Several years ago I was invited to give a talk at a conference held for the lay people and professionals who sit on the British National Health Service’s numerous research ethics committees. These committees, which meet in every corner of the country, are responsible for regulating the conduct of medical research. Any investigator who wishes to carry out a study in the NHS is required to submit detailed plans to the local committee, which will then debate the merits of the proposed investigation, ensure that any risks to patients are outweighed by likely benefits, and make sure that all those participating freely consent to doing so.

I had been invited to talk at the conference because the organizers thought that, during two decades of work as a clinical psychologist* studying severe mental illness, I was likely to have gained some insights into the specific problems encountered when trying to conduct research with psychiatric patients. The conference was scheduled to take place in the city of Chester, about 20 miles from my home, so I had reluctantly agreed to give my talk early on a Saturday morning, a time I normally prefer to spend with my family. As I made my way to the conference venue my mind was focused on a less cerebral

* The differences between the profession of clinical psychology (to which I belong) and the profession of psychiatry will be discussed at length as we proceed. Suffice it to say for the moment that psychiatrists first of all obtain a degree in medicine before receiving further training in the treatment of mental illness. Clinical psychologists, on the other hand, first of all receive a scientific training in psychology (the science of mind and human behaviour) before going on to take an advanced training (a taught doctorate in Britain and the United States) in the use of psychological techniques in the assessment and treatment of mental illness and other clinical conditions.
purpose – I had discovered that the film ET was going to be shown at a local cinema later in the morning and that, if I managed to leave promptly after my talk, I would be able to take my 5-year-old twins to see it.

When I arrived I found about a hundred delegates sitting behind long tables draped in white cloth. They looked like fairly ordinary folk and I reminded myself that they would be from a variety of backgrounds; quite a few doctors no doubt, a few professional philosophers, as well as many people from other walks of life. They were listening respectfully to a smartly dressed young surgeon who, from his position on the podium, was enthusiastically berating them. Although I had missed the first few minutes of his talk, his theme seemed to be that, by requiring the detailed scrutiny of every aspect of a proposed project, a process that could take many months, ethics committees were in danger of preventing vital research from happening at all. (Anyone who has tried to conduct research in the NHS is likely to have some sympathy with this position although, of course, this is not to suggest that research projects should not be subject to detailed independent review.)

Like the surgeon who preceded me, I wanted to say something about the increasing difficulties I was encountering when carrying out my research. However, I also thought that an audience of ethics committee members would appreciate hearing a talk that was thought-provoking, and which would stimulate debate. I therefore decided to challenge the widespread assumption that many psychiatric patients are unable to understand the purpose of research, and are therefore unable give meaningful consent. I began by listing some of the terrible abuses that had been perpetrated against psychiatric patients during the middle decades of the twentieth century – for example, the way in which they had been incarcerated in large asylums and subjected to cruel and ineffective treatments such as the prefrontal leucotomy (a crude brain operation). I suggested that these abuses had been possible because patients’ objections had been systematically ignored on the grounds that their mental illness disqualified them from offering a reasoned opinion about their treatment. I then went on to describe some recent psychological research which showed that even severely ill patients are usually capable of reasoning about their experiences.
I concluded that ethics committees should trust psychiatric patients and recognize their right to autonomy (that is, their prerogative to decide what is in their own interests; a fundamental right according to medical ethicists’), adding that patients would almost certainly get better treatment if clinicians dealt with them in the same way.

After my closing words, I took a deep breath and waited for questions. My mind was still focused on the problem of escaping as quickly as possible. As I smiled benignly at the audience, a middle-aged man rose at the back of the conference hall, and began to speak, ‘Professor Bentall has told us that he is a scientist,’ he began in an amiable enough tone of voice. He paused for effect, and then his tone suddenly darkened. ‘But he is not!’ he thundered. ‘Nothing that Professor Bentall has said – not a single word – is true. We have been forced to listen to a wild, antipsychiatric rant!’

