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Conflict and antagonism within global psychiatry: A discourse analysis of organisational responses to the UN reports on rights-based approaches in mental health

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Abstract

Between 2017 and 2020, the UN Special Rapporteur (SR) Dainius Puras published three reports that called for significant changes to organisation, funding and service provision in mental health care in ways that emphasise inclusive, rights-oriented, democratic and sustainable community health services. This article aims to examine formal organisational responses to the UN mental health reports and consider the underlying arguments that either support or delegitimise the SR stance on the need for a paradigmatic shift towards a human rights-based approach to mental health. By combining several different search strategies to identify organisational responses across the web, a total of 13 organisational responses were included in the analysis. Given the political nature of the responses, concepts from discourse theory were used to analyse the responses. The analysis showed how the responses articulated two binary positions and contesting articulations of good mental health care, which formed a backdrop for rejecting the SR reports in defence of psychiatry. The discussion elucidates how the responses tend to

resemble previous ways in which critique has been dealt with mainly by 'biological psychiatry', but that the counter-critical nature of the medical and psychiatric organisational responses remains in contrast to the broader reception within the UN community.

KEYWORDS
antagonism, discourse, mental health, organisational responses, rights-based approaches, UN

INTRODUCTION

In 2002, the UN Office of the High Commissioner on Human Rights (OHCHR) established a mandate for a Special Rapporteur (SR) on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In this context, an SR is an independent expert, serving in a personal capacity, rather than being directly employed by the UN (OHCHRa, nd). The mandate arose from a shared concern that the right to health, to be fully realised, required further development and oversight from the global human rights machinery.

The SR role is to 'gather, receive, request and exchange information' concerning the mandate, 'foster dialogue on possible cooperation with relevant actors', report on the realisation of the goals of the mandate across the world, and 'address specific cases of alleged violations' of rights within the mandate (OHCHRb, nd). Following two former mandate holders, Professor Dainius Puras, a medical doctor and psychiatrist from Vilnius University in Lithuania, was appointed a mandate holder for the period 2014–2020.

The SR's activities involved monitoring the highest attainable standard of physical and mental health across the globe, in particular, for vulnerable groups of people, undertaking country visits to gather firsthand information and engaging in dialogue with relevant actors at country and regional levels. The SR presents annual thematic reports to the General Assembly and the Human Rights Council (HRC), which is attended by country representatives (member states). Feedback is structured as 'interactive dialogues' where HRC member states consult with their own in-country stakeholders in advance to ensure that a wide range of views, comments and responses can be brought into the interactive dialogues between member states, international organisations and actors from civil society.

Given Puras' expertise in mental health and track record in human rights advocacy in mental health, the primary focus of the 2014–2020 mandate was on mental health. Following previous SR reports on torture and cruelty, inhuman or degrading treatment or punishment (Méndez, 2015), the 2014–2020 period saw a series of reports focusing on the development of further understanding of the right to mental health across a range of themes presented to the HRC by the SR. These reports documented the practice of mental health care in many regions worldwide, questioning the efficacy of the biomedical model as the primary framework in the field, the safety of psychotropic medicines, the influence of industry on research and practice and the significant overuse of coercion and routine violations of human rights ranging from the excessive use of force and restraint in some regions to forced or coercive use of medication in others.

In the face of global reports of problems in each of these areas, the SR reports called for significant changes to organisation, funding and service provision in mental health care in ways that

emphasise inclusive, human rights-oriented, democratic, socially just and sustainable community health services (Karlsson & Borg, 2022). Two reports in particular (A/HRC/35/21 in 2017 and A/HRC/44/48 in 2020) gained significant attention across several sectors in many countries. The reports were broad in scope, commenting on wide-ranging global problems and called for a global paradigm shift in mental health towards psychosocial approaches. To put this in context, within the same time period, the UN Committee on the Rights of Persons with Disabilities published a comment in 2014 on Equal Recognition before the Law and Guidelines on Right to Liberty in 2015 (Spivakovsky et al., 2020). These both raised similar concerns about global mental health care and were arguably more radical than the SR reports in that they called for more absolute reforms such as the abolition of capacity, detention and other practices that may violate human rights.

Broadly speaking, transcripts from HRC dialogues indicate that the SR reports were well received and that country representatives were generally supportive (see https://www.ohchr.org/en/hr-bodies/hrc/sessions). However, reception of the reports beyond the HRC dialogues in clinical and academic contexts was more mixed and pre-existing debates on rights-based approaches in mental health have backgrounded these reactions.

Prior literature reveals a range of critical discourses already in circulation before the UN reports concerning the application of rights-based approaches to mental health care and a number of ongoing debates around how best to deal with the persisting crisis in global mental health (Freeman et al., 2015; Morgan, 2015). It had been argued, for example, that researchers and other stakeholders concerned about rights were often ignored and that rights-based and recovery-oriented initiatives were commonly skewed or used as tokens by political–clinical actors and policymakers at regional and national levels to reproduce the traditional social order and hierarchies of mental health systems (Harper & Speed, 2014; Oute & Johansen, 2021). Similarly, it had been argued that clinical actors' commentary on advocacy for humanising mental health and supporting rights-based care had been silenced by way of routine or homogenous response strategies (Gøtzsche, 2015; Oute et al., 2020).

