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Limitations of the Critique of the Medical Model

Ken Barney

Cambridge, Massachusetts

A strengthened critique has thoroughly debunked the medical model, but remains limited in its explanatory power — it fails to incorporate wider sociopolitical dimensions in the analysis of both individual distress and the legitimation of the mental health system, whose power is undiminished. Critique's focus on the medical model tends to obscure the link between the mental health system and the powerful and fetishized psychological (psychologistic) perspective, which is, in turn, closely associated with the philosophy of individualism pervasive in late capitalist society. The contextualist alternative stops short of incorporating sociopolitical dimensions, especially the destructive aspects of late capitalist society, such as erosion of community and unrestrained individualism. Contextualism transcends crude medical model reductionism but not the prevailing psychologism and individualism, and the depoliticization of powerlessness, distress, and disorder.

In the 1960s fresh voices mounted a new challenge to the pretensions of psychiatry as a science and the mental health system as a successful humanitarian enterprise. These voices included: Ernest Becker (1964), Erving Goffman (1961), R.D. Laing (1967; Laing and Aaron Esterson, 1964), Thomas Scheff (1966), and Thomas Szasz (1961).[1] Their writings, along with others such as articles in the journal *The Radical Therapist* (Agel, 1971, 1973), were given the umbrella label "antipsychiatry" despite wide divergences in philosophy. This critical literature, in concert with an activist movement, emphasized the hegemony of medical model psychiatry, its spurious sources of authority, its mystification of human problems, and the more oppressive practices of the mental health system, such as involuntary hospitalization, drugging, and electroshock.

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[1]The writings of Franco Basaglia were made available in English only later (see Scheper-Hughes and Lovell, 1987).

In the 1970s, coinciding with the rightward political turn in Western countries, antipsychiatry withered — as did the liberal–reformist community mental health center movement. It did however, leave a legacy: a continuing project of critical analysis and writing, a feminist therapy movement, and a legal advocacy network. In addition, a small but energetic network of ex-patient activists continues to contest the more oppressive practices of the psychiatric system (Chamberlin, 1979, 1990).

Since the 1960s, the body of critical literature has been steadily expanded and now provides an even more impressive deconstruction and debunking of the medical model. The critique is now more compelling, both in its analysis of mental health system mystification of experience and also in its description of the traditional sources of support for this system, which include the mental health professions (clinical and academic), the pharmaceutical industry, the National Institutes of Mental Health (NIMH), and the widespread faith in the benevolence and healing power of science and medicine.

Critics may be presuming (optimistically) that, in time, the critical literature will become more widely disseminated, and thereby more influential. More problematical may be the presumption in this literature that accurate description of the supports of the mental health system adequately explains why this system remains so powerful. To be sure, the supports of the system are very powerful; in an *immediate* sense, they do account for the continuing power of this system. What is not addressed, though, is the possibility that analysis of wider sociopolitical factors may be necessary in order to adequately explain the continuing power of this system and its seeming imperviousness to compelling critique.

In fact, three decades of trenchant critique and rights advocacy have made little difference in either the language or the basic operations of the mental health system. Oppressive and dehumanizing practices continue unchanged; social and psychological services remain circumscribed or have become diminished; biomedical reductionism retains its great appeal. The paradox has been noted by others. Ingleby (1983) remarked on "the almost megalomanic air of competence and success displayed by the professions themselves, in contrast to the intellectual vulnerability of their theories and the uncertainty of their remedies" (p. 168). Jervis (1985) commented, "The theoretical foundations of psychiatry have been dissolved, but psychiatry continues to exist as pure power" (p. 62).

The article examines this dilemma for the project of criticism. The article argues that the strengthened body of critical literature is analytically limited: it stops short of incorporating sociopolitical dimensions, both in the analysis of individual and family distress and in the analysis of the continuing power of the mental health system. It stops short of examining the role of psychology itself in contributing to the mystification of the wider social and political

reality. It does not examine the link between psychology, the ideology of individualism, and the psychologization and depoliticization of distress.

