term existence of a new social movement of service users, some of whom demand the abolition of psychiatry.

Dominance over fellow professionals has been undermined by the diffused powers of coercion just noted and other measures such as nurse prescribing, as well as the shift of authority to primary care about 'common mental health problems' and even 'serious mental illness' during times of stable community living. In addition, the threat of an emerging psychosocial orthodoxy, complained about by Craddock *et al*., leaves a medical specialty with nowhere to go if it insists on a rigid biomedical stance.

These apparent threats to medical dominance, however, can be defused and even turned to the advantage of psychiatry. When and if psychiatrists now champion a psychosocial approach, for example in the rehabilitation orientation of a 'strengths-based' approach to recovery policies in services, then this galvanises their professional position. It is little surprising then that in response to Craddock *et al.*, unsympathetic colleagues made their position clear, thereby siding with others outside the profession. This, along with the break-down of singular legal powers of coercion for medicine, creates a new ambiguous authority in services, which crosses occupational boundaries.

The diffusion of authority across the psy complex and the production of a psychosocial orthodoxy in competition with biomedical tradition are also made more likely by mental health not being physical health (even though that dualism is open to philosophical attack, and the interaction between the two is readily demonstrated empirically). At the start of the movement towards 'critical psychiatry' during the 1980s, in a book with the same title, its editor noted that, potentially at least, physical illnesses are explicable in bodily terms alone. By contrast, attributions about psychological morbidity always entail a hermeneutic endeavour (Ingleby 1980).

Moreover that endeavour is always open to contestation because human science inevitably creates a plurality of models and methodologies in flux and in unresolved competition, as it operates in the fluid spaces between the a priori sciences (like maths), the a posteriori sciences (like geology) and philosophical reflection (Foucault 1973).

In this epistemological context, the Kraepelinian tradition was always weak because it confused its constructs about reality with reality itself, as if it were developing a non-problematic and incrementally certain version of natural science ('medical naturalism'). However, the other mental health professions, like nursing and psychology, have fared little better. They too contain a variegated mixture of theories and practices, in line with Foucault's analysis, within a modus operandi of pragmatic daily mutual tolerance. Contestation about theory and practice is a constant across the psy complex and so its impact is probably neutralised for any one particular occupational grouping.

This point is also reinforced by the consensus about 'recovery' we noted earlier. Although it actually means different things to different people, the working consensus across a range of groups, about recovery, means that it cannot be aligned as a strength or weakness with any one group in particular. Thus, contestation and an emphasis on recovery are evident features of all mental health work at present, and so are no more of a threat to psychiatry as a profession than any other.

That inability of any particular profession, or cross-cutting psychotherapeutic rationale, to acquire permanent pre-eminence about mental health problems, means that multiple perspectives are likely to continue across the field. What then may be at risk now is not psychiatry as a whole but that *biomedical version* of the profession, yearned for nostalgically by Craddock *et al.* Their reactionary pleas for respect and pre-eminence are being drowned out by widespread systemic and cultural shifts, entailing power sharing with others in a changed mental health workforce. These also involve a range of psychosocial approaches to mental health work, which, to the chagrin of Craddock and colleagues, are creating a new orthodoxy across professional boundaries. That new orthodoxy has been generated as

much by psychiatrists adapting to problems within their own profession, by experimenting with alternatives to biomedicine, as it has by external opponents.

Another consideration about the continuation of psychiatric authority, in a multidisciplinary service context, is that it contains two imperatives, whichever discipline plays out the dominant professional role. The first is the aspiration to create mental health gain for patients in ways that are measurably effective, acceptable and appropriate. The second is to ensure that some patients are lawfully controlled in the interest of third parties. So much of the controversy about psychiatry has been in relation to its traditional therapeutic efforts (or new ones about 'recovery') being inefficient, unacceptable or inappropriate, alongside its success at social control being too great. This has created a conservative emphasis on risk-minimisation, at the cost of patient civil liberties. But where is the certainty that competitors would be therapeutically superior, better at creating recovery or more patient-centred in their role as agents of social control? They may be but it is not a foregone conclusion.

