Eur Arch Psychiatry Clin Neurosci (2003) 253 : 61–67 DOI 10.1007/s00406-003-0407-8

ORIGINAL PAPER

Marcelo T. Berlim · Marcelo P. A. Fleck · Edward Shorter

Notes on antipsychiatry

Received: 19 November 2002 / Accepted: 20 January 2003

Abstract The present paper aims to provide a review of the history and basic principles of the antipsychiatric movement, as well as to discuss the work of its most important theorists. The authors searched recent literature, as well as drawing upon some of the basic antipsychiatric texts. Antipsychiatry emerged as an international movement during the 1960s as part of the historic tumult of the period rather than as a result of the evolution of scientific ideas. Antipsychiatrists radically opposed what they understood as a hospital-centered medical specialty legally empowered to treat and institutionalize mentally disordered individuals. Indeed, many antipsychiatrists argued against the very existence of mental disorders themselves. After the 1970s, the antipsychiatry movement became increasingly less influential, due in particular to the rejection of its politicized and reductionistic understanding of psychiatry.

Key words psychiatry · psychiatric hospitals · biological psychiatry

M. T. Berlim, M. D. (✉)
Rua Santana 312/201
CEP 90040-370, Porto Alegre, RS, Brasil
Tel./Fax: +55-51/32 21 37 40
E-Mail: mberlim@uol.com.br

M. P. A. Fleck, M. D., Ph. D.
Department of Psychiatry and Forensic Medicine
Federal University of Rio Grande do Sul
Rua Ramiro Barcelos 2350
CEP 90035-003, Porto Alegre, RS, Brazil

E. Shorter, Ph. D., FRSC
History of Medicine Academic Unit
Faculty of Medicine and Department of Psychiatry
University of Toronto
88 College Street
M5G 1L4, Toronto, Ontario, Canada

Introduction

Psychiatry was organized as a medical specialty late in the eighteenth century, with the therapeutic asylums of Vincenzo Chiarugi in Florence and Philippe Pinel in Paris (Shorter 1997). Since then, it has been periodically criticized, not only for its theoretical structure, but also for its clinical practice (Dain 1994). In contrast to the nineteenth century, when psychiatry critics were mainly lay persons (e. g., clergy and magistrates), in the second half of the twentieth century these criticisms were articulated in such a way that they ended up originating a movement whose most prominent ideologists were members of the psychiatric field itself (Crossley 1998; Dain 1989).

The term "antipsychiatry" was revived in 1967 by South African psychoanalyst David Cooper to designate a set of criticisms of psychiatry, understood as a medical specialty centered on hospital practice (Cooper 1967). More comprehensively, antipsychiatry was a social movement that questioned not only the legal privilege of psychiatrists to detain and treat individuals with mental disorders, especially in a compulsory manner, but also the increasing "medicalization" of madness. Finally, antipsychiatry questioned the very existence of mental illness itself. It is interesting to note, however, that the concept of antipsychiatry changed over the years in response to the intrinsic evolution of psychiatry, and because of the changing worldview of its critics, who increasingly used antipsychiatry to strike at the psychiatric establishment as well as at the political system that psychiatry served (Tantam 1991).

Turbulent decades for psychiatry

It is in the context of the social turbulence of the 1960s and 1970s, and under the impact of the counterculture, that the most damaging criticisms of hospital psychiatry emerged. They were launched by charismatic indi-

viduals within the psychiatric milieu itself. This "rebellion" (latter called the antipsychiatric movement) was influenced by the rejection of established authority that was a major feature of student and university campus life in these decades (powerfully fuelled in the United States by opposition to the Vietnam war). This Zeitgeist, which was almost equally powerful in Europe, provided uniquely fertile soil for the antipsychiatrists' ideas. Therefore, beginning in the 1960s, a number of forces (e. g., internal contradictions within psychiatry, the rise of the patient's rights movement, and the development of alternative treatments for mental disorders) converged to place psychiatrists in a defensive position never seen before (Dain 1989). In retrospect, it is likely that the most formidable of these forces was the 60s-style rejection of coercive authority, and what authority could be more coercive than the ability to lock up the rebellious and the marginal on the grounds that they were "insane".

