Professionalism and the Control of Knowledge

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PSYCHIATRY AND SOCIETY:

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Madness becomes mental illness through the joint project of psychiatry and the community of consensus lent to it. The psychiatrist, like the shaman (to paraphrase Leve'-Strauss), acts through the cultural plasma of his times. And the psychiatrist provides a definition for events, making mental illness of madness, while occupying a unique position within the scheme of society.

Psychiatry has been attacked from many directions in recent years. Despite these varied challenges, however, its power appears to have abated little if at all. How can we account for this fact? On the surface one might assume that the scientific basis or the treatment success of psychiatric practice provides the buttress to repel the ongoing attacks. But we suggest here that the continuing power and the prestige of psychiatry can be understood more clearly by examining its relation to society at large rather than the relation to its patients. There appear to be two analytically separate but empirically interrelated factors at work. First, and of main importance, is the absence of an acceptable alternative to psychiatric practice in American society and Western culture in general. The stress must clearly be placed upon the condition of acceptability. Second, and growing out of the first, is the professional and organizational "status" psychiatry enjoys and the benefits implied therein. The ensuing discussion will elaborate these points and attempt a critical examination of the relationship between psychiatry and society.

Knowledge Communities

Thomas Kuhn (1970) has provided a heuristically valuable analysis of how knowledge serves to structure "scientific" communities. Kuhn argues that scientific "paradigms" serve to guide the vast range of scientific activities. In fact, knowledge is "community" as a shared way of seeing the world and a commitment to a particular description of reality underlying it. This provides a common gestalt from which members act. Community membership is defined by shared adherence to a given paradigm.

There are clear parallels between Kuhn's notion of paradigms and scientific communities and the discipline of psychiatry. Psychiatrists would probably be the first to defend their discipline as "scientific," given its nominal connection with general medicine. Moreover, their professional activities are organized around a specialized body of knowledge. Taken together, their perception of the nature of problems, professional tasks, and appropriate solutions, provides a basis for "doing" psychiatry.

As in Kuhn's scientific communities, new members are inculcated by training; that is, they are shown how the body of knowledge, the paradigm, explains phenomena. They learn to "see" the world the way the paradigm depicts things. For example, where the physics student once saw "weight," after training, he sees "mass" as the correct description of reality. Likewise, upon being presented with an obvious "madman" while on rounds, the student psychiatrist (not to mention social workers, clinical psychologists, nurses, etc.) is informed that the patient is not simply "mad"... no, he is schizophrenic, paranoid type, or some other correctly "psychiatric" description. Such shaping soon has its effect, and the student becomes adept at the raison d' etre of psychiatry, diagnosis. Where madness was an inexplicable phenomenon, psychiatric nosology and nomenclature provide an organization to events - a rational description of the supposedly irrational (cf. Coulter, 1973).

The psychiatric paradigm provides a reconceptualization of the problem of madness, its technological application suggests a means of solution (i.e., treatment), and the resulting social organization structures the social relationships of practitioner and patient alike. Psychiatric "science" provides an organization to knowledge that leads the psychiatrist to "see" mental illness in the place of madness. As a commitment to a particular description of reality, the psychiatric paradigm lends typicality to the notion of mental illness, a "fact" largely taken for granted by members of the psychiatric community.

Professionalism, Paradigms, and Technology

The general nature of a professional community as a group of adherents organized on the basis of a specialized body of knowledge can be seen as consistent with the above framework. A common way of defining the concept "profession" is in terms of the control its members have over a body of knowledge, i.e., the technology of the professional specialty. That control comes in two ways. First, in political (if not actually legal) terms, only a "member" is allowed to put the knowledge into use -- only members can practice the technology. This autonomy is

the cornerstone of professional power (cf. Freidson, 1970). Second, and really a function of the first, is a "prolonged specialized training" (Goode, 1960) which limits the means of access to that knowledge and which leads to membership with its rights, privileges and power.

