

## The threat to political dissidents in Kennedy's approach to mental illness

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### Editor's note

*The author, a psychiatrist, argues that Kennedy's criteria for ascription of the status 'mentally ill' ignore the vital concepts of disturbance of psychological part-function and of impaired autonomy and paradoxically make it easier to label political deviants 'mentally ill'.*

It is tempting to conclude that Ian Kennedy's Reith Lectures provoked a hostile reaction from the medical establishment not so much because of their contents but because their author was a lawyer. After all doctors have been saying what Kennedy said for years. (Perhaps it might have helped if somewhere in his six lectures Kennedy had acknowledged this fact.) Summarising Kennedy's arguments, medicine has been found wanting in at least six respects. First, it is narrow, exclusively scientific and reductive. Secondly, it is conceived of by patients as well as by doctors as being about *cure*. Thirdly, doctors are encouraged to see themselves as the dispensers of cures and, as a consequence, seek and find more and more problems in life for which medical intervention appears indicated. Fourthly, modern medicine is obsessed with the notion of *disease*. Fifthly, today's doctors are pressurised into *doing* something to disease entities and, as a result, have become preoccupied with what Kennedy terms 'pseudo-scientific wizardry'. Finally, the teaching, organisation and funding of modern medical practice is too dominated by the hospital.

The temptation to ask what is new in all of this should be tempered by a consideration of Kennedy's audience. Many doctors may well be familiar with these arguments but the general public is still relatively naive as to the state of the debate over the proper direction and emphases within medicine. Kennedy has taken this debate out to the general public and sketched many of the central arguments over a broader canvas than has received them hitherto. In his defence he has never claimed that the arguments contained within the Reith Lectures are original. Nor indeed need he.

It is when Kennedy illustrates these various points with examples that problems arise and the relative simplicity of the central message begins to break down. For instance, to illuminate his point about the inappropriateness of the notion of cure in the light of many of today's ills, he chooses cancer,

heart disease, respiratory problems and accidents as well as colds, aches and pains and 'simple unhappiness'. It is a very fashionable list. But it does not stand up to the simplest of scrutinies. It is perfectly reasonable to think in terms of a specific cure for the common cold even if it does continue to prove elusive. Doubtless it is rather foolish to see any solution to many heart diseases in other than multifactorial terms but for the life of me I have never understood why it is so illogical to think in terms of a specific cause (and cure) for specific cancers. Such a view no more rules out environmental and psychological contributions (and interventions) towards origins and course of the disease than believing in Koch's bacillus involves a denial of the fact that defective nutrition and psychological debility can render one critically susceptible to developing tuberculosis. The problem, quite frankly, is that Kennedy's notion of disease is as narrow as that of Thomas Szasz. Having defined a narrow notion of disease Kennedy then rounds on doctors who believe in it for having a blinkered field of vision!

The hapless doctor who argues that the notion of disease is far older than modern biologically-based medicine and involves psychological and social components ends up accused of wanting to widen the medical brief to imperialistic proportions. It is ironic that the Reith lecturer, having spent much time wisely castigating many doctors for being excessively preoccupied with what they can see at the bottom of a microscope or a test-tube, should then reveal himself as a Cartesian dualist of the first order. His notions of psychological disturbance appear to rest on an assumption that all such disturbance is social. Whenever he gives an example it is to illustrate this assumption. Mrs Jones, married at 19, stays at home all day at 35, her husband at work, her children at school. She takes herself to the doctor. Her complaint is 'her dissatisfaction with a social and economic order which robs her of independence and ties her to the home'. The doctor, points out Kennedy, cannot change the economic and social order but with drugs he can stop her worrying about it so he prescribes drugs. A clear case of medicalisation of a non-medical problem. But nowhere in his six lectures does Kennedy consider the question of a genuinely medical 'mental' problem. What if Mrs Jones having just come home from having delivered her

second baby, was profoundly depressed, suicidal, threatening to harm her child, had become convinced that she was dying of cancer and that she was being poisoned? Evidence from her relatives, her husband and her friends confirmed that this turn of events seemed profoundly out of character. Is it not reasonable to treat this as a mental illness given that such a state of affairs is not unknown in the medical literature; that the hormonal, psychological and social events characterising the *post-partum* period can reasonably be understood as contributing to the disturbed mental state; and that with treatment, which includes drugs, psychological support and some social manipulations, such a mental state can be relieved? And, given these facts, is it helpful to refer to *post-partum* psychosis as a 'bogus' disease?

In so far as Kennedy is prepared to concede status to the notion of mental disease it is in relation to two elements – *dangerousness* and *sympathy*. The issue of mental disorder is raised, he argues, when behaviour 'goes beyond what we are prepared to tolerate' and/or when it 'evokes a particular kind of sympathy'. But how relevant is this? Many behaviours which go beyond what is tolerable do not raise any query concerning mental disorder while many behaviours which evoke sympathy do not do so either. This confusion is exacerbated when Kennedy turns his attentions to a consideration of how the status of mental illness might be more appropriately conferred than it is at present. He identifies three classes of person – the first denoted by the *dangerousness* of their conduct, the second by the fact that they *request help* and the third by the fact that they *ought to be helped as they appear helpless*. With regard to the last, such helplessness would have to be proved not by relating it to 'bogus diseases or disorders' but to a person's basic inability to perform the basic tasks of life such as procuring food, practising hygiene or finding lodgings.