Yet antipsychiatry was more than an anticustodial movement. In addition to the mental hospitals, it targeted the scientific aura that had taken over psychiatry from the 1960s on. With the advent of effective psychotropic medications and other forms of somatic therapy, many psychiatrists neglected the psychological aspects of their relationship with their patients, and concentrated purely on controlling the adverse effects of pharmacotherapy during their meetings. Such attitudes ended up generating a kind of alienation in the doctor–patient relationship and contributed significantly to the rising criticism of psychiatric practice (Shorter 1997).

What lent singularity to the antipsychiatric movement was its radicalism and scope. Its ideologues proposed a broader criticism of modern western society, sometimes placing the problem of mental illness in a secondary position (Crossley 1998). According to them, western society was an oppressive structure, distorting and repressing human potentialities in the name of its perfidious objectives. However, one should not overestimate the extent to which the antipsychiatric movement was organized. In reality, it was hardly organized at all, mainly because the so-called antipsychiatrists were such a disparate group of individuals with almost nothing in common with one another except that they were all, for different reasons, deeply critical of psychiatry and its professionals.

Moreover, antipsychiatrists did not just question specific coercive, custodial practices; nor did they simply demand a more humane psychiatry. Rather, they challenged the central concepts of psychiatry: its purposes, its basic doctrines of etiology and nosology, and the distinction upheld by "traditional" psychiatrists between madness and sanity. Therefore, by proposing the abandonment of the whole process of psychiatric diagnosis, treatment, and prognosis, the antipsychiatrists rejected the "medical model" on which psychiatry's clinical practice was based (van Praag 1978).

The theoretical substructure of antipsychiatry, developed especially by sociologists (such as the American Thomas Scheff) was called "labelling theory". According to this theory individuals are "labeled" as "deviant" or "mentally ill" because they have violated social norms in effect in their communities, i. e., any purported diagnosis of mental disorder is simply a reflection of what a society considers unacceptable behavior. *"Most chronic mental illness is at least in part a social role"*, said Scheff (Scheff 1966).

Furthermore, the antipsychiatrists attempted to discredit the evidence of an association between the so-called "labels" and underlying somatic factors, by dismissing neurochemical and genetic abnormalities found in individuals with major mental disorders. Yet their case did not rest on disproving such hypotheses as the monoaminergic theory of depression, but rather on a kind of visceral dislike of psychiatry's scientific underpinning, a refusal to believe that neurotransmitters could play a greater role in the genesis of dysphoria than poverty (Tantam 1991).

Therefore, many antipsychiatry theorists argued that mental disorders were not medical entities "defined by nature", but rather labels arbitrarily assigned by society and confirmed by psychiatrists with the intent of coercing and controlling individuals whose deviant behavior threatened society's orderliness and welfare. According to them, this "policeman" role was symbolized by the coercive use of psychosurgery, electroconvulsive therapy, and other treatments thought to cause serious harm. In fact, the antipsychiatrists argued vigorously against institutionalized treatment, which was seen as a despotic instrument of power (Berrios and Porter 1995).

In addition, the antipsychiatrists were influenced by some psychoanalytic concepts, most notably by the belief that many mental illnesses were caused by repressed (or forgotten) desires/wishes from childhood. Accordingly, since most of these experiences did not fall into separate and defined categories, there was no reason why mental illnesses should do so either. Thus, by abolishing the prevailing psychiatric nosology, psychoanalysts claimed that everybody had some degree of neurosis that could be resolved through analysis, i. e., that normal people differed from individuals with mental disorders only in degree, not in kind (Hobson and Leonard 2001). Apparently symptom-free citizens in the population were referred to as "normal neurotics".