These prior critiques of structures and practices in mental health care meant that there was a highly receptive community of academics, practitioners and policymakers ready to endorse a strong call for reform of mental health care. The UN reports, published in 2017 and 2020, arrived into a pre-existing critical discourse concerning mental health practices and to a large extent were then incorporated into this discourse (e.g. Speed & McLaren, 2022; Sugiura et al., 2020). A recent global review, for example, pointed to a complex relationship between mental health and human rights in accordance with the UN Convention on the Rights of Persons with Disabilities and the WHO Quality Rights Initiative (Mahdanian et al., 2023). The review argued that while mental health service provision develops slowly in terms of ensuring rights, minimising rights violations and decreasing stigmatisation, abuse continues to flourish in global mental health settings. A key concern in the critical discourse, both prior to and following the UN reports, is the excessive use of coercive measures, involuntary psychiatric admission and rights violations in decision-making (Oute & Johansen, 2021; Rose, 2019). Poor communication and power imbalances among stakeholders are argued to hamper respect for users' rights, self-determination and preferences in global mental health (Sugiura et al., 2020).

Equally, there was a prior discourse defending psychiatric practices within which critics tended to be categorised as 'anti-psychiatry'. The UN reports generated familiar defences and antagonistic discourse with commentators classifying the reports and the SR as 'anti-psychiatric' (Dharmawardene & Menkes, 2018; McLaren, 2019a, 2019b; Menkes & Dharmawardene, 2019).

In turn, both prior to and following the UN reports, critics of psychiatry have sought to theorise or classify arguments, which defend psychiatry, creating a further level of antagonism in

the field. For example, arguments defending psychiatry have been cast as 'strategic ignorance' (ignoring contesting perspectives and social facts to preserve an authoritative and coherent knowledge base) (McGoey, 2012), as 'conceptual bullshitting' that encompasses the co-option of skewed meanings of humanising initiatives, such as recovery or stigma, to fit political purposes (Frankfurt, 2005), as 'circular argumentation' (tautology) (if you are not a psychiatrist, you cannot say anything meaningful about psychiatry), as 'martyr and the enemy' rhetoric (positioning critics as violators and psychiatric actors as casualties) and as 'ex-communication' (delegitimising, excluding, ridiculing, professionally and privately threatening and secluding professionals, academics, advocates and users who propose alternatives to psychiatry) (Cosgrove & Jureidini, 2019; Oute et al., 2020).

While these debates have been evident in published articles with individually named authors or are enacted by individuals in social media contexts, in this article, we focus on a particular set of responses to the UN reports, which were neither academic publications, nor individual comments, nor in-person responses via UN interactive dialogues. These were formal organisational responses to the UN reports addressed to either the UN or the SR directly. To be produced, these would require a form of organisational consultation and internal agreement but would not be subject to academic peer review. These organisational responses can be seen as a window into broader political orders of global mental health (Bacchi, 2009; Però et al., 2011; Shore & Wright, 1997). They were produced at a particular moment in the course of the antagonistic discourse on rights-based approaches to mental health care, triggered directly by the UN reports. Therefore, the responses represent a useful set of data, which can be used to examine global, value-laden outlooks (cultures), opinion and debate among political actors within the field of global mental health and to shed light on the impact the UN reports had in this evolving antagonistic discourse. Thus, this article aims to examine formal organisational responses to the UN mental health reports (2017 and 2020) and to consider the underlying arguments that either support or delegitimise the SR's stance on the need for a paradigmatic shift towards a human rights-based approach to mental health.

METHODS

In order to identify relevant organisational responses, a formal search strategy was developed which sought to identify any written responses from any public organisation or authority as well as country-level responses (e.g. government or ministerial). Included responses were examined using discourse analysis (Joergensen & Phillips, 2002; Torfing, 1999) to map, categorise and interpret the ways in which these written responses frame rights-based approaches and reveal the impact of the UN reports in the field.

Search strategy

Because of the nature of organisational responses, it was not possible to create a search using keywords, subject headings, controlled vocabulary or consistent citation norms. Furthermore, because UN reports all have the same name (using only an identifying code for documentation purposes), it was challenging to target the 2014–2020 mandate. Given that formal organisational responses were unlikely to be indexed in research databases but scattered across the web, literature databases, such as Web of Science and other academic databases, were not useful. Instead,

we combined several different search strategies, which enabled a broader search of the Internet and included a wide range of potential sites and sources where non-academic publications could be found.

As a point of departure, we included 11 organisational responses, which had been directly shared with the SR and were available on a dedicated legacy website for the 2014–2020 UN mandate (www.handover-dialogues.org/legacy/). To identify additional responses, we created Internet search strategies to use on standard Web search engines and within selected targeted websites.

Web browser searches employed the following terms: 'Dainius Puras'; Puras AND UN; response AND Puras; 'human rights' AND Puras; response AND UN AND 'human rights'; 'psychiatric association' or 'psychological association' AND rights. We then carried out broad searches of relevant organisation websites to look for content relating to 'rights' or which might point to or refer to other organisational responses, including:

- National psychiatric and psychological associations across multiple geographic regions (e.g. American Psychiatric Association, Royal College of Psychiatrists, Indian Psychiatric Society, Royal Australian and New Zealand College of Psychiatrists, Japanese Society of Psychiatry and Neurology)
- Universal Human Rights Index, comprising all country-specific observations and recommendations currently available from Treaty Bodies, Special Procedures and the Universal Periodic Review.
- Health and Human Rights Journal containing reports and statements linked directly to the OHCHR website.