I was a bit stunned. I was used to being challenged politely, and on particular points (‘I would like to disagree with what you said about the effectiveness of antipsychotic medication’, perhaps) but I could not remember any previous occasion on which someone had tried to rubbish everything that I had said in a single sentence. Trying to gather my thoughts, and still mindful of the fact that I needed to get away as quickly as possible, I asked the speaker – presumably a psychiatrist – to identify any particular observation I had made that he thought was inaccurate. There then followed a slightly rambling intellectual tussle as, to the likely confusion of nearly everyone present, we debated whether schizophrenia is a genetically determined brain disorder. Eventually, our debate was interrupted by the chairman, who wanted to introduce the next speaker.

As I hurried away from the podium two people spoke to me. The first was the next speaker, another smartly dressed doctor, who, passing in the opposite direction, whispered, ‘Blimey, that was exciting!’ The second was a middle-aged woman, who chased after me and stopped me at the door. ‘Ignore that fool!’ she said, her eyes flooded with tears. ‘My husband has been mentally ill for twenty years. Nothing they have done has ever helped him. You’re the first person I have heard who has ever given me any hope.’
On the distinction between antipsychiatry and being against psychiatrists

As my experience at the conference demonstrates, debates about the causes and treatment of mental illness can provoke powerful emotions, perhaps because they are not mere intellectual games but affect the lives of real people. The heat in these debates has often been stoked by professional rivalry between different groups of mental health professionals. For example, psychiatrists (who are trained in medicine before going on to specialize in the treatment of the mentally ill) often (but not always) assume that mental illness is the consequence of some kind of genetically determined brain disease, and therefore often use drugs as their first line of treatment. On the other hand, clinical psychologists (who are first trained in the science of psychology before going on to learn how to apply psychological technique to clinical problems) usually (but not always) start from the assumption that mental illness is caused when normal psychological processes are placed under intolerable stress, and advocate the use of psychological treatments (with few exceptions, they are not licensed to prescribe psychiatric drugs).

As psychiatry is the older of the two professions and clinical psychology is a relative newcomer, it is the medical approach that has taken precedence in the mental health services of most countries of the world. However, as we shall see, throughout the history of psychiatry there have always been people who have opposed the medical approach, sometimes meekly but often with great energy. This opposition has come, not only from other mental health practitioners such as clinical psychologists, but often from within psychiatry itself. For example, during the 1960s and 1970s it was dissident psychiatrists such as Thomas Szasz and Ronald Laing who formed the core of what was known as the antipsychiatry movement, which, perhaps because it chimed with the anti-authoritarian spirit of the times, enjoyed widespread support amongst the chattering classes.

Of course, there have never been any anti-oncologists, anti-cardiologists, anti-gastroenterologists or even anti-obstetricians. Psychiatry has therefore been unique in the extent to which it has
generated both fascination and mistrust amongst intelligent people. Perhaps this is because, alone among the medical specialities, it has the power to compel people to receive treatment, and because some of the treatments inflicted on the mentally ill have seemed more terrifying than madness itself. Perhaps it is also because the human sciences of psychology and sociology seem to offer an obvious alternative to the medical way of thinking about human distress, leaving a suspicion that much of what passes for medical science in the field owes more to Frankenstein than to Louis Pasteur or Alexander Fleming.

The movement failed to achieve its aims, partly because it was unable to propose a convincing and workable alternative to traditional psychiatric care but also because startling advances in the neurosciences led to renewed enthusiasm for the medical approach to mental illness. Roll the clock thirty years onwards and we arrive at a time when a psychiatrist arguing with a clinical psychologist can use the term ‘antipsychiatry’ as a kind of sneer, a single word that can be deployed to signify that any opposition to conventional psychiatric thinking is crazy and as outdated as luxuriant moustaches and multi-coloured flared jeans. What has been lost in all this is that it might be possible to be rationally antipsychiatric, that conventional psychiatry might reasonably be criticized, not on hard-to-define humanistic grounds (although these are important) but because it has been profoundly unscientific and at the same time unsuccessful at helping some of the most distressed and vulnerable people in our society. This is the main argument of this book.