Influenced by such ideas, many antipsychiatrists considered irrelevant the demarcation between mental health and mental illness: for them the concept of "psychological adjustment" was more damaging to human capabilities than the personality distortions said to be found among mentally disordered individuals. More importantly, antipsychiatrists called attention to the frailty of the psychiatric diagnoses employed in the 1960s and 1970s, especially to their low reliability and validity. Indeed, some activists saw an experiment conducted in 1973 by Rosenham as providing a "validation" of their ideas: In this study, research assistants made false claims to doctors that they experienced auditory hallucinations. As "expected", they were promptly ad-

mitted to mental hospitals, where they were instructed to behave in a completely normal manner. This behavior, nonetheless, continued to be interpreted as psychotic by their psychiatrists.

A number of antipsychiatrists offered their own alternatives to conventional treatment, which included both individual therapy and the creation of "therapeutic communities". Yet these new "treatments" did not necessarily aim at achieving the same objectives as those of the so-called "traditional psychiatry" and did not always involve bringing greater therapeutic efficacy or more humanity to the care of persons with mental disorders. On the contrary, antipsychiatry opposed some of the promising new therapies of the day, such as psychopharmacology, and defended radically different alternatives. For example, in the English therapeutic community Kingsley Hall, where 194 individuals were housed from its foundation in 1962 until 1971, schizophrenia was conceived as an individual's journey into his or her "inner space". Accordingly, "treatment" consisted in helping the "traveler" through this "interior journey". The rising number of pregnancies and suicides, and the sexual violence and physical aggression associated with Kingsley Hall, led the British Department of Health to close it in the early 1970s, ending an experiment whose central feature was unrestricted freedom for patients and the abolition of all treatments considered conventional (Shorter 1997; Tantam 1991).

There had been previous movements critical of psychiatry in the 20th century. The first uprising against psychiatry, purportedly religious in nature, was started in the 1950s in the US by members of the "Scientology Church"; the second, which emerged in England in the beginning of the 1970s (with the formation of the "Mental Patients Union"), was led by the so-called "survivors" of psychiatry, i. e., former patients who rebelled against the treatments they had received and who began questioning the basis of psychiatric practice. Yet there were positive features in the "survivors-movement": even though its activists sometimes even denied the reality of mental illness and denounced psychiatrists' lack of sensitivity in relating to their patients, the movement did promote a higher evaluation of patients' views and welfare, as well as the idea that recovery was an achievable goal. Especially after the 1980s, this change in outlook was reflected in a narrowing of the gulf between psychiatrists and their patients, ex-patients and relatives (Dain 1989).

Finally, unlike previous movements, antipsychiatry gathered adherents from workers across the mental health professions who resented psychiatrists' monopoly over the diagnosis and treatment of mental disorders (Dain 1994). In these circles, a consensus had formed that the discipline of psychiatry was an illegitimate form of social control and that psychiatrists' power to lock people up must be abolished with the abolition of institutionalized psychiatric care, Pinel's therapeutic asylum. Activated by the political excitement of the 1960s, these individuals appropriated the ideas of antipsychiatry's key ideologists and spread them in the most varied ways: in the media and among patients, artists, politicians, and educators.

After the 1970s, the antipsychiatry movement became increasingly less influential (Postél and Quétel 1987), due in particular to the advances in psychiatry and neurobiology in elucidating the etiological basis of a number of mental disorders and in improving the efficacy of available treatments (Garfinkel and Dorian 2000). Yet in certain countries, the antipsychiatric movement still retains a tenacious admiration, influencing even in the third millennium many mental health policies and laws.

Antipsychiatry around the world: four "case studies"

Contemporary antipsychiatry was an international phenomenon, with repercussions not only in the United States and in the United Kingdom, but also in Italy, and in many other European and Latin American countries. Yet there was a great deal of disagreement between the main antipsychiatric ideologues, as each developed, added, or combined their ideas in different ways. Below is a summary of the central tenets of four of the most important antipsychiatrists: Ronald Laing, Thomas Szasz, Erving Goffman and Franco Basaglia. Because of space limits, other relevant ideologues of antipsychiatry will not be mentioned (as, for example, Michel Foucault (France), Aaron Esterson (UK), and David Cooper (South Africa)).

