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Discussion Piece

Truth and Reconciliation in Psychiatry: A response to Spandler and McKeown

Abstract

Purpose: To critique Spandler and McKeown's recent advocacy of a Truth and Reconciliation process in psychiatry.

Approach: A critique of a recent article in Mental Health Review Journal.

Findings: That Spandler and McKeown's advocacy of a Truth and Reconciliation process in psychiatry can be criticised from a number of inter-related practical, political and ethical perspectives.

Value: The present critique contributes to the ongoing debate about the desirability of a Truth and Reconciliation process in psychiatry.

Keywords: Forced psychiatry, Truth and reconciliation, Testimony, Democracy

Introduction

Helen Spandler and Mick McKeown's (2017) recent article in this journal on the prospects of a Truth and Reconciliation (T&R) process in psychiatry was strong and thought-provoking. Although this response offers seven criticisms against their arguments in favour of T&R, it accepts that the article establishes the terms of the current debate around T&R and, as such, is a significant text for activists, academics and professionals. It demands close attention. In response, I write as a sociologist of psychiatry in the UK in the post-WWII period and, in particular, as a historian of the user/survivor social movement from the 1970s onwards.[1] The goal of the response is to contribute to the debate around T&R.

[1] For consistency of exposition, I use the 'term' survivor' throughout this article.

Spandler and McKeown's argument

Spandler and McKeown's argument can be summed up briefly. T&R, canonically represented by the South African Truth and Reconciliation Commission, was a collective form of public apology and truth-telling about social injustice specifically motivated by a desire for peace and nation-building in one post-apartheid society. As Spandler and McKeown (2017, p. 84) observe, its aim was "restorative rather than retributive justice, providing amnesty for perpetrators and reparation for victims". They acknowledge a difference in the application of T&R to psychiatry in that there has never been a public apology for or collective recognition of *psychiatric* injustice either by a nation-state, supra-national organisation (for example the United Nations [UN]) or the institution of psychiatry itself. Nevertheless, they argue for a "grassroots" version of T&R in the absence of such recognition and they provide some recent examples in which "new spaces for…dialogue" (ibid, p. 87) have been opened up between survivors and mental health workers, leading to new and mutually beneficial "understandings". A strong aspect of Spandler and McKeown's argument is that they anticipate most possible objections to T&R: that there has been no public apology for social injustice therefore T&R cannot really "get off the ground"; that workers might feel alienated by the T&R process and not engage with it; that the analogy with other human rights abuses (such as apartheid) is inappropriate; and that T&R is just a manifestation of "therapy culture" (Furedi, 2003) that would be better replaced by the "real" business of political activism. They effectively deal with these objections but I want to pick up on some of the loose ends they leave hanging in the rest of this response. First, however, I want to contextualise the debate in terms of contemporary UK psychiatry.

Psychiatry as a social institution

How do Spandler and McKeown characterise psychiatry as a social institution? They describe it as a "set of related practices in which mental health professionals are involved" (p. 83). When it comes to specifying these practices they include amongst a "litany of harms…lobotomies, incarceration, seclusion and restraint, harmful drugging, electroshock and stigmatising diagnoses" (p. 85). They note that these practices are historical but also contemporary. More widely, they point to psychiatry's tendency to "colonising expansion" and to the "epistemic injustice" (*ibid.*) caused by the diminution of survivors' experiential knowledge by the dominance of the bio-medical paradigm.

However, there is more to be said about the historical/contemporary distinction because Spandler and McKeown tend to blur the boundary. This is my first criticism of their article. Historically, there can be no doubt about the use of psychosurgery, electroshock [ECT] and forced treatment generally associated with the asylum system of care (Mental Health Media, 2000). But how widespread are these practices in the UK today? Neurosurgery for mental disorder (Royal College of Psychiatrists [RCP], 2017a), the contemporary medical name for lobotomy, is very rare and cannot be performed without an individual's consent. In 2012/13 the mental health charity MIND noted that only 4 people had received the treatment (MIND, 2015). ECT is more common but still statistically rare: in 2016/17 1682 people were treated in England, Wales, Northern Ireland and Ireland mostly for severe depression of which 51% were informal patients who consented to the treatment (RCP, 2017b). As amended by the 2007 Mental Health Act, ECT can only be given with an individual's consent or, where formally detained and in the absence of mental capacity, second opinions have been sought (Department of Health, 2007). The practice of "forced psychiatry", a term employed by Tina Minkowitz to include all of the above plus the administering of medication without consent as well as "degrading practices" such as 'forced nakedness or wearing institutional clothing" (2015, p. 176), is more widespread. The Care Quality Commission's (CQC) recent report into "The state

of care in mental health services, 2014-2017" (2017) still found over 30% of institutional care "unsafe" and the "use of restrictive practices and physical restraint" still common.