The latter analysis, incorporating sociopolitical–psychological dimensions, may be found in the work of writers such as David Ingleby (1980, 1983, 1985), Russell Jacoby (1975), Joel Kovel (1980, 1981, 1987, 1988), and Richard Lichtman (1982, 1987). The work of these writers follows in the tradition of Critical Theory (Frankfurt School) Marxist analysis, which focuses on cultural and psychological dimensions, along with political economy (eschewing the economistic reductionism of orthodox Marxism). This perspective is missing in the body of critical literature.

The article will briefly review shifts in the mental health system, highlight the developments since the 1970s in the body of critical writings on the medical model and the mental health system, and then critically evaluate this literature from the radical sociopolitical perspective.

Shifts in the Mental Health System: Recent History

By mid-century, the psychosocial perspective had become dominant in the mental health system. Psychiatry had synthesized psychoanalytic discourse with the established medicalized diagnostic categories (Kovel, 1988, p. 141). This demedicalization trend accelerated in the 1960s, when the political climate promoted interest in social dimensions of psychiatric distress. The funding of community mental health centers (CMHCs) brought with it an influx of new, nonmedical mental health workers. The burgeoning private therapy industry included large numbers of social workers and psychologists. These professionals posed somewhat of a threat to psychiatric hegemony, since, with the exception of drug-prescribing, they could do the same work as psychiatrists, and for less pay.

The 1970s saw the beginnings of a trend toward remedicalization (Brown, 1985, pp. 149–166; Kovel, 1988, pp. 141–142). With the rightward shift in social policy and sociopolitical consciousness, interest in social dimensions of distress diminished. The more socially oriented programs of the CMHCs were curtailed or eroded in favor of cheaper behavioral and biological treatments (Dumont, 1992). This shift has been aided, in part, by the complicity of nonpsychiatric mental health professionals. Psychologists and social workers have been relatively silent about more controversial practices, such as involuntary psychiatric interventions. Also, for the most part, they have meekly accepted the diagnostic system and the official psychiatric *Diagnostic and Statistical Manual* (DSM) [Albee, 1990, p. 381]. Moreover, psychologists even lobby for hospital privileges and drug-prescribing power (p. 382).

The orientation of NIMH has become explicitly biomedical. Media initiatives promoting the disease concept have been stepped up. "Schizophrenia"

has already been established as a "disease" in the minds of the public. The NIMH, organized psychiatry, and the drug companies (mainly Eli Lilly) have now mounted an initiative employing television spots to promote the notion that depression is a treatable brain disease — there now exists an annual "National Depression Screening Day." *Listening to Prozac* (Kramer, 1993), a book on the best-seller list throughout most of 1993, has been excitedly promoting biopsychiatric ideology. For the most part, this book — which combines biomedical reductionism, superficial psychology, and philosophical banalities — has been received as serious analysis and philosophy. In short, biomedical psychiatry has become more prominent in recent years. This may suggest to critics of the mental health system that it would be wise to continue to focus primarily on the medical model and biopsychiatry. This article will argue that such a focus is limited; nevertheless, the importance of the critique of the medical model and biopsychiatry is certainly undiminished. For this reason, developments in it will now be highlighted.

Current Critique of the Medical Model

Diagnosis

The concept of psychiatric diagnosis has been thoroughly demystified (see Brown, 1987, 1990; Dumont, 1984; Kirk and Kutchins, 1992; Kovel, 1988; Mirowsky and Ross, 1989; Sarbin, 1990). Studies have shown consistently that the diagnostic categories lack both reliability and validity (Brown, 1990, pp. 391–394). The categories, catalogued in the DSM, psychiatry's "sacred text" (Kovel, 1981, p. 157), "degrade information, obscure patterns, and misdirect attention" (Mirowsky and Ross, 1989, p. 15). Kovel (1980) commented, quite aptly, that "any unencumbered look at human disorder will reveal [that] the only thing which permits the medical-style classification of emotional disturbance is superficiality of thought and observation" (p. 87).