United Kingdom

Ronald D. Laing (Laing 1960; Laing and Esterson 1964; Laing 1967, 1969)

In the UK, the antipsychiatric movement condemned the practice of psychiatry in its classical institutional forms, proposing truly community-oriented experiences. Eclectic in its doctrinal inspirations, which were not always rigorous, the movement was noted for its accomplishments and its political militancy; yet unlike its more politicized progeny in the United States and France, it never had a manifesto.

The most prominent ideologist of the British movement was psychoanalyst Ronald D. Laing. Born and trained in Scotland, Laing based his theories on humanistic psychology, a loosely structured set of views which maintained that the naturalistic approach used in science overlooked and destroyed the very qualities and essence of what it is to be human, i. e., Laing stressed freedom and subjectivity over determinism.

Laing saw mental disorders – or at least schizophrenia – as an understandable, even normal, response or adaptation of sensitive individuals to a mad world. Initially he argued that patients with schizophrenia had a

"split" inside their minds, and were "playing mad" to avoid social responsibilities. Later he claimed, on the basis of a methodologically rather weak study, that schizophrenia was a product of disturbed families which "victimized" one of their members. Accordingly, the odd behavior of schizophrenics became normal when viewed in the family context. In reaching this conclusion he was influenced by researcher Gregory Bateson, who developed a complex "double bind" theory of schizophrenia (Bateson et al. 1956). Bateson argued that conflicting and paradoxical demands (i. e., a pattern of disturbed communication) inside families could have an important role in schizophrenia's etiology and symptomatology, as it was capable of leading to the fragmentation of interpersonal relationships. Still later, however, Laing abandoned his previous "insights" and fought against hospital psychiatry by denying the very existence of schizophrenia as a disorder, which he called an *"entirely hypothetical pathological process"*. According to him, what psychiatrists called schizophrenia was, in reality, a possible vehicle for personal growth, i. e., a gifted and creative state of consciousness that took over sanity and could produce superior human beings. *"Future generations"*, said Laing (1967), *"will see that what we call 'schizophrenia' was one of the forms in which, often through quite ordinary people, the light began to break through the cracks in our all-too-closed minds"*.

Furthermore, Laing denied the need for any professional status or knowledge in treating the mentally ill: all that was required for the "healer role" was a concerned and authentic individual. For him, the treatment setting was a sanctuary where people could go through their "process of madness" under supportive care, and this arrangement was partially responsible for the blurring of the distinction between therapist and patient. In fact, Laing suggested that there was no abyss between psychiatrists and psychotic individuals; any apparent gap existed only in the former's subjective experience, which was influenced by a medical training that promoted the alienation of the patient. Additionally, Laing emphasized that practitioners should enter the treatment unfettered by their assumptions about reality and madness. Accordingly, the patient's own views about his or her situation had equal or perhaps more legitimacy than those of the therapist.

Moreover, from a "Laingian" perspective, a cure would eventuate when patients felt that they were free to make choices and deal with the realities of existence, even if they continued to maintain their previous nonfunctional behavior (but now in a way that did not trouble them or restrict their personal freedom).

Laing also stated that the diagnostic processes of modern psychiatrists were no more than a new type of mental disorder, which he called "psychiatrosis". His ideas would influence the activists who organized "communes" for schizophrenic patients, such as the Soteria House, where patients lived and governed themselves. As time passed, however, Laing started to increasingly dedicate himself to occultism, deciding to live among the monks of Tibet. In the later 1970s, while giving his lectures, he seemed vacuous and disconnected (and was in fact often drunk). Eventually, his teaching and innovations were a resounding failure – but not before he had acquired several years of fame.

United States

Thomas Szasz (Szasz 1960, 1973, 1974, 1979a, 1979b)

The main assailant of psychiatry in the United States was Thomas Szasz, a Budapest-born psychoanalyst, author of several works in which he denied the existence of mental illness as a medical entity, except in a small number of cases in which a somatic etiology was established, such as neurosyphilis and encephalitis. As he said (Szasz 1960), "w*hereas in modern medicine new diseases were discovered*, *in modern psychiatry they were invented"*. Therefore, Szasz restricted the concept of disease to entities with a defined anatomic, histologic or biochemical substratum, arguing that *"disease means bodily disease (…) The mind (whatever it is) is not an organ or part of the body. Hence, it cannot be diseased in the same sense as the body can. When we speak of mental illness, then, we speak metaphorically"* (Szasz 1974). In sum, for Szasz, so-called mental disorders were no more than "myths" or fraudulent impositions perpetrated by psychiatrists whose central intention was to preserve their privileged professional status.