These facts should be seen in terms of the wider context of increasing psychiatric coercion in the UK. In 2005/06 there were 43 361 detentions under the Mental Health Act (MHA) in England; by 2015/16 this had risen to 63 622 (NHS Digital, 2016). The main legislative reform of the period, the 2007 Mental Health Act which introduced Community Treatment Orders (CTOs) for the first time in the UK was expected to be rarely used; but it has been deployed for over 4000 people a year since 2011/12 (*ibid.*). Section 136 of the 1983 MHA – the police power to remove someone thought to be suffering from a mental disorder from a public place and taken to a "place of safety" – has increased four-fold in the last decade and stood at 22 965 detentions in England for 2015/16 (*ibid.*).

I state these facts because Spandler and McKeown's advocacy of T&R occurs, it seems to me, against the assumed backdrop of forced psychiatry within an asylum system of care. There is little doubt that there should be widespread public recognition of the human rights abuses of that historical system. But the system within which contemporary T&R might take place is different. It is not necessarily less coercive, as the above statistics confirm, but such coercion take place in a wider variety of institutional sites ranging from asylum-like "total institutions" (Goffman, 1961) (prisons and the "Special" hospitals), to psychiatric in-patient wards in general hospitals, accident and emergency departments (where section 136 patients are often deposited) to people's own homes (for CTOs). It may be that grassroots T&R may be applicable to these areas but the model of "speaking truth" to the power of mostly hospital psychiatrists and hospital nurses modelled on the "total institution" would surely have to be adapted to include, amongst others, community nurses, social workers, psychiatric liaison nurses, the police, and prison officers. Contemporary mental health care is complex but this complexity is not recognised in Spandler and McKeown's advocacy of TR.

Moreover, forced psychiatry is only part of this system. The rest of the "litany" of contemporary "hurts" comes under the heading of psychiatry's "colonising expansion" and "epistemic injustices". Again, contemporary psychiatry as a social institution needs to be adequately described if we are to situate the prospects for T&R within it. Just like forced psychiatry, "voluntary" psychiatry is complex. Here are some relevant facts: the UK government spends about £11 billion per year on mental health care split between 54 mental health trusts (in England) (Crisp *et al*, 2016); the psychiatric workforce (in the NHS in England) is comprised of approximately 40 000 qualified nurses, 21 000 unqualified nurses, and 4 500 consultant psychiatrists (NHS Digital, 2017). Social workers and voluntary sector staff would need to be added to this number to complete the staffing picture as would mental health workers in the devolved administrations of Northern Ireland, Scotland and Wales. These staff work across a range of secondary mental health services including hospital wards, community mental health teams, home treatment crisis resolution teams, assertive outreach and early intervention in psychosis teams. Secondary mental health services in England provided care to 1.8 million services users in 2015 and this resulted in a total of over 20 million face-to-face annual contacts (NHS Digital, 2015).

Again, I state these facts to emphasise the complexity of contemporary psychiatry. Spandler and McKeown do not recognise this complexity and their occasional comments on the contemporary situation seem to assume a scenario of forced psychiatry only according to an out-dated asylum model. Neither of the concrete examples they give from the UK where they claim "TR processes might help" (p. 85) (the Mid-Staffordshire Foundation Trust and the Winterbourne View abuse scandal) actually involved *psychiatric* care at all; whilst the USA example they cite of grassroots TR in practice fails to specify just what sorts of psychiatric services survivors had experienced or the jobs and statuses of the mental health workers present during the T&R process (pp. 87-88). The impression given is these were survivors of forced

psychiatry – but the details are never made clear. This, then, is my second criticism of Spandler and McKeown: they work with an abstract model of (out-dated) psychiatry and then graft onto that their advocacy of T&R which they then claim applies to the contemporary situation. The complexity of contemporary psychiatry goes unrecognised.

In the next section, I deal with some loose ends which Spandler and McKeown leave hanging in their attempt to forestall some predictable objections to T&R.

Loose Ends

- Psychiatric T&R is not state-sponsored and state-backed – so it has to come from the "grassroots" social movement.