Inclusion and exclusion criteria

Formal written responses to the UN reports from relevant organisations were included. Responses (and commentaries) from individually named authors were excluded (Cosgrove & Jureidini, 2019; Dharmawardene & Menkes, 2018; Menkes & Dharmawardene, 2019). Responses from organisations with very specific ideological or religious agendas (e.g. Scientology) were excluded as our focus was on professional and political organisations most relevant to practice and policy in the field. Responses were excluded if they were concerned with human rights more broadly speaking with no particular focus on the UN reports (Commissioner for Human Rights, 2021).

Although extensive, the search ultimately identified only two additional responses that had not already been shared directly with the SR. This may either indicate that the search was imprecise and not effective or that most organisational responses had been shared with UN officials because they specifically wanted the SR to respond or take on board their comments.

A total of 13 organisational responses were included in the analysis (see Table 1). One additional response (responding to specific points made in A/HRC/44/48 concerning the WHO list of essential medicines) shared directly with the SR by the WHO could not be accessed or included because it had been marked confidential.

The majority of responses were submitted by medical or psychiatric organisations, for example, the World Medical Association (WMA), the European Brain Council and the International College of Neuropsychopharmacology. However, one response (led by the British Psychological Society [BPS] and Mental Health Europe [MHE]) was submitted on behalf of over 50 organisations representing a range of fields, including psychology, psychotherapy and user-survivor

TABLE 1 Organisational responses included.

Available from Office of the High Commissioner on Human Rights legacy website www.handover-dialogues.org/legacy/	
2020	World Psychiatric Association and World Medical Association (WPA/WMA)
2017	World Psychiatric Association (WPA)
2017	The British Psychological Society (BPS) and Mental Health Europe (MHE)
2017	The German Association for Child and Adolescent Psychiatry (GACAP)
2017	The European Psychiatric Association (EPA)
2017	Society of Biological Psychiatry (SBP)
2017	The International College of Neuropsychopharmacology (CINP)
2017	The European College of Neuropsychopharmacology (ECNP)
2017	The Board of the European Brain Council (EBC)
2017	World Medical Association (WMA)
2017	American College of Neuropsychopharmacology (ACN)
Identified from Internet searches	
2020	Federation Global Initiative on Psychiatry (FGIP): www.gip-global.org/news/
2018	Canadian Minister of Health: www.canada.ca/en/public-health/news/2018/11/statement-from-the-minister-of-health-on-the-preliminary-findings-from-the-united-nations-special-rapporteur-on-the-right-to-health.html

organisations and charities. The latter represents the largest number of organisations overall. One response from the Canadian Ministry of Health is the only explicit government organisation response. The majority of in-country organisations represented are based in Europe, while there are also a number of global organisations, such as the World Psychiatric Association and the WMA. Most were published in 2017 or 2018 following the first report, whereas two were published in 2020 following the later report.

While the included responses represent international perspectives, the search failed to identify responses from organisational stakeholders from many countries, including USA, Australia, New Zealand, China, Japan or the Nordic Region. There was an absence of response from significant stakeholders such as the American Psychiatric Association, notable for its absence in the discussion in the face of calls from human rights groups for them to make a response.

Analysis

All included responses were coded and categorised to systematically document themes, communicative patterns and articulations including how and why stakeholders endorsed or rejected

the UN position in their response. Coding was conducted by both authors, supported by Nvivo 12 software, and focused on how the organisations responded to the UN reports and how they emphasise key features or the challenges of mental health care. Second, discourse analysis was applied to reveal how organisations' value-laden outlooks on mental health and practitioners' role in the field constitute the rejection (or endorsement) of calls for rights-based approaches and how they legitimise certain responses.

Discourse can broadly be defined as 'a particular way of talking about and understanding the world (or an aspect of the world)' (Joergensen & Phillips, 2002). Common methods of discourse analysis tend to start from the position that discourse does not neutrally reflect our world, identities and social relations but, rather, plays an active role in creating and changing them (Joergensen & Phillips, 2002). Discourse analysis can refer to a range of different analytical approaches, such as discursive psychology that analyses agents' use of interpretive repertoires; Foucault-inspired genealogies of the historical contingency of truth claims (Joergensen & Phillips, 2002); or discourse theoretical analyses of hegemony, antagonisms and positions (Laclau & Mouffe, 2001; Torfing, 1999).

Due to the political and conflictual nature of the responses, we used key concepts from discourse theory (Joergensen & Phillips, 2002; Torfing, 1999) for the interpretation of data. Here, the notion of articulations is used as an inclusive term for discourse but analysis also includes concepts, such as nodal points and elements (signifiers in the discourse), binaries (contrasting signifiers) and chains of equivalence (equivalent signifiers) in articulation of subject positions (formation of group identity), antagonism and hegemony (Laclau & Mouffe, 2001). We used these concepts to consider the overarching discursive patterns in the variety of responses to the reports.

FINDINGS

The coding revealed two overarching themes: 'Binary positions and contesting articulations of good mental health care' and 'Rejecting the UN reports in defence of Psychiatry'. Within these were subthemes that are presented as 'givens', facts or truths, which are upheld within the discourse employed by the respective organisations. The majority of stakeholder responses from medical and psychiatric organisations rejected and heavily criticised the SR position. In contrast, the BPS/MHE response firmly endorsed and aligned with the SR's reports. The Federation Global Initiative on Psychiatry (FGIP) response presented a more nuanced position. Ultimately, the analysis that follows is focused on the responses that present opposition to the UN reports because the two exceptions (BPS/MHE and the Canadian Minister of Health) fairly straightforwardly repeated recommendations set out in the report and provided endorsements, agreement or praise in their response without further elaboration. Therefore, the analysis is also by default focused on responses from medical or psychiatric organisations.