As a "radical libertarian" (i. e., a defender of radical individualism), Szasz was opposed to the involuntary hospitalization and treatment of individuals with mental disorders. For him, this practice was never in the patient's interests, but only undertaken to control them on behalf of their families (or the state). Such "coercive" psychiatric treatment resulted, he said, not only in an exacerbation of patients' symptomatology, but also in their infantilization. Moreover, Szasz generally argued that all behavior is rational (or at least intentional), and individuals are therefore always responsible for it. By this he means that even seemingly bizarre behavior, supposedly symptomatic of a mental disorder, was really goal-directed and meaningful; accordingly, to treat people otherwise is to strip them of their freedom and autonomy.

Szasz also stated that psychotherapy was no more than another "myth", i. e., that it was simply talk and not treatment. For him, mental disorders should be explained in terms of the "acting out" of family and religious games, and he proposed that ethics and morals might better substitute for psychiatry. Indeed, his own view was that schizophrenia was "bad behavior", or a pattern of behavior disliked by society. Accordingly, for him individuals with schizophrenia differed from "normal" people only in so far as they deviated from them in mode of speech or conventional standards of conduct.

With the spread of his ideas, Szasz gained the support of a series of psychiatry critics, among them patients and former patients, legislators, liberal professionals

and political activists. Nevertheless, Szasz objected to being called an antipsychiatrist and was openly critical of other antipsychiatrists such as Ronald Laing and David Cooper, whom he regarded as woolly-minded and misguided socialists. Indeed, he refers to his relationship with them as that of Churchill to Stalin, i. e., as having nothing in common with them except a common enemy.

In restrospect, Szasz's "pathoanatomic view" might be seen as merely one among many competing notions of disease (as, for example, the patient-centered or phenomenologic approach) (Pies 1979). There has never been a single set of criteria for the ascription of disease, and by using Szasz's definition one might claim that diagnoses such as essential hypertension, migraine, and idiopathic epilepsy, which lack consistent pathophysiologic and histopathologic findings, are not real medical entities. As Roth (1976) argued, *"it is with the tribulations of people that the analysis of the scope and limitations of psychiatry has to begin. 'Disease' is a highly complicated concept, and to impose upon the word the concreteness of hard fixed objects of one's personal choice is something very different from understanding"*. The reality is, if we may say so, that a number of mental disorders, albeit lacking any obvious pathoanatomic lesion, may be considered diseases as they entail suffering and incapacity to those who suffer them. Indeed, there is no place in Szasz's schema for consideration of the anguish and disability suffered by individuals with mental illnesses or the distress and despair which this creates in their families and friends. Finally, over a period of 40 years, Szasz has made numerous pronouncements about the care and treatment of patients with mental disorders, but in no case has he submitted his views to formal tests that could have disconfirmed or substantiated them.

Erving Goffman (Goffman 1961)

It was another American dissenter, sociologist Erving Goffman (whose book "Asylums" was published in 1961), who had had an even greater impact on intellectuals. In the context of a fellowship in 1955–1956 at the National Institute of Mental Health, he did field work at St. Elizabeths, an institution that, at the time, had over 6,000 patients. Goffman did not like what he saw, interpreting the mental hospital as a "total institution," responsible for infantilizing patients and restricting their freedom. Psychiatrists used asylums, he said, as "brainwashing machines" to control disturbing individuals. He saw institutionalized individuals with mental disorders as inmates in a prison – wasting their lives in the name of psychiatry – a dubious medical specialty responsible for the very conditions it was supposed to cure. Indeed, he argued that among psychiatric patients *"there is a strong feeling that time spent in the establishment is time wasted or destroyed or taken from one's life. (…) As a result, the inmate tends to feel that for the duration of his required stay – his sentence – he has been totally exiled from living"* (Goffman 1961).