Psychiatry is able to wield tremendous power, both over other professionals in the field and, as well, over the millions of people receiving mental health services, over judges and juries, over politicians and, all too frequently, over the organization and direction of everyday life. In the legal arena, for example, the psychiatrist is recognized as an "expert;" his professional status and power has been insured by legislative act. The psychiatrist passes judgment, often of a final and damning nature, over the membership status of persons previously thought to be among the sane (cf. Szasz's (1961) discussion of the psychiatrist as moral entrepreneur). Psychiatry is a necessary (and often defacto sufficient) element in issues of legal competency and commitment. The psychiatrist has been allowed to administer "treatments" (e.g., lobotomies, shock therapy, interminable seclusion and confinement - to mention a few) that, in another context, would resemble "war crimes."

Yet, can we account for the powers psychiatrists daily exhibit by virtue of their political affiliation or professional lobbying alone? Such efforts help, to be sure, but are rightly placed under the heading of organizational action, thereby after the fact of the psychiatrist's existence. This is to suggest that the relationship of psychiatry and society may exist at points additional to the level of organizational structure. The question then becomes, "What is the nature of the link that makes the profession of psychiatry possible?" and, secondarily, "Why does this link provide for psychiatry instead of something else?"

Psychiatric Knowledge

Part of the answer would appear to lie in the concept of a profession and the application of a specialized body of knowledge, i.e., the practice of psychiatric "technology." But how is assessment of this practice to be accomplished? Are there criteria for evaluating the application of psychiatric knowledge in the sort of means-to-ends schema that technology implies?

An obvious gauge of knowledge for technology is its instrumental efficacy, a measure of what Thompson (1967) terms "technical rationality." That is, given a goal, does the knowledge lend itself to a solution, i.e., is the knowledge applicable in a technical sense? If this is the issue, then it does not resolve the problem of "explaining psychiatry," for "efficacy" is not the forte of psychiatric practice.[1] In any case, short of producing obvious "cures," psychiatry may provide little evidence understandable by non-members. The man in the street,

not sharing in the underlying knowledge, is likely unable to perceive the intangibles of "therapeutic" progress.

Given this apparent absence of an effective psychiatric technology, we are faced with something of a contradiction. If psychiatry is not manifestly effective in dealing with mental illness, how is it that the psychiatric paradigm (often referred to as the "medical model") constitutes the basis for present-day practice in mental health activities?

We suggest that measurement of the positive effects of application of psychiatric expertise, i.e., instrumental efficacy, is not really at issue. Returning to the concept of "profession," we are reminded of a central tenet, not just the existence of a body of knowledge, but pro-fessional control of that knowledge. One corollary of professional sta-tus is self-regulation -- that only members are qualified to judge tech-nical questions since they alone, by definition, possess the requisite knowledge to make such judgements. Outside evaluations are simply not considered legitimate.

Therefore, professional autonomy shifts the question from one of direct evaluation of knowledge and practice to one of the psychiatrist's status of expert. This amounts to a shift from concern with the "idea" of psychiatry to the social "relationship" between psychiatry and socie-ty (cf. Warren, 1977). As we have seen, this relationship does not con-sist of the direct sharing of knowledge, and thereby cannot be explained by reference to psychiatry alone.

This relationship between psychiatry and society is evidenced in a number of ways. For example, psychiatry in the courtroom is only a spe-cific instance of the psychiatrist as "expert" in society (cf. Berger and Luckmann, 1967; Znaniecki, 1940). The real power base of psychiatry, as with other socio-political institutions, must of course lie in socie-ty at large. It can be argued that, like politicians, psychiatrists may produce little in the way of obvious benefit, but as in the case of the political "expert," the layman is hard pressed to offer up a plausible alternative to back up his entreatment to "throw the rascals out!" The layman, having little knowledge of psychiatric technology, has scarcely any basis for judging the instrumental actions of psychiatrists. He must rely largely upon their claims, if he seeks to judge them at all. Outwardly the relationship is one of status and, consequentially, pro-fessional power.

What then is the nature of this relationship through which psychia-try receives support from society? We propose that there are two dis-tinguishable, but not mutually exclusive, elements at work. First, there are the underlying "common-sense" notions about the "madman" that inhere in our culture, and second, the "referral logic" of professional

practice. The link appears to reside in the notion of "mental illness" itself. Mental illness involves not only an acceptable way of seeing madness, but also fits into an acceptable pattern of relationships whereby members of society delegate power and authority to "official" agents or institutions.