Binary positions and contesting articulations of good mental health care

The analysis that follows presents a number of 'psychiatric givens' evident in the discourse and how they constitute articulations of conflicting approaches to mental health care. These are that 'psychiatric stakeholders have authority', 'the SR is unscientific and dangerous', 'abandoning

biomedicine and long-term psychiatric care would be harmful', 'Psychiatry is scientific and ethical', 'psychiatry is a branch of medicine', 'psychiatric science always advances', 'Critiques of the biomedical paradigm are wrong' and 'psychiatric pluralism is common sense'.

Psychiatric stakeholders have authority

Responses tended to use homogenous rhetoric to ensure that the reader understands the authority from which the response is made. This appears to set the scene in terms of why the reader should keep reading and not ignore the response.

For example, by arguing that '*The EPA represents over 80,000 psychiatrists and 42 National Psychiatric Associations*', it is noted that the organisation responding represents large numbers of psychiatrists across the world that collectively have knowledge, power and authority and should be listened to and consulted with. Similarly,

> The EBC...represents a vast network of patients, doctors and scientists, and these stakeholders make it eminently suited to work in close partnership with the European Parliament and Commission, national governments as well as other international organizations [and] policy making bodies.
>
> (EBC)

By claiming to represent true authority and collective positions, this rhetorically works as a focal point to depict the SR as making unscientific claims without authority. The representation of this unscientificness is argued to be located in the individual SR rather than the UN as an organisation. In this line of thought, most responses were explicitly addressed in a formal letter style either to Puras directly, either as 'Mr Puras' or as 'Dr Puras' (in one instance) but never as 'Professor Puras', or to someone more senior within the UN such as the UN High Commissioner for Human Rights or the President of the HRC who appoints UN special procedure mandates.

The SR is unscientific and dangerous

As opposed to psychiatric organisations, the SR is portrayed as holding individual biases and accused of unscientific practices, such as failing to cite evidence properly, 'not making sense', being ambiguous, failing to adequately define terms and being political or ideological. The responses tend to either contest the examples given in the reports or emphasise concerns about the SR's unscientificness by questioning the lack of scientific rigour and truthfulness in the reports.

The responses offered several examples of the proclaimed lack of adequate citation and reasoning, thus presenting the SR as ambiguous, misguided or even pathological:

> ...lack of a consistent view leaves the reader baffled, and reinforces the sense that statements are made for inflammatory rhetorical effect, with no systematic or disciplined link to the scientific evidence.
>
> (ECNP)

Often this was done by articulating that the reports suffer from unscientificness. In this sense, the responses repeatedly questioned the SR's concerns about the scientific basis and validity of

diagnostic manuals, overuse and overprescription of psychotropic medications, the benefits of long-term in-patient treatment and institutionalisation, treatment cultures concerning coercion, medicalisation, right-based approaches and the biomedical model.

> Note that what is said to be at issue here is usually characterized in the Report as "medicalization," but at times referred to "over-medicalization," "pernicious forms of medicalization," "mass medicalization," "excessive medicalization," and "coercive medicalization," suggesting confusion regarding the precise basis for the issue. We regret that nowhere is a clear definition offered of what constitutes "medicalization" or the associated "biomedical model," which is also disparaged, or of the variants of medicalization noted in the Report.
>
> (WPA/WMA)

Abandoning biomedicine and long-term psychiatric care would be harmful

The contestation of the value of the reports' recommendations and calls to reduce reliance on biomedicine and long-term mental health care are systematically questioned in the majority of the responses. This is done by claiming that the reports do not rely on proper science underpinning psychiatry, which holds the legitimate mandate to advance the true understanding of and means to safeguard patients, remedy mental illness, reduce risks to self and others and avoid harm in contemporary society.

> ...pharmacological treatments have been shown to reduce the risk for suicide and self-harm in the mentally unwell as well as lessening the likelihood of homicidal acts.
>
> (CINP)

In contrast, it is argued that efficacy of long-term care has been significantly reduced as a result of the availability of medicines—it is rarely used and only in extreme circumstances and so biomedicine should be lauded not criticised for preventing more harm. It is frequently claimed that there are no alternatives to long-term care (including utility of coercive measures), so it would be harmful to abandon these.

> These statements... taken on their face, would significantly–and recklessly–limit the treatment options available to patients and considerably increase the sum total of patient suffering.
>
> (ECNP)

By dismissing the reports for not adequately providing citations for statements, there are implicit accusations that the SR is himself unscientific, and his recommendations are potentially harmful or dangerous.

> ...the reader is forced to conclude the Special Rapporteur's intention is polemic rather than evidence-driven analysis.
>
> (ECNP)

In this manner, the SR is depicted as an unethical and dangerous enemy who does not understand science but is driven by ideology and has personal motivations. The rhetoric effectively stages a large influential group against a lone individual with little or no real authority.