Goffman's influence on American intellectuals must not be underestimated. Ronald Laing and Thomas Szasz were widely read and became cult figures for the radical left in the late 1960s, but neither had much influence on psychiatrists or on Health Department policies. Goffman, on the other hand, provided convincing arguments that mental hospitals were not merely profoundly antitherapeutic institutions in practice but were almost bound to be so because of the profound power gulf between patients and staff, and the latters' total control over the lives of the former. He therefore provided Health Departments and taxpayers with a justification for closing large numbers of expensive hospitals, many of them in urgent need of repair, thereby enabling bureaucrats and taxpayers to save large sums of money while simultaneously convincing themselves that they were acting in the best interests of those hospitals' patients.

In hindsight, although Goffman drew attention to serious weaknesses in mental hospitals, again the underlying assumption was that there was no such thing as mental illness and that the pretension of professionals to treat it was nothing more than a shameless power-grab. Additionally, the process of deinstitutionalization has revealed that the asylums did after all perform some important functions. In fact, deinstitutionalization (carried out in a number of countries) has proven paradoxical in that it helped perpetuate, or even heighten, the stigma associated with mental disorders by causing, among other problems, a rapid growth in the number of mentally disordered homeless individuals (Lamb and Bachrach 2001).

Italy

Franco Basaglia (Basaglia 1968, 1981, 1982)

It was in Italy that the doctrines of the antipsychiatry movement received their most extreme expression. Under the leadership of physician Franco Basaglia and his collaborators, the country became transformed into a kind of psychiatric museum for the antipsychiatry theories of the 1960s. In conformity with the principles of antipsychiatry, the so-called Law no. 180 (approved in 1978) mandated the complete closing of all public asylums. (This was not actually completed, however, until the late 1990s). Likewise in Italy, the doctrines of psychoanalysis reigned undisputed in private practice psychiatry. To complete the inventory of the Italian antipsychiatry museum, electroconvulsive therapy (ECT) became shunned and feared by the population following a relentless campaign on the part of the intellectual classes. After the 1970s, ECT could be conducted only in select institutions such as the Psychiatry Clinic in Pisa. In many large cities, ECT became unavailable as a medical treatment. It is worthwhile, therefore, to pay some attention to the notions of Basaglia.

Basaglia was very much a child of his time, influenced

by the neo-marxist "new left" of the 1960s and thereafter. Just before his death, he wrote: *"Thus the state gives us an enormous quantity of psychiatric care* [techniche] *that is not the result of an assessment of* [human] *needs but rather the expression of the needs of the social system"* (Basaglia 1982).

Influenced by ideas of this nature that he had encountered in Europe and North America, Basaglia was responsible for instituting, in an atmosphere of militant activism, a community life in the miserable state asylum in Gorizia (a small city in north-eastern Italy). Accordingly, all wards were gradually opened and patients allowed to move freely within the hospital and in the town. ECT, seclusion and restraints were banned, and a program of discharge implemented.

In the course of the next few years Basaglia convinced trade unions and student organizations that the inmates of mental hospitals should be freed, and that the traditional psychiatric hospitals – considered anti-therapeutic institutions responsible for the annihilation of patients' identities – should be destroyed. Basaglia criticized the concept of mental disorder (seen as an unreal entity) and compared the mentally ill to the poor and condemned: all victims of a selfish society in which the strong wreak violence on the weak. Thus, for him, the causes of mental disorder were not biological or psychological, but rather social violence and exclusion, i. e., patients' psychiatric symptoms arise from their "political dialectical inability" to face up the contradictions of reality. Accordingly, Basaglia developed the concept of "circuit of control", which was said to lead "deviant" individuals from material disadvantage and affective disturbance to violence and aggression, to committal in mental hospitals and consequent loss of autonomy, and then to further violence and material deficits.