Certain underlying assumptions, exemplars in Kuhn's terms, seem to be shared by psychiatry and society. Primarily this amounts to an assessment of "individual deficiency" readily applied to all who deviate in certain directions in our society, e.g., the poor, the delinquent, and the insane (cf. Freidson, 1970). An historical account of the "images" of madness in the western world illustrates how the typifications applied at any point in time have reflected other currents in society, e.g., metaphors such as "possession" in religious times, or a "ship of fools" in more secularly oriented contexts (Foucault, 1973). Further, individual deficiency can be seen to be merely the other side of the conceptual coin from a notion of productivity. Unproductivity in an achievement oriented society is a common feature of most deviant categories and of particular significance to attitudes towards the insane (Bastide, 1972). Like the poor, the criminal, and the mentally deficient, persons exhibiting bizarre behavior do not integrate well into a culture of "rationalization and routinization" (Weber, 1947).

The second element of the linkage involves the "referral logic" that brings the psychiatrist and his patient together. The affiliation of psychiatry with general medicine, both in an institutional and legal sense, lends a tradition of authority and prestige backed up by increasing evidence of technological success in medicine,[2] despite the apparent lack of technological success in psychiatry itself. The exemplar of "treatment," derived from physical medicine and easily extended to the realm of psychiatric "medicine," constitutes a crucial metaphor in modern thought, legitimating mental "illness" and consequently psychiatric "practice."

This phenomena of cultural support for technological actions, particularly respective of human "materials," has in one instance been termed "institutionalized thought structure" (Warren, 1971, 1974). It is suggested (on the basis of empirical observation combined with keen insight by Warren) that society will support an "intervention strategy" (e.g., the involvement of professionals with people who have "problems" and need "help") when such actions are commensurate with the "supporting belief/value system." The madman is seen to be defective and in need of help -- so psychiatric referral follows logically. This "symbolic universe," of which mental illness and treatment are constitutive parts, is

maintained by the social organization of psychiatric practice (Berger and Luckmann, 1967:92-128) and can be considered, following Warren, an institutionalized thought structure.

The single notion of "treatment" does the most to differentiate the criminal and the pauper, with their respective brands of social "intervention strategy," from the mentally ill. The criminal must be "reformed or rehabilitated," the poor are "cared for," while the mentally ill are "treated." Treatment implies an end result of cure, i.e., the removal of a pathologic condition. Reform and rehabilitation suggest that something need be added to the old personality structure or it must be reshaped. Those poor most acceptable as objects for intervention (i.e., welfare) are seen as unable to improve or change their condition; they must be "cared for." The course of institutional response to these preeminent "social problems" can be distinguished by these respective metaphors attached to them and the resulting socially legitimated "strategies" and "agents" of control employed as solutions (cf. Rothman, 1971).

Organizational Action

Similar to other organizations, psychiatry -- and mental health in general -- acts within a domain and in relation to a task environment (Thompson, 1967). The purpose of organizational action is to support the underlying technology: providing for its needs, blocking disruptive external influences, and above all, preserving the technological system itself. This has amounted to the maintenance of the psychiatric view of madness, its "paradigm."[3]

Given the power it receives from society at large, psychiatry has in turn consolidated that power and protected its technology through influencing other institutions in the system, mainly the federal government and the legislative/judiciary system at both local and national levels. Among organizations in general, Thompson (1967) asserts, professed aims and goals cannot be relied upon as statements of the "actual" basis of decision-making and organizational action.

If mental health organizations are not successful in treating and curing the mentally ill (their "manifest" function, largely recognized by all), then we can only look at the consistent pattern of "management" of the mentally ill and conclude that the practice of psychiatry serves some "latent" functions, perhaps most succinctly phrased as "social control." This sort of "efficacy" seems both compatible with

societal views on social problems in general and accessible for assessment by the layman. As a function, social control may be "latent" only from within a community which "professes" treatment, social control being historically the manifest reaction to all forms of deviance.