> We fear that the personal views of the Special Rapporteur, which are not reflective of the vast majority of his colleagues in the mental health professions nor of the extensive body of data that has been collected about the efficacy of psychiatric treatments hold the potential for causing substantial harm.
>
> (WPA/WMA)

In contrast to the representation of stakeholders' collective scientific authority, the portrayal the SR as being unscientific and dangerous contests the reports' credibility with anti-scientific terms, such as 'unscientific', someone who 'does not define terms', someone who 'does not cite evidence', 'is not credible', is 'truculent' and 'politicised'. This representation of the SR's stance as the antithesis of psychiatry rhetorically sets up the stakeholders as being the opposite: scientific, ethical and politically neutral.

Psychiatry is scientific and ethical

The rhetorical function of the articulated binary is to pit the authority belonging to the discipline of psychiatry against one rogue individual (rather than a large influential global organisation with equal scientific credentials).

> The mission of the society is....to disseminate the highest quality knowledge regarding the scientific basis of psychiatry.
>
> (SOBP)

This position is articulated by presenting psychiatry as a discipline that is inherently scientific and applies scientific practices. Therefore, these organisations have the authority to make particularly truthful and evidence-based claims by referring to the existence of peer-reviewed evidence and scientific literature.

In spite of accusing the SR of being unscientific and dangerous, the responses paradoxically reflect a position where the responses do not demonstrate these practices either, since they are from the authoritative, scientific discipline of psychiatry while the accused SR is presented as a rogue individual who must prove himself to be scientific. The organisational responses are articulated as representing facts that should be taken at face value. In other words, responses accuse the SR of not citing research adequately while at the same time making scientific claims in the form of 'evidence demonstrates' or 'robustly demonstrated' without providing citations.

> It has been robustly demonstrated that the introduction of antipsychotic, mood stabilizing, and anti-anxiety medications in the 1960s enabled many people with chronic mental illness to leave the asylums and, for the first time [no citations].
>
> (CINP)

> Treatment with psychotropic medications is presented as useless if not harmful, ignoring the bulk of evidence on its effectiveness [no citations].
>
> (EPA)

Psychiatry is a branch of medicine

Similar to drawing on the authority of scientific position, there are instances across responses where it is emphasised that psychiatry is without questioning a recognised branch of medicine. This is achieved in part by reference to the WHO's recognition of psychiatric diagnoses in the International Classification of Diseases and in part by drawing natural parallels with medical practices, such as prognosis and treatment, in order that psychiatric practices are assumed to be exactly equivalent rather than analogous to these practices.

> ...there is an astonishing stability in the key features and symptoms, so that diagnoses are at least comparable to other medical disciplines in terms of the prognostic stability.
>
> (GACAP)

In aligning psychiatry to medicine, it is then possible to portray any criticism by the SR of these practices as being critical of medical practice and as a denial of the validity of recognised approaches in medicine. Aligning psychiatry with medicine by articulating that such scientific equivalence is given enables the overall response to carry further authoritative weight and discredit the SR.

Psychiatric science always advances

The portrayal of psychiatry as proper medical science, in direct contrast to the unscientific SR, is often presented alongside assertions that science is naturally progressive and enlightening. With progress of time and more scientific research, it is given that many more problems will eventually be solved.

> Advances in neuroscience are occurring at a remarkable pace. Fundamental new insights into the causes, mechanisms, and treatments for mental illness are emerging... there is a continued need to study brain mechanisms underlying mental illness as the understanding this brings to our understanding of the causes of such disorders will bring even more effective treatments.
>
> (CINP)

Thus, the articulations naturalise the idea that more brain research will eventually find solutions to all mental illnesses, putting an end to the crisis of mental health.

> The vision of SOBP is to advance understanding, investigation, and treatment of psychiatric disorders until they are eliminated as a cause of human suffering.
>
> (SOBP)

Since psychiatry is presented as an undeniably scientific and medical discipline, psychiatry is therefore also a force for good; psychiatry should be granted more resources to carry out more (predominantly) brain research in order to advance mental health care and reduce the burden of mental health across the world.

> Why doesn't this Report call for greater investment in biomedical approaches to mental illness and psychiatric training? [...] moving forward, there is a continued

> need to study brain mechanisms underlying mental illness as the understanding this brings to our understanding of the causes of such disorders will bring even more effective treatments.
>
> (CINP)

Rhetorically, it is given within the responses that certain types of scientific inquiry within disciplinary boundaries of psychiatric research, such as brain-, pharmacological and neuro-cognitive research, are most vital and will inevitably lead to scientific advances. The articulation of this position implicitly downgrades other forms of research, including social studies in mental health, user-led experiential research, critical evidence research and clinical evidence.

At the same time, these articulations limit the meaningfulness of discussing key scientific issues, such as a growing concern around financial conflicts of interest in pharmacological research. This delineation often emerges more subtly. Where evidence is cited, these are highly selective, stated as fact, ignoring conflicts of interest among authors and leaving out or failing to engage with any counter evidence or critique of the cited material. For example, the following is given with a citation:

> ...an important recent meta-analysis has shown that the efficacy of psychiatric medicines is entirely comparable to those of other diseases [citation given]. To call the effectiveness of these treatments a "myth" (para. 19) is simply wrong.
>
> (ECNP)

However, the citation is to a publication, which contains the following declaration of interest by authors:

> In the past 3 years S.L. has received fees for consulting and/or lectures from the following companies: Bristol-Myers Squibb, Actelion, Sanofi-Aventis, Eli Lilly, Essex Pharma, AstraZeneca, MedAvante, Alkermes, Janssen/Johnson & Johnson, Lundbeck Institute and Pfizer, and grant support from Eli Lilly. W.K. has received fees for consulting and/or lectures from Janssen-Cilag, Sanofi-Aventis, Johnson & Johnson, Pfizer, Bristol-Myers Squibb, AstraZeneca, Lundbeck, Novartis and Eli Lilly. All authors work in psychiatry.
>
> (Leucht et al., 2012)

Critiques of the biomedical paradigm are wrong

The delineation of social studies, user research and critical studies includes rejections of the critique of the medical paradigm, the biomedical model, reductionism and medicalisation.

