

diseases of the brain, but as involving ‘social, cultural and psychological dimensions’.

We agreed with much of the paper’s substance, yet found ourselves concerned by the implied route to implementation. Given their audience, Bracken *et al* can be forgiven for failing to acknowledge the existence of clinical psychology; yet their arguments owe a great deal to advances, both theoretical and empirical, made in this field. By calling for psychiatry to shift its epistemology and praxis, it might seem not only that they want to adopt an alternative philosophy, but quietly to move their tanks onto the lawns of fellow professionals.

One could follow their argument to a different conclusion. If the goal is a mental healthcare system in which problems are seen principally as ‘social, cultural, and psychological’ in origin rather than biomedical, then the case for having medically trained professionals in positions of seniority is substantially weakened. Rather, clinical leadership would need to be provided by people who have received a comparably extensive training in psychological, social and cultural causes of distress.

Reforming the whole of psychiatry from the inside out can hardly be the most practical means of realising this vision. Instead, consider that there are some 10 000 clinical psychologists in the UK, the majority of whom work in the National Health Service (NHS). A substantial number of psychiatric posts go unfilled,² while clinical psychologist posts are being cut and downgraded across the country despite training places being vastly over-subscribed. We could begin by imposing a moratorium on filling psychiatric posts and use the money saved (about £100 million, at a conservative estimate) to reverse the process of downgrading, increase the number clinical psychologists at higher leadership grades and expand the number of training places. That – at zero net cost to the NHS – could help move us towards Bracken and colleagues’ vision.

To be clear, this is not an ‘anti-psychiatry’ argument. We do not dispute psychiatric expertise in several technical areas, principally psychopharmacology. Although the benefits of antipsychotic medication have often been gravely overstated³ and the utility of diagnostic categories is a source of constant dispute,⁴ we would not be among those who deny that pharmacological interventions are ever a useful part of the treatment armoury, nor would we join the ranks of those criticising the profession of psychiatry. But if we want mental health services to be structured around the epistemological and theoretical assumptions outlined by Bracken *et al*, psychiatry should not aspire to colonise the territory of social, cultural, and psychological disciplines, but instead adopt a more genuinely equitable stance.

1 Bracken P, Thomas P, Timimi S, Asen E, Behr G, Beuster C, et al. Psychiatry beyond the current paradigm. *Br J Psychiatry* 2012; **201**: 430–4.

2 Royal College of Psychiatrists. *Census 2009: Workforce Figures for Psychiatrists*. Royal College of Psychiatrists (<http://www.rcpsych.ac.uk/pdf/2009%20Census.pdf>).

3 Whitaker R. The case against antipsychotic drugs: a 50-year record of doing more harm than good. *Med Hypotheses* 2004; **62**: 5–13.

4 Kinderman P, Read J, Moncrief J, Bentall R. Drop the language of disorder. *Evid Based Ment Health* 2013; **16**: 2–3.

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Authors’ reply: Our central argument is that, for too long, academic psychiatry has been in the grip of a bioreductionist ideology

that has prevented a truly ‘evidenced-based’ discourse to emerge. This ideology has encouraged us to see our discipline as simply ‘applied neuroscience’ and we have been promised over and over that the neurosciences will deliver insights and results ‘in the future’. But this promised future never materialises. Our analysis of the literature about how drugs and therapies actually work, about how recovery from serious mental illness is promoted in the real world and about what service users and their organisations are telling us about their lives and their encounters with services has led us to seek a post-technological psychiatry: one that is able to acknowledge the primary importance of relationships, meanings and values in mental health work. We believe that the available scientific evidence endorses this position and the demands from service users and their organisations for a very different sort of medical engagement with mental suffering.

Of course, there is work to be done in mapping the implications of this analysis. Moving ‘beyond the current paradigm’ is not about a search for another singular framework, but a realisation that the complex world of mental health demands openness to multiple paradigms. We believe that a mature psychiatry will be one whose practitioners are comfortable with the epistemological, political and therapeutic implications of this. Many psychiatrists strive to work in this way already and there is evidence that an increasing number are keen to move towards recovery-oriented service models.¹

We do not claim to have all the answers and value the work of Professor Holmes, for example in relation to the role of narrative in mental health practice.² However, we would caution against any attempts to explain the insights of psychodynamics through the discourse of neuroscience. We fear that this is another example of what the physician and philosopher Raymond Tallis calls ‘neuromania’,³ a contemporary intellectual fashion which seeks to explain every aspect of the human condition through the terms of neuroscience. One of Freud’s greatest insights was the realisation that relationships are at the heart of mental health work, both in terms of explaining how problems emerge as well as offering solutions. Although neuroscience can offer some speculative ideas, it cannot be used to ground a science of interpersonal dynamics. In reality, human relationships, meanings and values are given their coordinates by the social context in which they exist. This context is deeply textured with cultural, linguistic, political and economic dimensions. It is the product of centuries of human history and simply cannot be grasped with the reductionist logic of biomedicine.

We are not too sure what to make of Professor Holmes’s tone in referring to our ‘encouraging service user involvement’. We would like to reiterate that we do indeed see this as a vital ingredient in any progressive debate about the future of psychiatry.

Kinderman & Thompson support our analysis but seem afraid that we are attempting to create a psychiatry that will seek to colonise the territory of other disciplines such as their own (psychology). This is a misreading of our project and our intentions and we can reassure them that we have no tanks to move onto anyone’s lawn! If human suffering fell neatly into specific domains there would probably be no need for psychiatry at all. Neurologists would deal with the brain and its disorders, endocrinologists would grapple with our hormones and psychologists could work with thoughts and feelings. However, human reality is not neat, and human suffering is often multidimensional. There aren’t discrete domains. At its best, psychiatry involves an attempt to bring medical insights and practices to bear on the complex nature of mental problems. Such problems can emerge through purely psychological pathways but, most often, they involve social, economic, political and biological

factors as well. Psychopharmacology is an important aspect of our work but so too is our understanding of the physical body and its diseases and our skills in relating this knowledge appropriately. We do not seek a psychiatry that has abandoned biology but a discipline that is more engaged with the humanities and the social sciences.

We do not accept the accusation that we failed to acknowledge 'the existence of clinical psychology', given the number of direct references to psychological research in our paper. Most of our discussion of the literature on counselling and psychotherapy is based on research by psychologists and our discussion of the 'recovery approach' points directly to the work of Professor Mike Slade (a psychologist).

We seek a different, not an expanded, psychiatry. We are not colonisers but neither do we believe that the answer is simply to replace psychiatrists with psychologists. Indeed, much of contemporary academic and clinical psychology is also guided by a technological paradigm.

The change we seek is not a replacement of one group of professionals with another. It is about a different 'way of seeing' what mental health work is about. Moving beyond the technological paradigm does not involve a rejection of everything we do now. It offers a different way of understanding why some of the things that we do work well, while at the same time appreciating the fact that some people are damaged by the way in which psychiatry frames their problems and intervenes in their lives. Crucially, it involves a rethinking of the nature of mental health expertise and, with this, a commitment to rethinking the power structures of our field.

- 1 Baker E, Fee J, Bovingdon L, Campbell T, Hewis E, Lewis D, et al. From taking to using medication: recovery-focused prescribing and medicines management. *Adv Psychiatr Treat* 2013; **19**: 2–10.
- 2 Holmes J. Narrative therapy in psychiatry and psychotherapy: the evidence? *Med Humanit* 2000; **26**: 92–6.
- 3 Tallis R. *Aping Mankind: Neuromania, Darwinitis and the Misrepresentation of Humanity*. Acumen, 2011.

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