There is an arena though in which medicinal psychiatry is particularly vulnerable – its own scientific emphasis on evidence-based practice. This vulnerability has two aspects. First, the evidence of the *acceptability* of medication-centred regimes to service users has made psychiatry a particular target of patient disaffection (Crossley 2006). Secondly, inside psychiatry, the logic of evidence about the *effectiveness* of medication weakens the biomedical lobbying about incremental pharmacological progress in the field. For example, two recent large, non-commercial clinical trials, comparing first- and second-generation antipsychotic drugs for people with a diagnosis of chronic schizophrenia, demonstrate that the newer drugs were no more effective or better tolerated than the older ones (Lewis and Leiberman 2008). In response to this we find this editorial commentary from the *British Journal of Psychiatry*:

> We are reminded by Lewis & Lieberman that the Orwellian chant of 'atypical antipsychotics good, typical antipsychotics bad' is indeed the vacant refrain of sheep-like adherents to an outdated chimera of progress (Tyrer 2008: 242).

This poses a problem for evidence-based medicine: what happens when the evidence does not support the rhetoric of incremental scientific progress in the discipline favoured by those like Craddock *et al.*? One implication of being hoisted by its own evidence-based petard is that a propitious opportunity is offered for psychiatry's critics.

At the outset we noted the notion of a 'legitimation crisis' (Habermas 1975). In his later work he moved his focus from system crisis (following Parsons) to what he called 'legitimation deficits' and 'legitimation challenges', with an emphasis on lifeworlds (and so got closer to Weber) (Habermas 1987; 1993). With this shift came less of an emphasis on crisis and more of one on *chronic discontent and disputation* in late capitalism (hence the favoured title for this paper). This picture has certainly been evident about the role of psychiatry in society, which is made inevitable by the contention that always surrounds human science (noted earlier) and any version of social control (in this case 'therapeutic law' and the consequent mixing of voluntary and coerced service recipients).

It is evident that the differentiation of lifeworlds within and across the psy complex on the one hand and its targets on the other (those with mental health problems) leads to a multiplicity of alliances and disputes, which implicate the consciousness and conduct of both individuals and sub-groups. These are organised around roles (*e.g.* patient, psychiatrist, carer, nurse, psychologist) and ideologies, perspectives or shared discourses (five core competing strands are noted above in psychiatry alone, but there are others elsewhere in

the psy complex and service users' movement). Habermas emphasised lifeworld forms as 'networks of communicative action' or 'legitimately ordered interpersonal relationships' (Habermas 1993).

Thus, Craddock and colleagues with their biomedical lobbying were 37 voices in a shared network articulating their own version of legitimacy but speaking to a wider mixed audience. The latter contained other lifeworlds with different views about what is and is not legitimate (hence the mixed response in the correspondence about the clarion call article). As we now note in conclusion, we do not know for certain how representative each of these positions is in routine practice.

Conclusion

Currently, there are two broad predictions to be offered about the future of British psychiatry. The first is that the profession is surviving well but that a reactionary biomedical rump (exemplified by the Craddock *et al.* petition) is certainly threatened and, consequently, stridently special pleads for its own survival. The second is that Craddock *et al*. are predicting, with good cause, that the whole of the profession is under threat. We would argue that there are no grounds yet for this extreme conclusion.

This article, however, has necessarily been a broad overview. There remain empirical questions to be answered by further research. In particular, we do not know at present the extent to which the biomedical approach to psychiatry represents the clinical norm in routine services. Not all the signatories of the Craddock *et al.* petition were academics; many were NHS Consultants. If their position is indeed now the norm 'on the ground', then it is possible that the profession is under serious threat because that position is, as we have argued, organisationally and legally untenable. Alternatively, if the biopsychosocial model and convivial multi-disciplinarity are now the routine features of specialist mental health services, then psychiatry as a medical specialism will remain safely intact.

A final empirical question, which we noted above, is that if evidence-based practice truly guides clinical norms, then the biomedical emphasis on medication may well bring new challenges to the profession. It is already becoming evident that little true progress has been made about either the acceptability or effectiveness of medicinal solutions to social and existential questions. If services are, in practice, routinely medication-focused, then this will weaken the mandate of psychiatry to lead services and maybe even survive within them.

For the time being, our analysis of the profession seems to confirm Nietzsche's homily that 'that which does not destroy us makes us stronger . . .'. However, the empirical questions, which are begged here, suggest that even this conclusion remains tentative. Put differently as a form of unsolicited advice: if the total occupational group called 'British psychiatry' is to survive, then its pragmatic leaders, trainers and everyday practitioners should now distance themselves from biodeterminism and a narrow diagnostic and medicinal emphasis. They need to embrace an alliance with outsiders, such as politicians wanting new ways of working and improved risk management, service users wanting to be citizens, not coerced patients, and other mental health workers favouring psychological interventions and social explanations.

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