> the main obstacle repetitively and obsessively mentioned in the report is the "biomedical model" of psychiatry. It remains unclear on what basis this restricted view is formulated. Moreover, citations of the scientific literature are largely biased in the direction of purely ideological perspectives, again with no scientific evidence.
>
> (EBC)

Similarly, the concept of medicalisation was roundly dismissed. As illustrated by WMA (see above), these articulations tend to deny the existence of any detrimental effects of medicine or

other psychiatric interventions. These interventions (traditional in-patient treatment, coercive measures and psychotropic medicines) are instead presented as treatments that should be celebrated as significant scientific advances for humanity. These articulations include the assumption that medicines have improved individual autonomy through the closure of asylums.

> It has been robustly demonstrated that the introduction of antipsychotic, mood stabilizing, and anti-anxiety medications in the 1960s enabled many people with chronic mental illness to leave the asylums and, for the first time...
>
> (CINP)

Psychotropic medicines are presented as vehicles to promote human rights to good health, not vice versa as suggested by the SR. This inversion of the SR's discourse depicts medicines as the most effective treatment overall, reducing suicide, self-harm and homicide. These statements are frequently made without citing evidence as they are self-evident facts.

> We would like to emphasize the important role of pharmacological treatment, whose efficacy is widely proven by large evidence-based data [no citation].
>
> (WMA)

In spite of arguing a strong antithesis to the contents of the UN reports, organisational responses also at times claim that they are in fact in agreement with UN's recommendation to ensure '*the highest attainable standard*' of health:

> the WPA and the WMA share most of the goals reflected in the Reports of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> (WMA)

Hence, the biomedical model and standard forms of medical treatment are presented as the only meaningful way forward to address this goal, invalidating nearly all of the other claims made in the UN reports.

Psychiatric pluralism is a common sense

Finally, a common thread within the organisational responses concerned the natural truth that pluralism is a common sense position in psychiatry.

> The Special Rapporteur seems unaware that most of the hard-fought improvements in psychiatric treatment standards have come from within the mental health care profession, or that the "biomedical model" that he repeatedly denigrates as "narrow" and "reductionist" has been long since superseded by new approaches, which are energetically exploring the linkages between genes, environment, lifestyle, experience and human biology, and their application in new and better treatments.
>
> (ECNP)

Acknowledging that there are some differences within the psychiatric family, several responses imply that pluralism of thought and approach is the natural position and modus operandi for psychiatry as a whole.

> Biological, psychological and sociological approaches are, of course, complementary, and biomedical hypotheses do not, at all, contribute to coercion or abuse.
>
> (EBC)

Without considering any underlying epistemological and ethical issues pertaining to psychiatric diagnoses and treatment, pluralism is framed as an inclusive, open, broad church stance and an appropriate framework from which to advance the treatment of mental illnesses.

Rejecting the SR reports in defence of psychiatry

This second overarching theme presents the articulated reasons for rejecting the UN reports—all of which are logically underpinned by the above psychiatric givens. These reasons are that 'the report damages patient trust in psychiatrists', 'the report is offensive and unfair' and 'failures in mental healthcare are located in society, governments and patients'.

The report damages patient trust in psychiatrists

The key argument articulated most commonly is that the report itself is harmful and dangerous.

> Misinformed generalisations serve not only to harm patient care, but to undermine mental healthcare professionals.
>
> (ECNP)

This includes that criticising psychiatry and psychiatrists will damage doctor–patient relationships and will therefore ultimately harm patients.

> It undermines the therapeutic alliance between psychiatrists, users and relatives by casting doubts on the image of psychiatry.
>
> (EPA)

This implies that psychiatric treatment only works well if patients trust the psychiatrist and/or the system. However, the responses tend not to flesh out why the doctor–patient relationship is so important to ensure that the medicines work.

The report is offensive and unfair

Across the stakeholder responses, it is frequently signalled that the UN report has been received as 'offensive', 'unfair', insulting and 'slanderous' towards psychiatrists.

> This assumption [that Psychiatry is reductionist, enslaved to industry and guilty of human rights violations] is absolutely slanderous as it attacks an entire professional community without distinction and–what is more-is absolutely not evidence-based.
>
> (EBC)

Psychiatry is portrayed as a profession doing a great deal of good in the world, using science to inform practice where the intention is to help and combat illness.

> The Special Rapporteur seems unaware that most of the hard-fought improvements in psychiatric treatment standards have come from within the mental health care profession.
>
> (ECNP)

Psychiatrists are presented as modern, scientific, dedicated professionals deserving of respect and admiration. It is also noted that it is not truthful or fair to suggest that psychiatrists are corrupt or dangerous or that they collude with industry. Responses articulate that psychiatric stakeholders and their practices have been portrayed unfairly and misunderstood.