Schizophrenia

The idea that "schizophrenia" is a hidden disease entity, with a soon-to-be discovered biogenetic "cause," has been thoroughly debunked (see Becker, 1964; Bentall, Jackson, and Pilgrim, 1988; Ciompi, 1984; Carson and Sanislow, 1993; Cohen, 1989; Cohen and Cohen, 1986; Dumont, 1984; Hays, 1984; Hill, 1983; Kovel, 1987; Lewontin, Rose, and Kamin, 1984; Sarbin, 1990, 1991; Sarbin and Mancuso, 1980; Strauss, 1989, 1991; Wiener, 1991). Schizophrenia is a catchall term for a wide variety of disturbing and often perplexing behaviors. With careful and thoughtful appraisal, such behaviors may be understood as complex responses to unmet needs, powerlessness, constricted action, or overwhelming conflict and stress.

Critical analysis of the research enterprise into the "cause" of schizophrenia reveals a pattern of inconclusive findings, nonreplication of earlier findings, and confusion of correlations with causality (Carson and Sanislow, 1993; Sarbin and Mancuso, 1980, pp. 123–150). The yield, after the many decades of research, is nothing more than a bewildering array of correlates. There is no foundation for the widespread belief that genes — alone or even primarily — can cause behavior (see especially Lewontin et al., 1984, pp. 206–228; see also Carson and Sanislow, 1993, pp. 308–313). Twin and adoption studies, and more recently, studies based on DNA linkage approaches, have been trumpeted as establishing the validity of this hypothesis. These studies not only *disconfirm* the genetic hypothesis, but even highlight the contribution of social and environmental factors; they provide additional support for the idea that behavior results from the complex interaction of genetic, physiological, and social-environmental factors (Billings, Beckwith, and Alper, 1992).

The pattern of premature "breakthrough" announcements — along with the mere existence of all of this sustained research activity — is interpreted as "evidence that the schizophrenia construction is a tenable one" (Sarbin, 1991, p. 187). The media plays a major role here. With the hunger of the media for upbeat science news, announcements of discoveries are much more attractive than news of research failures. The media rarely inquire about peer review or seek critical appraisal before disseminating the latest news of a "breakthrough" (Billings et al., 1992, p. 236). The media rarely report retractions, disconfirming studies, or concessions of failure or skepticism. In short, they help spread the message that the solution to the "riddle of schizophrenia" is right around the corner.

Psychiatric Drugs

Important critical work in the area of understanding psychiatric drugs has been produced in recent years (see especially Breggin, 1983, 1990, 1991; see also Cohen and Cohen, 1986; Coleman, 1984, pp. 131–151; Fisher and Greenberg, 1989; Lewontin et al., 1984, pp. 173–206; Richman, 1987; Sarbin and Mancuso, 1980; Van Putten, 1974, 1975; Van Putten and Marder, 1987; Van Putten and May, 1978; Van Putten, May, Marder, and Wittman, 1981; Van Putten, May, and Wilkins, 1980). All critical observers note that the various classes of drugs "work" by *generally* dampening emotion and behavior. None of the major classes of drugs possess the specificity of action implied by their names (e.g., antipsychotic, antidepressant, etc.): individuals with different diagnoses often respond to the same drug, and individuals with the same diagnosis often respond to different drugs (Wiener, 1989, p. 305; 1991, p. 213). The drugs are not magic bullets, hitting precise target sites — they are more

like "explosions of shrapnel flying in many directions" (Lewontin et al., 1984, pp. 193–194).

The drugs may "work" by reducing symptoms and subduing unwanted behavior, but no definitive statements can be made about their efficacy. Outcome studies show a pattern of biases and serious flaws in methodology, including the frequent ignoring of high relapse rates (Fisher and Greenberg, 1989, pp. 309–334) and minimizing of serious side effects (Cohen and Cohen, 1986, p. 21). Moreover, studies reveal that the neuroleptic drugs do not help veteran users in the enhancement of their powers and critical resources, that is, those energies and skills necessary for active engagement in life (Carson and Sanislow, 1993, pp. 323–324).

Side effects of the various classes of psychotropic drugs are regularly minimized by mental health professionals (Brown, 1985, pp. 149–158; Brown and Funk, 1986; Cohen and McCubbin, 1990, p. 466). There is mounting evidence of the high incidence of akathisia (restlessness), akinesia (poverty of movement), and cognitive blunting produced by the neuroleptics; moreover, these behavioral side effects may be late-appearing and irreversible, similar to tardive dyskinesia (Breggin, 1990, 1991). The whole picture may be accurately termed "a major iatrogenic disaster" (Cohen and Cohen, 1986, p. 22).