Basaglia said that under the social and political conditions of the late 1960s, any purely technical treatment, such as psychopharmacology or psychotherapy, was worse than mental disorders themselves, because it tended to "objectivise" the patient. These therapeutic approaches were said to be nothing more than instruments for the control of deviant individuals by the "system", and responsible for the preservation of capitalism's *status quo*.

From the "Basaglian" perspective, a cure would be obtained only when patients gained insight into their exclusion from society and refused to accept it. Accordingly, anything aimed at inhibiting aggressive behavior against society or abandoning the conflict was considered anti-therapeutic. In sum, "denial of the institution" was his watchword.

In 1974, Basaglia founded a nationwide association imbued with the anti-institutional ideal, which he called "Psichiatria Democratica". This movement quickly became a pressure group of almost religious fervor, using a wide variety of means to spread its message across Italy. In 1978, as we have seen, under the influence of "Psichiatria Democratica", a parliamentary committee was charged with reforming psychiatric practice. This reformulation changed the care of individuals with mental disorders by forbidding any further mental hospital admissions, by restricting compulsory commitments, by limiting the number of beds available for psychiatric patients, and by replacing the old asylums with community-oriented services (Burti 2001). However, it is important to notice that Italian reform has not been monitored adequately in a scientific way. As pointed out by Girolamo & Cozza (2000), *"disappointingly very few outcome studies have been carried out in Italy since the approval of the law. Therefore, it is difficult to evaluate the overall results of the radical change in mental health in a standardized, evidence-based fashion, avoiding impressionistic or opinion-biased statements; and to understand how the system change has been reflected in parallel changes in the clinical condition of different typologies of patients in contact with the services"*.

In conclusion, the Italian movement was not a typical example of antipsychiatry in the sense of denying the reality of mental illness; it was rather a strongly politicized enterprise that saw mental illness as organically related to social adversity. Although the confinement in asylums may – perhaps more in Italy than elsewhere – have incorporated an element of social control, the simplicistic equation between deprivation, or poverty, and mental illness was wrong. Over time, the strong anti-medical orientation of the original reform movement has had two specific consequences. First, its impact has been more political than scientific, Basaglia's ideas becoming a banner carried into parliament by the various Italian socialist parties. Second, "Basaglianism" has itself become an obstacle to progressive reform, opposing rational improvements and focusing on totally secondary targets (e. g., fighting mechanical restraint).

Conclusion

Antipsychiatry in retrospect may be seen as an ideological movement based on a politicized and reductionistic understanding of psychiatry, devoid of an empirical basis and putting itself in clear opposition to any scientific data stemming from the medical specialty of psychiatry. Yet its influence has been undeniable.

Antipsychiatry has approached psychiatry as a demon to be exorcised. Its advocates used methods present in many fanatic religious movements. The Zeitgeist of the 1960s and 1970s, epitomized by the rebellion against the "system", helps explain not only why antipsychiatrists were so influential at the time but also why they were slowly forgotten afterwards.

Yet by questioning psychiatric diagnoses and naming them "labels", antipsychiatry inadvertently contributed not to the extinction but to the considerable refinement of psychiatric nosology. Nowadays, every competent trainee starts at the very beginning to learn that disease-labels – indeed psychopathology as a whole – have their obvious merits and their hidden perils. Diagnostic labels can, of course, be dangerously misused; yet, without

categories or dimensions, there could be no order and no progression in our field of study and practice (Mindham et al. 1992). Additionally, while ferociously criticizing the function of psychiatric hospitals as "total institutions", antipsychiatry helped to revise practices of committal, influencing new models of care then arising.

Thus, the existence of a movement such as antipsychiatry is a demonstration of psychiatry's richness and complexity. In any other medical area, a group such as "anti-cardiologists" or "anti-pediatricians" would be unthinkable (Bracken and Thomas 2001). Antipsychiatry's legacy is likely derived much more from the absorption and incorporation of its criticisms by mainstream psychiatry than from the direct application of its fundamental tenets.

Acknowledgment The authors would like to thank Professor Robert E. Kendell, MB, FRCP, FRCPsych, for the careful review of this paper.

