Correspondence

EDITED BY TOM FAHY

Psychiatry and the politics of the underclass

Sir: Thomas *et al* (1996) ascribe "the death of community care" to the failure of psychiatry to meet the needs of service users. Although I share their concern about our adherence to the medical model, I believe historical and social factors have not only exposed its inadequacies but have also contributed to its persistence.

In the UK, our adherence to the medical model is the direct result of decisions taken by the Macmillan Committee in 1924 in the belief that a disease model would destigmatise patients by removing the charge that they were responsible for their plight, allow access to the "sick role" and a means of securing resources for mental health care. More recently, there has been an undue emphasis on the right of the individual to succeed or fail without collective responsibility for social adversity. In this context it does not seem surprising that psychiatrists have attempted to protect their patients from stigma and blame by an adherence to the medical model.

Psychiatry has found itself caught in a double bind as de-institutionalisation has inexorably proceeded. A redefinition of community mental health services should be possible in the future but only through a political and economic climate that encourages society to consider mental health as a public health issue and assume collective responsibility for disadvantaged members, allowing us to move on from the medical model.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**: 401–404.

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Sir: Thomas *et al* (1996) reiterate well-established arguments on political influence in psychiatry, and the devaluing of social factors and causation of illness through the pursuit of biological psychiatry. By providing us with few recommendations on how to alter our culture in their conclusions, they have unwittingly illustrated a core issue: that physicians have little sway with the forces of society and culture that may shape an illness' aetiology, diagnosis, treatment, course and prognosis. From the helplessness produced by this conflict, biological psychiatry can be seen as a secure base, and there is no shame in this approach.

In their conclusion, the argument becomes less clear when Thomas *et al* advocate clearer communication and understanding (i.e. treatment), at the expense of the diagnostic interview. The latter is of prime importance in establishing some order in the chaotic life of the patient. After this, ventilation, understanding, help with jobs and housing can begin, namely through the well-established disciplines of psychotherapy and social work.

It is correct that the argument about "our blind devotion to biology at the expense of all else" needs dusting off and reframing for the present political climate. However, their recommendation for social definitions of illness would lead us constantly to rework our models of illness, depending on the prevailing wind of politics and culture.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**: 401–404.

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Sir: I wonder whether I am the only psychiatrist who was disappointed with your October editorial by Thomas *et al* (1996). The authors draw conclusions that people who use mental health services are disillusioned. Do they mean everyone? This is not my overall experience but if it were true, even of some, could it be related to the kind of disillusion among mental health services staff that such negative articles risk engendering?

The authors also conclude that, "There is no sharing of languages, no common tongue with which to forge a genuine understanding". Concentrating on psychiatric rehabilitation, I take issue with this. Individuals affected by long-term mental illnesses may suffer a range of impairments, handicaps and disabilities. These are useful concepts, particularly the latter which can further be understood as primary, secondary and tertiary (Wing & Morris, 1981).

It seems to me to be the mental attitude to achieve positively for those disadvantaged by long-term mental illness in the community, rather than the language, which is lacking. Much can be done and is being done, for example by a wide range of intelligent, energetic, caring and committed staff such as those working in psychiatric hostels and day centres who have taught me a great deal about attitude.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**: 401–404.

Wing, J. K. & Morris, B. (1981) Clinical basis of rehabilitation. In *Handbook of Psychiatric Rehabilitation*. Oxford: Oxford University Press.

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Sir: We were pleased to read Thomas *et al*'s (1996) editorial. As child and adolescent psychiatrists, we have been forced to see the micro and macro social context of virtually all the problems presented to us. The trouble is that once general psychiatrists open their eyes to the social damage with which they have to deal, they will become politicised and possibly unable to continue working in the way in which we were all trained.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**: 401–404.

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Sir: Thomas *et al* (1996) have highlighted an issue which is fundamental to the practice of clinical psychiatry. I agree with them that

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