The Alternative Contextualist Perspective

Counterposed to the medical model is the whole range of less reductionistic perspectives that may be referred to as psychosocial or contextualist. (In the remainder of the article, "contextualist" will be used, keeping in mind the heterogeneity of the positions included within the category.) With this perspective, psychosocial dimensions are primary; they are not reduced to secondary "factors," "triggers," or "stressors." Biological dimensions are viewed as concomitant events, not as "causes." Individual characteristics, identities, and behaviors are explained by complex interaction of inborn traits, funded experience, immediate situation, and personal choice, understood in full historical and cultural context. Problematic and disturbing behaviors are viewed as failed attempts to solve problems or sustain life meaning in the face of complex and often overwhelming reality.

In its outlines, this perspective is comprehensive. *Substantively*, however, it remains within the confines of the prevailing *psychological* perspective. In other words, its major limitation is psychology itself: psychology as *psychologism*.

Psychology as Ideology

What accounts for the power of the psychological perspective? Why is this the "age of psychology" — "the psychological century" (Prilleltensky, 1992, p. 315)? Why do we fetishize psychology (Kovel, 1980, p. 75)?

Psychology is persuasive because it "reflects the isolation, antagonism, fragmentation, and subjectivism of contemporary life"; it reflects the individual experience and at the same time legitimates it, "redefining the individual as the primary agent of social life" (Lichtman, 1987, p. 128). Hence, it constitutes its own order. It has even acquired the status of a formal science — owed in no small part to the disciplinary fragmentation of the social sciences, a continuing impediment to the achievement of a comprehensive perspective about human action (Becker, 1964, p. ix).

Psychology and Late Capitalism

There is a particularly strong link between the culture of late capitalism, the philosophy of individualism, and the power of psychology. Individualism is a key element in the ideology of capitalism. It is more than simply a belief in individual responsibility, self-reliance, and the pursuit of self-interest. Individualism, reflected by psychology and reinforced by it, promotes the glorification of the self, "self-actualization," and faith in the capacity of the individual to transcend society (Cushman, 1990; Jacoby, 1975; Kovel, 1980, 1981; Lichtman, 1982, 1987; Prilleltensky, 1989, 1990, 1992).

The development of monopoly capitalism has been accompanied by the steady erosion of communal and public life, with growing privatization (isolation) of individuals and families. The irrationalities of current economic arrangements have brought about the qualitative degradation of work, along with the more obvious problems of exploitation, unemployment and underemployment. While the oppressive situation of particular categories of people is especially glaring, deterioration in the conditions of life has become widespread. Individuals and communities have become increasingly powerless in relation to the growing concentration of power, hidden or rationalized by the "logic" of the market. With the erosion of community and the increasing isolation, individuals become primarily responsible for their own fate. The notion of individual responsibility is reinforced by psychology. Individual vulnerability and powerlessness, magnified by the mystification of the structural sources of powerlessness, become further magnified by the ideology of individual responsibility promoted by the psychological view.

With the general bewilderment about sociopolitical forces and history, and no prospect for democratic socialist transformation — or any public discussion of such a vision — individuals see no hope for change except through

their own individual efforts. As Kovel (1980) commented, the failure of Western socialism and the demise of religious community have left the desire for transcendence with "no place to go other than the personal sphere" (pp. 83–84).

By reflecting and simultaneously mystifying experience, psychology itself becomes a powerful socializing force. It serves to create norms, not simply police them. This soft, constitutive or "productive" type of social control is a central feature of the modern state; it is far more extensive and arguably more effective than the repressive type of social control (Ingleby, 1985, p. 91).

Psychology, the mass media, and mass culture. The transition from early, liberal capitalism to monopoly capitalism has been accompanied by commercialization and centralization of the news media and the development of mass culture. Active public dialogue has diminished to the point where discussion of economic and political matters is no longer a part of the fabric of everyday life. Mass media and mass culture dominate communication, colonizing the mind. They create false needs, especially for consumer goods, promising compensation for the emptiness of the self (Cushman, 1990). The culture industries, along with psychology and pop psychology, feed the hunger of individuals for "role models" and for solutions to problems.