References

1. Basaglia F (1968) L'Istituzione Negata. Einaudi, Turin
2. Basaglia F (1981) Breaking the circuit of control. In: Ingleby D (ed) Psychiatry and Anti-psychiatry. Penguin, Harmondsworh, pp 121–137
3. Basaglia F (1982) Conversazione: a proposito della nuova legge 180. In: Basaglia FO (ed) Franco Basaglia, scritti, vol. 2, 1968–1980: dall'apertura del manicomio alla nuova legge sull'assistenza psichiatrica. Einaudi, Turin, pp 42–56
4. Bateson G, Haley J, Jackson D, Weakland J (1956) Towards a theory of schizophrenia. Behav Sci 1:251–264
5. Berrios GE, Porter R (1995) A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders. New York University Press, New York
6. Bracken P, Thomas P (2001) Postpsychiatry: a new direction for mental health. BMJ 322:724–727
7. Burti L (2001) Italian psychiatric reform 20 plus years after. Acta Psychiatr Scand 104 (Suppl. 410):41–46
8. Cooper D (1967) Psychiatry and Antipsychiatry. Tavistock, London
9. Crossley N (1998) RD Laing and the British anti-psychiatry movement: a socio-historical analysis. Soc Sci Med 47:877–889
10. Dain N (1989) Critics and dissenters: reflections on "antipsychiatry" in the United States. J Hist Behav Sci 25:3–25
11. Dain N (1994) Reflections on antipsychiatry and stigma in the history of American psychiatry. Hosp Community Psychiatry 45:1010–1014
12. Garfinkel PE, Dorian BJ (2000) Psychiatry in the new millennium. Can J Psychiatry 45:40–47
13. Girolamo G, Cozza M (2000) The Italian psychiatric reform – a 20 year perspective. Int J Law Psychiatry 23:197–214
14. Goffman E (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Penguin, New York
15. Hobson JA, Leonard JA (2001) Out of its Mind: Psychiatry in Crisis. Perseus Publishing, New York
16. Laing RD (1960) The Divided Self. Tavistock, London
17. Laing RD, Esterson A (1964) Sanity, Madness, and the Family: Families of Schizophrenics. Penguin, Baltimore
18. Laing RD (1967) The Politics of Experience. Penguin, London
19. Laing RD (1969) Self and Others. Tavistock, London
20. Lamb HR, Bachrach LL (2001) Some perspectives on deinstitutionalization. Psychiatr Serv 52:1039–1045
21. Mindham RHS, Scadding JG, Cawley RH (1992) Diagnoses are not diseases. Br J Psychiatry 161:686–691
22. Pies R (1979) On myths and countermyths – more on szaszian fallacies. Arch Gen Psychiatry 36:139–144
23. Postél J, Quétel C (1987) Historia de La Psiquiatría. Fondo de Cultura Económica, Ciudad del Mexico
24. Rosenham DL (1973) On being sane in insane places. Science 179:250–258
25. Roth M (1976) Schizophrenia and the theories of Thomas Szasz. Br J Psychiatry 129:317–326
26. Scheff TJ (1966) Being Mentally Ill: A Sociological Theory. Aldine, New York
27. Shorter E (1997) A History of Psychiatry: From the Era of the Asylum to the Age of Prozac. John Wiley & Sons, New York
28. Szasz T (1960) The Myth of Mental Illness. Hoeber-Harper, New York
29. Szasz T (1973) The Manufacture of Madness. Granada, St. Albans
30. Szasz T (1974). The Second Sin. Anchor Books, New York
31. Szasz T (1979a) The Myth of Psychotherapy. Oxford University Press, Oxford
32. Szasz T (1979b) Schizophrenia: The Sacred Symbol of Psychiatry. Oxford University Press, Oxford
33. Tantam D (1991) The anti-psychiatry movement. In: Berrios GE, Freeman H (eds) 150 Years of British Psychiatry: 1841–1991. Gaskell, London, pp 321–352
34. van Praag HM (1978) The scientific foundation of anti-psychiatry. Acta Psychiatr Scand 58:113–141