This position is correct. There has never been any state-recognition of the harms caused by psychiatry by the UK government – nor is there ever likely to be outside of specific inquiries into scandals and abuses. Spandler and McKeown make the best of this scenario by building the contribution of social movement-initiated ("grassroots") T&R. But surely this distinction between post-apartheid T&R and psychiatric T&R is a difference that makes a *big* difference. It is a question of legitimacy and power. South Africa's Truth and Reconciliation Commission was established by act of parliament and possessed wide-ranging legal powers to subpoena witnesses, grant amnesties to perpetrators of abuses and award reparations to victims. Psychiatric grassroots T&R, by contrast, would have no such legitimacy and possess no such powers. To run with the analogy would be to imagine the African National Congress (ANC) deciding to set up the T&R commission *before* they won elected power in South Africa. It is true, as Spandler and McKeown argue for psychiatric T&R, that they could still have gathered "multiple testimonies" (p. 88) – but without the judicial status of the commission the truth of these testimonies could have been questioned and the process accused of bias. The same criticisms would surely be levelled at grassroots T&R and this would affect the willingness of

mental health workers to engage in it. This is my third criticism of their article. It brings me on to my next point.

- Workers might feel alienated by the T&R process and not engage with it.

Spandler and McKeown tend to minimise this point and argue instead that workers might benefit from T&R through its capacity to raise awareness that they are also "damaged by the system that they work in" (p. 90) and are victims of violence too. Unfortunately, violence against mental health workers has increased (Trades Union Congress, 2016). But it is implausible to argue that T&R could be a vehicle for addressing the issue. T&R's raison d'etre is survivor, not worker, experience – and that is appropriate. The violence experienced by mental health workers forms a part of the overall context of "crisis" within which psychiatry currently functions. Services were axed by £600 million during the Coalition government and this included nursing cuts at the same time as workloads were surging upwards (McNicoll, 2015). In this context, it is hard to see nurses willingly embracing a T&R process that is by its nature challenging. Precisely the same observation could be made for social workers. It is not so much that they might feel alienated when confronted by T&R; it is more that they may just feel burnt out by excessive workloads and management bullying. The workers who would be most likely to engage with T&R would be those already recruited to the survivor movement's cause. An example would be the testimony of Chris Chapman (2014) in the book *Psychiatry Disrupted*, confessing to his own use of physical violence in an institutional setting. Ironically, though, the participation of such self-reflective workers in the T&R process would really be surplus to requirements as these would be precisely the workers who would benefit from the experience least. T&R would be preaching to the converted. So, I think grassroots T&R would in practice struggle to recruit the mental health workers it needs for the process to work outside of those already committed to the movement's cause. This is my fourth criticism of Spandler and McKeown.

- The analogy with other human rights abuses (such as apartheid) is inappropriate

It is absolutely appropriate that psychiatry should be understood according to a human rights framework. Indeed, the most important global development in the field of mental health in the last decade has been the incorporation of "psycho-social disability" into the UN's Convention on the Rights of Persons with Disabilities (CRPD). It follows from this that any analogy with other human rights abuses is not only appropriate but could be illuminating. On the other hand, an analogy is really just a comparison, one which emphasises relevant similarities and differences between two contrasted phenomena. The comparison with apartheid, or with genocide, is similar only to the extent that it emphasises the oppression of collectives; the difference is that apartheid or genocide "pick out" collectives for oppression based upon clearly defined constructions of ethnic identity – they are basically forms of racism. The oppression associated with psychiatry is not a form of racism – although psychiatry can be racist (see Fernando, 2014) – it is essentially a form of discrimination based upon what Minkowitz (2015) called "perceived disability". Distressed or euphoric people come into contact with psychiatry where they may be perceived as "mad" and a range of oppressive practices may then flow from that perception, including forced psychiatry. This specific form of discrimination is what the activists within Mad Studies have called "sanism" (Menzies *et al*, 2013). This invites a number of analogies and comparisons. The most obvious one is with the disability rights movement and the social model of disability. But Spandler and McKeown hint at another analogy when they point out the "increasing evidence of links between childhood abuse and mental health problems" (p. 85). This emphasises a similarity between survivor-experience and feminism in terms of a range of traumas of the life-course (childhood abuse and sexual violence primarily). What is significant about this analogy is the way in which it tends to minimise the prospects of T&R. Generally, feminist activism has made much use of the practice of survivor testimony, in the form of, for instance, rape crisis "speak outs", but this has not been for the purpose of