The language of psychology is ubiquitous, and through mass culture (the "unreality industry"), especially television, penetrates every area of life. Television itself is a kind of psychic terrorism, providing a steady bombardment of repetitive images and talk, both titillating and frustrating, mystifying reality and numbing the mind. It tells individuals that they can keep their lives moving forward in interesting ways, like the various celebrities and the characters appearing on the screen: the images reinforce the belief that current arrangements for conducting human affairs are natural or rational.

The Family: Victimizer or Victim?

There is widespread agreement that the family is in a state of crisis. The situation of the family in late capitalist society is, in fact, uniquely problematical. We need not sentimentalize earlier forms of the family — forgetting patriarchy and other oppressive aspects of traditional family life — in order to comprehend the current crisis of the family. With the deterioration of the culture and the decline of community, the burden of responding to unmet emotional needs falls on the family. As work becomes more impersonal and unfulfilling — if not frankly exploitative — the family is expected to be the "haven." It is still expected to function as the primary agent of socialization, even though the socialization process has been gradually taken over by extrafamilial forces: arguably, the culture industry is today the primary agent of socialization. The family no longer has much control over the conditions

encountered by children, including the requirements of adult roles. As Kovel (1981) commented, "The burden of overcoming the general depersonalization of public life . . . falls to the family, or better, falls *on* the family, squashing it and eventually causing it to rupture" (p. 117).

The biogenetic reductionists have little to say about the family, of course. For those with a contextualist perspective, the role of the family is critical; and it is viewed primarily as a *cause* of oppression — rarely as a *victim* of contemporary society (Jacoby, 1975, p. 133). The turmoil of the contemporary family is not viewed in its historical and social context. The introduction of general systems theory into family therapy brought with it an expectation that family therapy would transcend the medical model and widen the context beyond the family to include the larger society. Instead, family therapy has settled for a shallower grasp (Jacoby, 1975, pp. 131–145; Kovel, 1980, p. 97; Prilleltensky, 1990, p. 774), becoming another group psychology technique. The focus has been shifted from the individual to the family, thus widened, but the full social reality remains out of focus. The family is then seen, in Kovel's (1980) words, "as an end in itself rather than the plaything of larger societal forces" (p. 97).

Severe Dysfunction, the Family, and the National Alliance for the Mentally Ill (NAMI)

The family psychology perspective is anathema to proponents of the biogenetic causation of severe dysfunction such as "schizophrenia." Among such proponents the most vocal group is NAMI, an organization of relatives of psychiatric patients. NAMI has strong ties to NIMH and organized psychiatry and is an active player in mental health politics. NAMI militantly trumpets the notion that "schizophrenia" is a brain disease and considers biogenetic causation to be an established fact (Cohen and McCubbin, 1990, p. 474; McLean, 1990; Mosher and Burti, 1989, pp. 102–105). While NAMI lobbies for social support services, medication is defended as the primary treatment. The organization argues that the psychosocial perspective is so unscientific and guilt-producing that to hold it or disseminate it borders on professional irresponsibility.

The position of NAMI members is understandable. Moreover, it is deserving of sympathy, not simply because psychotic experience is usually painful or even horrific and so often guilt-producing for those who are close to it, but because the family psychology perspective does, in fact, produce surplus guilt. This perspective does amount to "family-bashing," because of its failure to provide a balanced view of social reality and the predicament of families. Such a need is especially critical in the case of psychosis, where behavior is perplexing and disturbing enough to invite biogenetic explanation.

Biogenetic reductionism may be an impediment to understanding, but a narrow focus on families represents another kind of mystification. A more balanced view would emphasize how difficult it is for families to protect themselves and their members from a destructive culture characterized by unrestrained competitive individualism and diminished communal structure and sentiment. In this culture, people who are more vulnerable or less competitive are in a precarious situation; if things go badly for them, it is both illogical and destructive to ascribe primary responsibility to their families, who are often relatively powerless to soften the impact of harsh reality. Families are faced with enormous challenges and responsibilities, but to acknowledge this is not the equivalent of saying that family responsibility is *primary* or *decisive* for the fate of any of its members. Again, such a position produces surplus guilt, even if the placing of blame is not the overt, moralistic variety.

