

Peter Stastny and Peter Lehmann (Eds.)

Alternatives Beyond Psychiatry

Preface by Robert Whitaker

Contributions by Volkmar Aderhold, Laurie Ahern, Birgitta Alakare, Karyn Baker, Ulrich Bartmann, Agnes Beier, Regina Bellion, Wilma Boevink, Pat Bracken, Stefan Bräunling, Ludger Bruckmann, Giuseppe Bucalo, Dorothea S. Buck-Zerchin, Sarah Carr, Tina Coldham, Bhargavi Davar, Anne Marie DiGiacomo, Constance Dollwet, Jeanne Dumont, Merinda Epstein, Sandra Escher, James B. Gottstein, Chris Hansen, Geoff Hardy, Petra Hartmann, Alfred Hausotter, Michael Herrick, Guy Holmes, Andrew Hughes, Theodor Itten, Maths Jespersion, Kristine Jones, Hannelore Klafki, Miriam Krücke, Peter Lehmann, Bruce E. Levine, Harold A. Maio, Rufus May, Shery Mead, Kate Millett, Maryse Mitchell-Brody, David W. Oaks, Peter Rippmann, Marius Romme, Marc Rufer, Gisela Sartori, Erich Schützendorf, Jaakko Seikkula, Andy Smith, Zoran Solomun, Peter Stastny, Chris Stevenson, Dan Taylor, Philip Thomas, Jan Wallcraft, David Webb, Uta Wehde, Scott Welsch, Salma Yasmeen, Laura Ziegler and Ursula Zingler

Translations by Christine Holzhausen, Katy E. McNally and Mary Murphy

Peter Lehmann Publishing · Berlin · Eugene · Shrewsbury · 2007

Pat Bracken

Beyond Models, Beyond Paradigms

The Radical Interpretation of Recovery

The word “recovery” was first used to signal an alternative agenda in mental health in a number of prominent survivor narratives. In recent years, the word has been increasingly used in different contexts. Sometimes it is argued that what is needed is a shift from a “medical model” to a “recovery model.” The word “paradigm” is also used. In the U.K., the move to a recovery agenda has been presented as a “paradigm shift” in our understanding of mental health problems. In this article, I will argue for a more radical interpretation and suggest the recovery movement is not about shifting from one paradigm to another (or one model to another) but about moving beyond paradigm thinking and models altogether.

First, it is important to be clear about what it is we are seeking an alternative to. Usually, this is presented simply as the “medical model.” The problem is understood to be that the medical framing of experiences of madness and distress is wrong and destructive. This medical framing leads to the unnecessary and harmful use of drugs and ECT in a misguided attempt to treat “symptoms.” While this is obviously a major problem, I believe that the medical model is only one manifestation of a more fundamental problem: the tendency to see human problems as technical difficulties of one sort or another. I call this the “technological paradigm.” This paradigm shapes our most fundamental assumptions about ourselves and the nature of health and healing. It frames the way in which problems show up for us and works to orient our thinking on many different levels. Essentially it promotes a “model-based” way of looking at human difficulties. Through this, it underscores not just the medical model but also most psychological and managerial approaches to mental health. Alongside biological models of “symptom” production, we

have cognitive-behavioural models, psychoanalytic models, even social models of different sorts.

The technological paradigm puts issues to do with the development of models, classification systems, comparisons of different interventions, etc., at the centre of the mental health discourse. That this is currently dominant is evidenced by a quick look through the pages of most psychiatric and psychological journals. In this technological paradigm, issues to do with values, meanings, relationships and power are not ignored but they are always secondary to the more important technical aspects of mental health. In this paradigm, the technical aspects are primary. Furthermore, this paradigm underscores the centrality of “experts”: professionals, academics, researchers, codes of practice, training courses and university departments. Service users might be consulted and invited to comment on the models and the interventions and the research, but they are always recipients of expertise generated elsewhere.

For me, the recovery agenda and the emergence of a mental health discourse that is user/survivor led present a radical challenge, not just to the medical model, but to the underlying technological paradigm. This user/survivor discourse is not about a new paradigm or a new model, but reorients our thinking about mental health completely. It foregrounds issues to do with power and relationships, contexts and meanings, values and priorities. In the non-psychiatric literature about recovery, these become primary. As I read it, this literature does not reject or deny the role of therapy, services, research and even drugs but it does work to render them all secondary. For example, when it come to drugs and their use, the literature emerging from independent users and survivors of psychiatry seeks to prioritise access to information about the mode of action, the unwanted effects and debates about efficacy. It also works to ensure that psychiatric drugs are only administered with consent and has exposed the profits made by Big Pharma in the area of psychotropics. It has challenged the ways in which corporate interests have shaped the agendas of university departments of psychiatry and examined how this alliance between academic psychiatry and Big Pharma has worked to shape the very models and classification systems that are used in psychiatry.

In my opinion, we should judge how much the recovery agenda is being accepted by looking at how much prominence is afforded this user/survivor discourse in the training of professionals and academics. The most radical implication of the recovery agenda, with its reversal of what is of primary and secondary significance, is the fact that when it comes to issues to do with values, meanings and relationships, it is users/survivors themselves who are the most knowledgeable and informed. When it comes to the recovery agenda, they are the real experts.

Peter Lehmann and Peter Stastny

Reforms or Alternatives?

A Better Psychiatry or Better Alternatives?

Modern Psychiatry

In line with the biological-medical paradigm, psychiatry presents itself as a pharmacological discipline, rooted in the practice of prescribing psychiatric drugs over the long term. This, in turn, is enhanced by laws that ensure, if necessary through coercion, the administration of these drugs either during hospitalization or in an outpatient setting. The laws also provide for the appropriate methods of surveillance as well as for any additional interventions deemed necessary such as electroshock or psychosurgery. Information regarding risk and side effects is generally withheld—with good reason.

Psychiatry underwent reforms everywhere after World War II. In particular, community psychiatry, also known as “social” or “democratic psychiatry”, was developed and further advanced. In several countries, including Germany, many of the large old asylums were replaced by smaller new ones. Inmates were transferred to residential facilities close to their communities. The psychiatrist Harald Neumann longed for some of these community-based satellite facilities as early as 1961 and remarked,