Failures in mental health care are located in society, governments and patients

Ultimately, many responses indicate that psychiatry and its basic model are not the real problem. Following the homogenous logic across most of the organisational responses that psychiatry has been unfairly attacked, blame for the persisting crisis in mental health is located elsewhere. Responses argue that lack of funding is the real problem, while at the same time presenting psychiatry as being subject to stigmatisation and that unsatisfactory treatment outcomes are attributable to patients' low compliance or a lack of availability of treatments.

> The biomedical approach is regarded as a source of neglect, abuse and coercion and as the key factor explaining the current unsatisfactory status of mental health care, while neglecting the main issue, i.e. the still unmet need for parity of esteem between mental and physical health of citizens and the paucity of financial resources allocated to mental health care.
>
> (EPA)

It is argued that psychiatrists should not be criticised because the universal problem with mental health is the lack of investment by governments in mental health care and in proper regulation of the ill. Rather, mental health should be funded on par with medicine.

A related way in which blame for the persisting crisis is located elsewhere is in the idea that society (not psychiatry) is to blame for discrimination and stigmatisation. Discrimination is described as a cultural and social issue, which psychiatry fights against and is subject to. Although presented as a critique of the report, the argumentation pertaining to poor compliance and stigma to some extent shares conceptual resemblance with the SR reports, which calls for radical social change. In representing problems as being located in society and governments, responses rhetorically align their argumentation with the UN reports on the need for radical social change.

> Amelioration in societies in general of those determinants requires radical social and political change. Ensuring that people with psycho-social disabilities have access to available social "goods" on an equal basis with others would represent a reasonable and potentially attainable first step.
>
> (FGIP)

Criticism of society includes the unjust stigmatisation of psychiatrists by patients, citizens and governments and the unfair depiction of the biomedical model as coercive.

> To have their efforts so carelessly disparaged, and stigmatised as a "culture of coercion, isolation and excessive medicalization" (para. 88)–by no less than the Human Rights Council of the United Nations–is a grave injustice, and one that cannot be allowed to stand.
>
> (ECNP)

In summary, responses from psychiatric organisations systematically articulate a homogenous rejection of the UN reports, rather than endorsing them.

> We strongly believe that the UN report is harmful to our missions and to all patients who suffer from the burden of mental disorders [...], we represent together the national and international professional communities here in the US and abroad. We welcome any opportunity to assist further in this communication to oppose the inaccurate and misleading UN report.
>
> (CINP)

Taken together, the body of discourse in these responses conveys the impression that the UN reports could be harmful and that psychiatric organisations have been unfairly treated and must jointly and uniformly reject the recommendations presented in the reports. Furthermore, the way this rejection is constructed constitutes a counter-critique, which accuses the SR (and thus in part the UN) of violating psychiatry, psychiatrists, harming patients, in effect co-opting the concepts of rights-based mental health to demand protection for psychiatry from abuse.

DISCUSSION

Our analysis found that responses from medical and psychiatric organisations (constituting the majority of the responses) were largely or wholly critical and deployed a relatively homogenous discourse reflecting a number of firmly held assumptions underpinned by the depiction of a binary relationship between the SR and themselves. The medical and psychiatric organisations' use of discourse articulated several incontestable facts or truths about the nature of the psychiatry, psychiatrists and psychiatric practice on one hand and the UN position on the other. In turn, these assumptions created a foundation for the subsequent opposition to the reports on the grounds that the reports were attacking, distorting or were out of sync with these fundamental truths. Articulations of the antagonistic relationship between these organisations and the SR were portrayed as a backdrop for rejecting the UN reports, deflecting any criticism in them and legitimising their own takes on how best to conceive of and deal with the persisting global challenges in mental health. Hence, the counter-criticism was articulated as a necessary defence of psychiatry and the biomedical model, which are depicted as being under attack from the UN. These binary positions are represented in a way that deflects criticism of contemporary mental health care and actively utilises the representation of a sublime, authoritative medical or psychiatric professional organisation to articulate a complementary approach to dealing with the persisting mental health crisis.

Provocation, disruption or continuation of discursive tensions in global mental health

As noted previously, the SR reports arrived into an existing antagonistic discourse across the mental health field, and in part, our aim was to consider the impact, if any, that the reports had

on this. Earlier we noted a number of routine or homogenous strategies responding to critics of psychiatry and these appear to have some resemblance with our findings, suggesting the UN reports may have provoked responses, which draw on all of these strategies in order to roundly and forcefully defend psychiatry in general. The represented binary, for example, echoes the 'martyr and the enemy' rhetoric and 'ex-communication' strategies, given the SR is rhetorically positioned as a rogue anti-psychiatrist, violating professional norms and victimising psychiatry at large.

With 'biological psychiatry' seen to be dominating American and subsequently global psychiatry, critical perspectives have tended to be dealt with as antagonistic rather than legitimate critique (Rose, 2019). The term 'anti-psychiatry' has sometimes been used as a form of insult, although it is also claimed that the term has been used to signify a philosophical position, misguided activism or biased hostility towards psychiatry, among other uses (Aftab, 2023). Double (2019) notes that 'the term anti-psychiatry has generally been used within mainstream psychiatry in response to criticism which it does not accept'. Hence, this division at the heart of psychiatry, its very identity in modern times, has been present since the medical model first became dominant in psychiatry and for at least the last 50 years.