A good example of the family-as-responsible position may be found in an exchange about the causes of "schizophrenia" that appeared in a magazine a few years ago. The exchange was between a therapist/writer (Bader, 1989, 1990) and a NAMI member (Zelnik, 1990). Bader made the case against the biomedical reductionist view in compelling fashion. He then went on to argue the family-as-responsible position, claiming that he was not placing any moral blame on families. He even took pains to acknowledge that external social factors and institutions can play a significant role in some instances. But he had nothing *substantial* to say about such "factors." The only institution that he discussed in any depth was the family, and he did so repeatedly, emphasizing the family's responsibility. Despite the writer's claim that his view was non-moralistic, the message was clear enough: the family is responsible for causing "schizophrenia." Such a position, which typifies the view of family therapy, leaves the family with the choice between two explanations: a defective family or a defective brain. Not surprisingly, the latter is usually chosen.

The Status of the Project of Criticism

We may return now to the dilemma described at the beginning of the article: the literature of criticism is compelling in its debunking of the medical model and its identification of the traditional supports of the mental health system, but it does not adequately address the reasons for the sustained power of this system. While there is little reason to expect critique to have much impact at this time, given the undiminished power of this system and its supports, there is still the problem of critique's limitation: its failure to consider the role of wider sociopolitical factors, both in the analysis of the system's sustained power and in the analysis of individual suffering. What is left unexamined by critique is the psychological perspective itself — the prevailing psychologism and its link with the ideology of individualism.

Thus, critique's primary focus on the medical model and biopsychiatry — and the clash with the contextualist paradigm — may be seen as limited. It tends to obscure the fact that the psychological perspective is the primary perspective of the mental health system, providing this system with stronger legitimation than the medical model provides. The latter, in its radically mechanistic, biomedical form, might even be considered as a variant — a crudely reductionistic one — within the overarching category of individual psychology. Moreover, the current prominence of the medical model may not, in fact, be enduring; it may turn out to have been only a *phase*. In contrast, it would appear that the psychological approach will endure. Consider the following scenario.

If there is another shift — back toward a more psychological and less medicalized conception of distress, it need *not* be accompanied by change in the fundamental nature of the mental health system. Social control does not require medicalization. The current system of psychiatric labeling is convenient but it is not a necessity. Nor is psychiatric hegemony among mental health professionals necessary for the functioning of the mental health system. Nonpsychiatric professionals are as good as psychiatrists (or at least no worse) at making judgments of "dangerousness to self or others" and "need for treatment." In the courts, professional psychology credentials can suffice for the all-too-cooperative court system — judges require very little for the rationalization of their massive deference to professional judgment in these matters (see Stefan, 1992). Nonpsychiatrists can manage asylums and clinics — they do this now. Drugs can be prescribed by psychiatrists who accept diminished status, and they are already prescribed by other physicians, nurse practitioners, and certain psychologists. In short, particular conceptual framework and professional hegemony are not decisive, as long as the system can function efficiently and economically.

Moreover, the growing amount of suffering that is accompanying the gradual disintegration of Western society is likely to *increase* the perceived need for mental health services, providing even stronger legitimation for the mental health system. The Western world is steadily deteriorating, producing even more conflict, violence, alienation, despair, and "psychopathology." Yet, with the help of the culture industries and psychology, all of this is mystified. The contextualist alternative contributes to the mystification, in this sense. It transcends the crude reductionism of the medical model, but it is still a part of the bigger problem of psychology, which both mystifies the wider reality and also plays a central role in legitimizing and sustaining the mental health system, including its overtly oppressive practices.

Psychology makes no substantial contribution to the creation of an emancipatory vision. Nevertheless, sound ideas for creation of a fully reformed mental health system have come forth from a few workers in this area.

Interim Measures: Proposals for Reform

A range of services. Even if there is no current prospect for an emancipatory movement, or even a well-developed guiding vision, it is still possible to struggle for the creation of services that speak to some of the basic needs of current "clients" of the mental health system. Such a vision of reform is described by Mosher and Burti (1989, pp. 91–183). The range of services would include: counseling and psychotherapy services; a variety of crisis centers and humane asylum locations (small and nonmedicalized); a full range of housing alternatives (independent and supported); rehabilitation programs; self-help programs; and supported work and transitional employment programs — not "sheltered workshops." (One issue skirted by Mosher and Burti is whether the whole range of mental health services belongs in the "health care" system at all; arguably, all of these services belong in the general human services sector.)