Kennedy's approach here is very close to that advocated by some representatives of MIND but in fact it actually opens up a larger hornet's nest than it removes. If we take the contrary cases of the manic and the dissident we can see why. Few manic patients are dangerous. Few recognise themselves as ill, least of all when they are in the most grandiose and excited stages of the disorder. Fewer still are 'helpless'. Quite the contrary. They spend money they do not have, carry out inordinate and otherwise exhausting routines and are perfectly capable of persuading credulous and non-informed individuals of their basic health. Such 'helplessness' as occurs does so *after* manic patients have inflicted a considerable amount of economic, social and personal damage on themselves and, often more seriously, on their spouses, children, employers and friends. Mania is hardly a bogus disease whatever the learned lawyer might say. It is a readily recog-

nisable clinical syndrome characterised by a number of reasonably reliable signs and symptoms. Its cause is not known and its treatment, while effective, is empirical but that is true of such 'legitimate' physical disorders as trigeminal neuralgia, migraine and idiopathic epilepsy. But the diagnosis of mania does not rest on notions of dangerousness, helplessness or subjective distress but on identifiable signs of psychological dysfunction. In the absence of these, whatever else might be present, mania cannot be diagnosed. The dissident's situation is quite the opposite. By Kennedy's criteria, the political dissident is *mentally ill*. He is dangerous, particularly if, as in Soweto or Northern Ireland, he adopts a policy of violence. His *behaviour* is clearly at odds with the norms of society and if he is not obviously helpless it would hardly be too difficult to argue that a man who puts his preoccupying political views before the basic necessities of a job, income and a place of shelter teeters precariously on the borderline. The one criterion which distinguishes between the deviant and the criminal on the one hand and the mentally ill on the other, namely the presence of a disturbance of psychological part-function cannot be entertained because Kennedy has already dismissed the possibility of ever arriving at such a notion, an act of folly which actually opens the door to greater political abuse of psychiatry rather than slamming it ever more tightly shut. 'If non-conformity can be detected only in total behaviour', argued Aubrey Lewis in what is still, some 25 years after it was written, one of the seminal essays on the subject, 'while all the particular psychological functions seem unimpaired, health will be presumed not illness (1). Kennedy is of course right, though hardly the first, to draw attention to the fact that at the present time our knowledge concerning mental dysfunction is nugatory. But that hardly entitles him to conclude that it is non-existent.

There is little mention in the lectures of the notion of impaired autonomy which lies at the heart of the concept of disease. I refer here to the idea that an individual who is diseased cannot freely and personally correct this state of affairs nor is he entirely (though he may be partially) responsible for being diseased in the first place. A diabetic cannot be blamed for remaining in a diabetic coma (though he may have contributed to his state by not injecting himself as instructed) nor can he be blamed for not having the 'willpower' to emerge from the coma. The alcoholic may be blamed for drinking but once confused, deluded and hallucinated in the DTs, can hardly be held responsible for his mental state. Such a notion of impaired responsibility is at the heart of mental diseases too. After all, it was the lawyers rather than the doctors who first raised doubts as to the 'responsibility' of Daniel McNaughton in the celebrated trial of 1843 not because of his 'dangerousness', though he was

indeed dangerous, nor because of his 'behaviour', (shooting at people, however unacceptable it might be, was not even then a pathognomonic sign of mental illness), but because the nature of his psychological functioning raised profound doubts concerning his personal autonomy and his legal as well as moral responsibility.

It would be unrealistic to expect Kennedy to have gone into such issues in any depth in his series but not unreasonable to have expected him at least to have acknowledged them. It is this lack which makes his references to and considerations of mental illness somewhat disappointing. More disappointing, however, is his failure to take the debate about mental illness much beyond where it has been for the past twenty years. However, I recognise that this latter reproach is somewhat unfair. In uttering it, I have fallen victim to the very sin against which I preached at the outset, namely taking Kennedy to task for failing to do something which quite reasonably he never claimed to be doing anyway. The Reith Lectures are less a prescription for what might be done than an analysis of what is. As an analysis, they contain much that is true. The strictures concerning psychiatry and mental illness are

strictures commonly expressed. Kennedy has given them a wider public airing than even Laing or Szasz. Psychiatrists cannot object that they are undeserved strictures, even irresponsible ones. They have to argue their case painstakingly and stubbornly, foregoing any claims to a hearing merely because they are psychiatrists. My own personal view is that the arguments over the concept of mental illness are very much more complicated than Kennedy acknowledges in his lectures and I believe that in his heart he knows they are too. He was, in a sense, successful. But if the lectures are not to go the way of Illich and McKeown (absorbed into the conventional wisdom of medicine so that now even the most biological seminar is not complete without an obeisant nod to the sages of Mexico and Birmingham) then the arguments within them must be taken somewhat further than Kennedy was able to take them.

### Reference

- (1) Lewis A. Health as a social concept. *British journal of sociology* 1953; 4: 109.