The mental health industry, under the dominance/leadership of psychiatry, has served as a basis for warding off threats to psychiatry itself as much as it has manifestly acceded to societal demands. In the face of strong criticism over conditions in mental institutions (the source was largely governmental -- in terms of skyrocketing costs -- and social critics concerned with "humane" treatment) the mental health industry succeeded in shifting its place of operation to the community, thereby removing the burden of the institution, while not radically altering basic practices (Roman, 1971). Psychiatric practitioners themselves helped bring on the crisis of the hospitals, this serving (at least latently) to focus attention upon the asylum and away from an examination of psychiatry itself. Psychiatry has also been successful organizationally in broadening its domain by redefining ever more "problems" as psychiatric in nature, e.g., drug abuse, marital counseling, alcoholism.[4] In these terms the community mental health "revolution" surely appears to have "liberated" the psychiatric practitioner as much, or very likely more, than the mental patient.

The Prospects for Change

We have claimed that the basic reason for psychiatric dominance is the absence of an acceptable alternative technology. In the sense of our extension of Kuhn's ideas, we can speak in terms of the lack of an alternative or "competing" paradigm precluding change in the pattern of professional dominance enjoyed by psychiatry. Can this claim be justified, however? For example, the behavioral modification proponents in psychology and education have for some time claimed success at changing problematic behavior patterns -- something psychiatrists rely upon psychotherapy and drugs to accomplish, often with unpredictable and unfortunate results.

The psychiatrist is the resource to which nearly everyone turns when faced with madness. Analogous to the policeman and crime, the psychiatrist has apparently done little to reduce the incidence of mental illness, yet his mode of action "makes sense." In lieu of an equally acceptable and more efficacious alternative, he appears likely to remain an established part of the system of institutional structure in society.

But given the schema set out above, there are potentially two alternative paths to change for psychiatry and mental health: (1) a change in the technology (through altering psychiatric knowledge and the paradigm underlying it) and/or (2) organizational (structural) change.

First, in terms of psychiatry's knowledge base, we can return to Kuhn's description of change in communities of knowledge as "revolutions." According to Kuhn, change takes place only when two conditions are met: (1) the reigning paradigm is faced with "anomalies," i.e., things it cannot explain, and (2) there exists an alternative paradigm, one that offers to replace the present paradigm's explanatory power while holding out heuristic merit not presently available under the "old way of seeing." But we have added a third criterion, "public acceptability," to this list. Especially for knowledge that is to be applied as professional technology, the outward manifestations of the technology must be compatible with the cultural "belief/value system." Kuhn is not altogether silent on this point, though it receives lesser emphasis. Probably this lack of emphasis reflects an assumed and somewhat artificial distinction between the realms of science and technology which places less need upon understanding the relationship between acceptable "scientific" paradigms and the culture in which they exist. Yet, Kuhn does acknowledge that the choice of a new paradigm is not wholly an "objective" process; values and other subjective conditions do come into play.

But what does this imply for change in mental health? Given that psychiatric medicine has long faced anomalies -- things it often could not explain away -- then the first condition exists for change. But an acceptable competing technology must also be available for change to occur.

Earlier we referred to behaviorism as a possible challenger, and on the face of it this would appear so. Yet, change in that direction is if anything, uncertain. Given the ability, albeit proclivity, of one paradigm co-opting another when the challenger does not find ready cultural acceptance (as Warren (1971, 1974) has noted with poverty programs), behaviorism may simply be "overwhelmed" by psychiatry. The "strategies" of behavioral science are not commensurate with the cultural metaphor, "treatment," held with regard to the mentally ill (cf. Rieff, 1968, for one reading of this relationship). The stigma and prognosis of mental illness are likely more compatible with medical and medical/moralistic images than those accompanying a behavioristic perspective (cf. Orcutt, 1974; Freidson, 1970). Only in those circumstances where behavioral techniques can be used to the ends of psychiatric

"strategies" is behaviorism likely to survive in mental health settings. In those instances where behaviorism is employed towards mental illness (e.g., token economies, aversive conditioning, etc.) the context is typically psychiatric, usually institutional. It is unlikely that the layman would accept the full implications of the behavioral paradigm as a treatment modality. Whatever the theoretical implications, it is extremely difficult to tolerate madness in the community, let alone do so while restructuring social conditions as an effective reinforcement schedule.