Work. This subject merits special attention, since its critical importance is not adequately addressed in reform proposals. A range of well-paid, flexible work opportunities is crucial for those who have difficulty working because of psychological problems — especially for who have been marginalized by the mental health system. (The need is, of course, a *universal* one.) The proposal is logical and reasonable enough, but it seems almost chimerical to even suggest such an idea, given the conditions in late capitalist society: permanent structural unemployment, underemployment, exploitative work, stupefying work, inflexible work arrangements, and fundamental hostility toward democratic organization of work. It is difficult to imagine how a serious demand for decent, flexible, well-paid work — for a significant number of people — might be formulated apart from the envisioning of genuine democratic socialist economic arrangements. Such a transformation is necessary, if there is to be any serious hope for the restoration of human community, a need which is universal, but especially critical for anyone who is more vulnerable. There may be no current prospect for transformation; still, it is important that radical proposals about work be included in the proposals or demands for serious reform of the mental health system.

The limitations of psychotherapy. Psychotherapy is a necessary activity, and one that will always be valued, whatever its forms and however they are named. Nevertheless, advocacy of psychotherapy, unaccompanied by sober acknowledgment of its limitations, serves to obscure sociopolitical reality. By now, the limitations of psychotherapy should be obvious enough: at best, it cannot contribute to any real change in the fundamental sources of misery (Albee, 1990). There is little explicit acknowledgment of this; one can only agree with Kovel's (1980) conclusion that "the ultimate impact of the mental health industry is to increase alienation and false consciousness . . . by the

content of what it conveys, namely the myth of individual psychology and cure in the midst of a diseased society" (p. 100).

Summary and Conclusion

The critical literature provides a compelling analysis of the medical model and the mental health system. What critique tends to overlook (or not understand), however, is the more pervasive role that the mental health system — and psychology, generally — plays in the mystification and repression of the wider sociopolitical dimensions of experience and mental distress. The culture of late capitalism — with its fragmentation and dissolution of community and general deterioration in the conditions of existence — plays a crucial role in the production of constricted existence, insecurity, and powerlessness, creating and aggravating individual and family suffering and disorder. The failure of critique to include this dimension contributes to the sustenance of reductionistic medical model versions of individual disorders, especially where they are more severe or perplexing.

Psychology's role in mystifying this wider social reality has been underestimated. Psychology, now ubiquitous, both reflects and reinforces the unrestrained individualism omnipresent in late capitalist society. Psychology is fetishized. (Its power is also sustained by the disciplinary fragmentation of the social sciences.) Psychologism effectively depoliticizes experience. Contextualism may transcend the crude reductionism of the medical model, but it does not transcend psychologism; it fails to politicize experience.

The contestation of the more oppressive practices of the mental health system is still the most urgent task for the project of criticism and activist contestation. (This urgency is highlighted by recognition of the limitations of the legal rights strategy.)[2] Given the immediacy of this task, the relevance of this article's focus on sociopolitical dimensions and psychologism may be called into question: clearly, psychiatric power is undiminished; in fact, biomedicalism is currently ascendant. But the argument in this article is that the legitimation of the medical model and psychiatric power (including its repressive social control functions) cannot be understood simply in reference to its traditional sources of support and legitimation. This legitimation is, in fact, more closely tied to the power of psychology, which is in turn linked to the philosophy of individualism and the culture that produces it. The mental health system draws additional strength from the mere existence of the growing misery accompanying the deterioration of Western society and late capitalism.

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[2]Substantial discussion of this situation is beyond the scope of this article. For a description of the situation by legal advocates, see Perlin (1992, 1993) and Stefan (1992). Some of the problems in this area include the well-documented pattern of deference of the courts to psychiatric expertise and the general failure of dedicated legal advocates to become educated and articulate about the critique of the mental health system.

The need for the critique of the medical model and the mental health system is undiminished, of course. This critique is even more compelling now. Still, it is limited in its explanatory power. This power can only be enhanced by the appropriation of a wider perspective.

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