Of course, one difficulty in making this argument is that it provokes defensiveness in even the most forward-thinking of psychiatrists. Responding to a highly critical history of the profession by the American journalist Robert Whitaker, a British doctor of my acquaintance (whom I would count as on the side of the angels), remarked that he felt as bruised as a sinner who had been denounced by a strident evangelical preacher. This kind of response reflects an understandable difficulty in distinguishing between being antipsychiatry and being against psychiatrists. It is logically possible to object to much of the theory of medical psychiatry and to exclusively biological treatments for psychiatric disorder, while at the same time recognizing that even the most conventionally minded psychiatrists usually want the very
best for their patients, and that there are many amongst their number who, sometimes despite their training, are highly skilled and empathetic clinicians. It is also possible to object to conventional psychiatry while recognizing that some of its most influential opponents today, just as in the 1960s and 1970s, are psychiatrists themselves. Rather than dispensing with psychiatrists, perhaps we need more psychiatrists who are better trained, and who are better able to help their patients.

**The purpose of this book**

One important difference between the 1970s and today is that we now know much more about psychiatric disorders. Far from shoring up the medical approach, however, recent scientific research shows that it is fatally flawed. As a consequence, a new picture of mental illness has begun to emerge. In my previous book, *Madness Explained: Psychosis and Human Nature*, I tried to describe this new picture in detail. My aim was to show how modern research was leading to a coherent understanding of madness that is dramatically different from that found in even the most recent textbooks of psychiatry. In the process, I found it necessary to explain what was wrong with some very widely accepted theories of mental illness, but I avoided launching an all-out assault against conventional psychiatric treatment. Anticipating criticism from my medical colleagues, I made sure that the relevant evidence was meticulously referenced, with the consequence that the book was long – 512 pages followed by another 110 pages of notes. On the whole, it was well received (it won the British Psychological Society Book Award in 2004). However, its length may have prevented the dissemination of its ideas as widely as I would have liked.

This book tackles some of the same themes but is shorter and therefore (I hope) more accessible. However, it differs from its predecessor in some important respects. It focuses much more on the stories of patients, and is also much more concerned with the effects of different kinds of treatment, which were not discussed at any length in the previous book. I argue that many of these treatments are nowhere near as powerful as is often believed, and that their effects have been exaggerated by skilful pharmaceutical industry marketing.
An important theme I have tried to address throughout, and which I entirely neglected in *Madness Explained*, is the crucial importance of relationships in psychiatric care. After adopting a technical, biomedical approach to mental illness during the 1980s, psychiatry (especially in the United States but also in Britain to some extent) decided that talking to patients is not very important. The result is a style of care that many patients find coercive and dehumanizing. Ironically (although perhaps not to the surprise of many outside psychiatry), the research evidence shows that warm, collaborative relationships, far from being dispensable, are the key to success in psychiatric care. Hence, if psychiatric services are to become more genuinely therapeutic, and if they are to help people rather than merely ‘manage’ their difficulties, it will be necessary to rediscover the art of relating to patients with warmth, kindness and empathy.

For those readers who would like a more detailed outline of the contents of *Doctoring the Mind* I proceed as follows. In Chapter 1, I ask whether there is any evidence that psychiatry has made a positive impact on human welfare. Surprisingly, it seems that there is not. For example, whereas the recent history of physical medicine has been marked by dramatic breakthroughs, leading to measurable improvements in the likelihood of surviving life-threatening diseases, there is no evidence of similar advances in our ability to treat severe mental illness. This leads me to ask why psychiatry has failed when other branches of medicine have been so successful.