Other proposed alternatives for handling the mentally ill include viewing mental patients as "voluntaristic actors" who should be sent to "retreats" rather than hospitals (Braginsky, et al, 1969). Similarly, Fairweather (1974) has experimented with the concept of "lodges," or self-sufficient community housing, as a viable alternative to institutional confinement. Both point out the problematic nature of their proposals, especially that the community finds them largely unacceptable, but fail to see the basic role cultural "exemplars" play in structuring societal resistance to such change. From the perspective presented above, however, the problem can be seen as not merely a matter of developing new programs as alternatives, but of placing, literally placing, these alternatives into a setting of established cultural images as well as organizational structures which must be acceptable to layman and professional alike.

The second alternative, structural change, would appear to be a more likely course. However, the potential for change lies not in directly influencing the basic exemplars of mental illness, thereby altering the psychiatric paradigm, but in using structural relationships to alter the conditions of practice by establishing new exemplars in connection with the mentally ill. While some organizational change has taken place, perhaps to the benefit of the psychiatrist, (e.g., the community mental health movement) other change has benefited the mental patient in terms of providing an opportunity for raising issues of legal and civil rights. As recent court decisions regarding, e.g., "right to treatment," indicate, the organization of psychiatry is most susceptible to change when directed from other powerful members of its task environment, e.g., the federal government, local and state bureaucracy, and the courts.

More change may be in the offing, but a crucial ingredient in producing a real "revolution" for the mental patient would appear to lie in removing the unrestrained power of decision now in the psychiatrist's hands. New legal exemplars for the mental patient, much like those for minority groups, serve to restructure the relationship between individuals and powerful agents of society, in this case between the psychiatrist

and his "patient." Those anomalies that lead to further restructuring of psychiatric legal authority are likely the primary route to eventually replacing the "medical model" description of madness. Such new exemplars do not directly confront the old one...they simply make the use of the psychiatric paradigm problematic. The conflict over legal versus medical definitions of madness offers inroads to structural change which in turn may influence the ability of psychiatry to sustain the predominant metaphors and maintain the present institutionalized thought structure of mental illness. As a result, professional dominance, or the lack of it, may well be the determining issue with regard to change in the face of madness in the future.

FOOTNOTES

1.   Psychiatric practices can be roughly divided into two categories: psychotherapy and somatotherapy. Psychotherapy has not been demonstrated to be effective (Epstein and Shontz, 1971) and is so inefficient as to be limited to cases with the best prognoses (Mechanic, 1969), perhaps those least in need of mental health services (Chu and Trotter, 1974). Drug therapy, by far the most frequent somatotherapy, has shown mixed results at best, with no clear assessment of whether or not that effectiveness is due to treating the environmental context through the patient (Prein and Kett, 1972).

2.   This argument may be further extended to consider psychiatry's "scientific" status as an effective means of securing cultural legitimacy through implied association with the "technical rationality" of general medicine while not demonstrating success against technical criteria of efficacy (cf. Habermas, 1970).

3.   While it may be argued that there are many paradigms in psychiatry, leading to a multitude of techniques of practice, the central exemplars of "mental illness" and "treatment" serve to unify the field. Even Szasz (1961), while preferring the term "problems in living" over that of "mental illness," continues to think in terms of "treating" the individual. When this diversity among psychiatric practitioners, including para-professionals, is contrasted with structural explanations for madness, and resulting social change strategies for relief, the variance within is certainly outweighed by that between these two opposing paradigms (cf. Braginsky, Braginsky, and Ring, 1969; Warren, 1971). Further, like God, psychiatry may be "dead," but neither its intellectual death nor its mystical overtones has done much to undermine the basic pattern of social relationships that remain recognizably psychiatric, and ostensibly therapeutic (cf. Torrey, 1971, 1974).

4.   An example of the length to which this trend has been carried is given in a request that a panel of psychiatrists study drivers in California to determine why the new 55 mph speed limit was being consistently violated. In another, the wholesale application of psychiatric criteria yielded a claim that over 80% of the residents of Manhatten were in need of some sort of psychiatric help (Srole, et al, 1962). These exercises attest to the considerable influence psychiatry has over other professions and members of society in general.

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