"reconciliation". On the contrary, feminist testimony has functioned primarily to build the movement and to identify perpetrators; whilst feminist legal activism has rarely concerned itself with restorative justice but, rather, with retributive justice and legal reform in pursuit of that end (see McGlynn, 2011). It would not seem conceivable, for example, for sexual abuse survivors to engage in a T&R process with those who had abused them. This analogy rather seems to suggest that psychiatric survivors should not give up too quickly on retributive justice or legal reform (for example, the repeal of existing mental health law and its replacement with legislation that is CRPD-compliant). One example of contemporary sexual abuse survivor activism has been their involvement in the Independent Inquiry into Child Sexual Abuse (IICSA), which is state-sponsored and state-backed - but not a T&R process. So, my fifth criticism of Spandler and McKeown is that, in advocating for T&R as a form of social justice which is specifically restorative, they may be giving up too quickly on more substantive forms of retributive justice and legal reform.

- T&R is just a manifestation of "therapy culture" (Furedi, 2003) that would be better replaced by the "real" business of political activism.

Spandler and McKeown correctly oppose this perspective arguing that it creates a "false dichotomy" between personal transformation and "structural critique" (p. 90). As they rightly observe, the personal is political and vice versa: the individual testimonies that might be witnessed in a T&R process are neither forms of therapy nor just autobiographical statements. They form part of a political project in which the "dialogical potential of grassroots T&R provides opportunities for bottom-up transformation grounded in the practical, concrete and hard-fought realities of struggle" (*ibid*.). However, in the next section I criticise Spandler and McKeown for the use of two notions which are central to their advocacy of T&R but remain undeveloped in their article: *testimony* and *democracy*.

Testimony & Democracy

Spandler and McKeown *do* see survivor-testimony as central to the truth-telling aspect of T&R. The "public expression of private pain" can "promote greater compassion and community, raise collective consciousness, provide accountability and promote healing" (p.84). Nevertheless, they note limits to testimony within T&R due to its potential to re-traumatise the survivor; but more significantly, because T&R involves a "reciprocal commitment to critical self-reflection, cognisant of the complexities of the distribution of harms both between and within groups" they argue for a need for it to go "beyond testimony…in emphasising a common humanity" (p. 85). The problem here is the over-simplification of testimony understood as a form of political activism.

There is now a significant literature on testimony within the survivor movement (Costa et al, 2012; Cresswell, 2005; Morrigan, 2017; Woods, 2012). This tends to distance itself from academic research on illness-narratives (for example, Frank, 2013) by emphasising the *political* functions of testimony. There are three of these: 1) testimony builds the movement by recruiting new members who are inspired by its emotional impact; 2) testimony contests power by indicting the abuses of psychiatry and by substituting survivors' experiential knowledge for psychiatry's "objective" knowledge; 3) testimony resists its own co-optation by psychiatry for the purposes of shoring up its (psychiatry's) power through the dissemination of diluted testimonies of "mental illness" and "recovery". These functions are essentially double-edged: they may fail or even provoke a backlash either because the witness to a testimony – in the case considered here, the mental health worker during a T&R process – disbelieves it, re-interprets it as a "symptom" of clinical pathology, or else is moved by its impact but only as a "voyeur". The latter phenomenon has been castigated as little more than "patient porn" (Pembroke, 2004; Costa *et al*, 2012).

At first sight, it may seem that these functions of testimony are conducive to Spandler and McKeown's advocacy of T&R. Indeed, I can imagine a scenario in which a survivor of, say, restraint and seclusion in an in-patient setting, gives testimony to that effect during a T&R process, the testimony is witnessed and accepted by mental health workers resulting in sincere apologies and a "reconciliation" based upon a shared understanding of the "complexities of the distribution of harms" in that particular clinical setting. Perhaps the survivor will also listen to workers recount incidents of "patient" violence so that she can then acknowledge those "complexities" too. The problem, though, is that a simplification has occurred in this scenario based upon a misunderstanding of the functions of testimony. Because Spandler and McKeown's primary purpose is to build alliances between survivors and workers, they relegate the status of testimony to that of a precursor to the development of "more peaceful relationships" (p. 85). But testimony is not necessarily a precursor to that; essentially, it is a truth-claim in which a witness (a mental health worker) is called upon to validate survivor-experience and to accept responsibility for the political consequences of that validation. However, as noted above, such validation is only one possible consequence of bearing witness to testimony: denial, pathologisation and voyeurism are others. Considering such possibilities, it is hard to see *why* survivors should commit to a T&R process. They may bring the "truth" with them into the process. But *why* should they wish for the "reconciliation"? This simplification of testimony is my sixth criticism of Spandler and Mckeown.