The historical section of the book, which occupies the next three chapters, explains how the current ineffective approach to psychiatric care has evolved. Whereas the historical chapters in *Madness Explained* focused exclusively on the development of theories of psychiatric classification, in this book I focus much more on the evolution of different kinds of psychiatric treatment. Of course, any history must be selective, emphasizing some events and neglecting others in an attempt to weave a coherent narrative. For obvious reasons, I have tried to provide an antidote to the kind of Whig history contained in books such as Michael Stone’s *Healing the Mind*, and Edward Shorter’s *A History of Psychiatry*, which, despite having many strengths, inaccurately portray the glorious present as the culmination
of centuries of steady scientific progress. Along the way, I consider the impact of the creation of the new profession of clinical psychology at the end of the Second World War, which has been completely overlooked by conventional histories. (A psychiatrist reviewing Madness Explained argued that naked professional rivalry had undermined its arguments.) This observation made me think carefully about how I portrayed the relationship between clinical psychology and psychiatry in this book. However, in the end, it seemed to me that ideological and professional conflict between the two professions has been a historical reality and so I decided that it was pointless to pretend otherwise.) After describing how the discovery of chlorpromazine prompted renewed optimism in biomedical approaches to mental illness, I explain how the emergence of the new technologies of neuro-imaging and molecular genetics has reinforced the modern view that psychiatric disorders are genetically determined brain diseases that must be treated with drugs.

The next three chapters deal with some myths about the nature of severe mental illness that underpin current psychiatric practice. Chapter 5 is the only chapter that overlaps considerably with Madness Explained, and considers the value of psychiatric diagnoses. In Chapter 6, I review what the current evidence tells us about the genetic and environmental determinants of psychosis, contrasting theories that locate the causes of illness within the person with those that locate them in the world. A particular target of my critique is the statistical measure of heritability, which is often cited by those who believe that psychiatric disorders are genetic diseases. This is probably the most technically demanding chapter in the book but I hope that I have explained the relevant concepts in a way that will be easily followed by the intelligent lay reader. In Chapter 7, I consider whether and to what extent psychiatric disorders can be said to be caused by brain disease. It turns out that this question is much more easily addressed if we attempt to explain particular kinds of complaints (symptoms) such as hallucinations and delusions, rather than meaningless diagnostic categories such as ‘schizophrenia’. The picture that emerges is much more consistent with the idea that severe mental illnesses are influenced by the social environment, than with the idea that they are genetically determined disorders of the brain.
The following three chapters consider the effectiveness of modern psychiatric therapies. I begin by describing the emergence of the evidence-based medicine movement, which has led to widespread faith in the randomized controlled trial (RCT) as a measure of treatment effectiveness. Focusing on antidepressants, I show how the pharmaceutical industry has systematically distorted RCT data to promulgate a wildly over-optimistic impression of what psychiatric drugs can do. In Chapter 9, I extend this analysis by showing that the evidence in favour of antipsychotic drugs is much less compelling than is usually supposed, and that psychiatrists have been blinded to the adverse effects of these drugs in much the same way that they were blind to the effects of the crude brain operations and other extreme remedies used in the middle years of the twentieth century. Unfortunately, as we discover in Chapter 10, this does not mean that drug therapies can be entirely replaced by psychological treatments. Although the last decade has shown growing enthusiasm for one particular type of psychological treatment for severe mental illness – cognitive behaviour therapy (CBT) – the evidence that any one type of therapy is better than any other is by no means clear-cut. This observation provokes two kinds of responses. Some hardline biological psychiatrists have concluded that CBT is just some form of elaborate placebo but a better conclusion is that it is the quality of the therapeutic relationship that determines outcome. Hence, by paying attention to this relationship, and placing it at the centre of psychiatric practice, we can see a way to develop services that are more humane and effective. As much as psychiatric services today are an improvement on those of the past, it is because they are kinder and more respectful of the needs of patients, rather than because of the availability of new therapies.

This conclusion leads me to the last chapter, in which I address what is to be done to improve psychiatric services in the future. It will be no surprise that I think that they need to be much less medically orientated, but perhaps a disappointment to some of my colleagues that I do not see the solution as a full-scale takeover bid by Clinical Psychology Inc. Indeed, I argue that it is the engagement of patients in the design and development of services that is most likely to lead to lasting improvements.