It could be objected at this point that I am being too pessimistic about T&R. After all, Spandler and McKeown make their own optimism clear: "T&R processes…are based on an optimistic view of human relationships and a belief that social change is possible" (p. 84). But, here, I think we should be careful about words. "Opimistic" and "pessimistic" are everyday adjectives that carry a lot of pejorative meaning. And when you apply them to *democratic* processes, they also carry a lot of theoretical meaning. Spandler and McKeown do not say much about

democracy in their article although Spandler has for years been associated with *Asylum* magazine, subtitled "the magazine for *democratic* psychiatry". In the section of their article with the subtitle "Communicative processes in reconciliation" (pp. 87-88), they highlight some of the key democratic features of the T&R process: it "creates new spaces for conversations, listening and dialogue…The 'understandings' reached may not belong to any individuals, rather being collectively constructed through concerted attention over the course of the proceedings" (*ibid.*).

Elsewhere, Spandler and McKeown have written explicitly about the sort of democratic processes they advocate in building alliances between survivors and mental health workers. For instance, in their chapter in *Madness, distress and the politics of disablement* (2015), they endorse a modified form of Jurgen Habermas's (1986) deliberative democracy:

> "Democratic forums must insist on equalised power relations…and respect for difference. Reason and persuasion are privileged and participants must be prepared to enter any debate ready to change their mind…Lengthy, considered discussions are often required, to explore more fully issues and different points of view, rather than a rush to achieve dominance or a too easy consensus" (McKeown and Spandler, 2015, p. 274)

Basically, they transfer this model of deliberative democracy onto the T&R process so that whether it "works" or not largely depends upon the validity of the Habermasian framework. This is not the place to enter into a critique of that but it is the place to say that it is not the only theoretical framework available.

Historically, there have been two sorts of theory that have opposed Habermas: first, the theory of power associated with Michel Foucault (1990); second, the theory of "radical democracy" associated with Ernesto Laclau and Chantal Mouffe (2001). These oppose Habermas from two directions. First, Foucault's notions that "power is everywhere" (1990, p.93) and "there is no exteriority in relation to power" (*ibid*, p. 95) challenge the idea, fundamental to T&R, that there

can be "equalised power relations" within the T&R process. On the contrary, whatever unequal power relations existed exterior to the process, Foucault's theory implies, will also be reproduced inside it. The double-edged responses to testimony noted above (acceptance, denial, pathologisation and voyeurism) basically follow this Foucauldian line – discriminatory practices directed against survivors may simply be reproduced *inside* the T&R process. Second, contra Habermas, Laclau and Mouffe maintain that it is social *antagonism* and not *consensus* that defines democracy. In other words, although the purpose of T&R, as Spandler and McKeown advocate, is "more peaceful relationships" and "reconciliation", if it actually resulted in more anger and hostility between survivors and workers that would not necessarily make it any *less* democratic. The reason is that, for Laclau and Mouffe, radical democracy depends upon the construction of "friends" and "enemies" and upon political alliances forged through those oppositions. In a democracy, we cannot all just become "friends" – even after a T&R process. This leads to my seventh and final criticism of Spandler and McKeown: their "optimistic" account of the democratic processes manifest in T&R may in fact turn out to undermine democracy. They demonstrate a bias towards consensual and reconciled outcomes; whereas a more "pessimistic" outcome based upon the maintenance of social antagonisms may be more democratic. Given that Spandler and McKeown envisage a wide-ranging constituency for T&R – "bringing together service users, survivors and refusers of services with the staff who work/ed in them" (p. 83) – the "pessimistic" outcome might emerge as an admittedly antagonistic yet entirely realistic and democratic one.

Conclusion

There is no doubt that Spandler and McKeown have produced a piece of strong advocacy in favour of T&R in psychiatry. It should structure the debate about T&R for some time to come. In response and to contribute to that debate, I have offered seven criticisms:

1. That Spandler and McKeown blur the boundary between what is historical and what is contemporary psychiatry such that their advocacy of T&R assumes a model of asylums and “total institutions”.
2. That they do not recognise the complexity of contemporary psychiatry.
3. That grassroots T&R without state-backing would lack power and legitimacy.
4. That mental health workers would not engage with the T&R process.
5. That they give up too quickly on retributive justice and legal reform.
6. That they over-simplify the political functions of testimony.
7. That the consensual-bias of the T&R process could undermine democracy.

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