It is therefore evident that the medical and psychiatric organisation responses analysed fit within this antagonistic discourse at the heart of modern psychiatry. Moreover, the mental health field, compared to 50 years ago, now encompasses many more non-medical professionals and user organisations with increasingly legitimate claims to authority in the field. The position of these other groups (including psychologists, psychotherapists, user or survivor organisations) uniting in support of the UN report and therefore in opposition to psychiatry is relevant in that it stems from an existing oppositional discourse within non-psychiatric disciplines, which are traditionally critical of psychiatry (sometimes referred to or referring to themselves as anti-psychiatry) and the medical model of mental health. In other words, the oppositional discourses seen in these responses reproduce existing antagonistic discourses already evident in the field of mental health, at least in Western contexts, both within psychiatry itself and within mental health professions and user organisations more broadly. However, the counter-critique—that psychiatry is in fact the victim—is arguably more prominent and forceful than in other contexts where the 'martyr and the enemy' rhetoric is employed, which may reflect a degree of provocation felt by these organisations and the fact that this particular criticism of psychiatry has been deployed by a major, respected international institution rather than a small or inferior group of individuals.

Our findings also reflect the concept of 'circular argumentation' described previously. The organisational responses claim a position of authority and truth underpinned by science such that any statements should be taken at face value. This is contrasted with a depiction of the SR lacking scientificness and authority. This circular argumentation depends on a rhetorical differentiation between psychiatric organisations as the true authority in contrast to the SR's illegitimate position, suggesting that the SR is unable to make meaningful claims about psychiatric practice and science.

There are also findings that might fit with the concept of 'strategic ignorance' mentioned previously as a strategy for dismissing critiques. For example, the responses included dismissal of the idea of medicalisation as this was an erroneous unheard-of concept. Although the concept of medicalisation has been oft debated (Busfield, 2017; Correia, 2017) and in spite of some variations across the responses (e.g. FGIP), the denial of any knowledge at all of the concepts appears to strategically ignore what is a fairly well-rehearsed challenge to psychopharmacology, psychiatric diagnosis and a range of other psychiatric practices and the well-described detrimental long-term effects of medicalisation for mental health service users and families (Speed et al., 2014).

Finally, we see some use of the 'conceptual bullshitting' strategy (Frankfurt, 2005), for example, in articulations of psychiatric pluralism and advocacy for the biopsychosocial model. In a

summary of 'critical psychiatry' perspectives, Double (2019) notes that given the emergent division within psychiatry, from the late 1970s, prominent psychiatrists, such as Anthony Clare and George Engel, attempted to unite the profession around a middle ground position represented by the 'biopsychosocial model'. Resonating with that, others have found this to be an inadequate recognition of the limits of the medical model (Read, 2005). Advocacy for the biopsychosocial model across the organisational responses without regard to its epistemological challenges and required changes to organisation and hierarchies in mental health appears to be an attempt to co-opt humanistic perspectives in mental health or skew the meaning of professional pluralism to sustain the hegemonic position dominated by biomedicine.

We therefore return to our previous point that the counter-critique seen in the organisational responses was particularly prominent, probably provoked by the strength of criticism from an authoritative, independent expert appointed by the United Nations. Here, we further propose that the biopsychosocial model is used discursively in these responses as a 'unifying trope' (a metaphor used rhetorically to represent the idea of psychiatry as a broad united church to dismiss the idea of conflict and antagonism). The biopsychosocial model, most often attributed to Engel (1977), has had various iterations and been subject to support and critique in various forms. It appears in this set of responses, less as a clearly defined theoretical position and more as a discursive trope or signifier of unity. In this context, in conjunction with pluralism, the trope appears to offer a mantra, which psychiatrists can all support in the face of existential threat from what may feel like a hugely influential global authority, the UN, attacking them. Therefore, if we consider the identified psychiatric givens as conflict tropes or unifying metaphors, they can be taken together as a rhetorical deflection of the threat and an imperative for the SR to withdraw the proclaimed threats. As noted in the analysis, this is then coupled with a set of discourses, which, taken together, provide justifications for why the SR's threat is misdirected and why psychiatry should not be the target of the attack, rather there are other legitimate targets for attack, such as governments, society, mental illness itself.

These forms of rhetorical manoeuvring may seem curious in that they contradict stakeholders' expressed wish to lead the development of good mental health practice with service user needs centred and evidence in the driving seat. Relative to more radical positions, such as calling for the abolition of detention and related practices, it could be argued that SR reports reflect a fairly middle-ground position in contemporary debates about the way out of the global mental health crisis. It may therefore be pertinent to question why the stakeholder responses analysed so firmly deflect the need for change in this instance. While the answers to this lie outside the data included in this analysis, it appears possible that the belligerent response reflects an intrinsic drive to retain professional hegemony in mental health (Karlsson & Borg, 2022) along with the perpetual struggle to be recognised as a true scientific discipline within Medicine (Szasz, 1974). The tendency to draw on narratives of provocation, claiming offence and slander on behalf of the whole profession along with a willingness to counter-attack the SR personally may resemble what Nietzsche called slave morality (Paley, 2002) in the sense that the antagonistic responses resemble that of an underprivileged branch of medicine seeking to antagonise, reject and invert the belief system and values of an international authority in mental health as represented by the SR.

Limitations

As noted, we found no responses from key psychiatric organisations, including the American Psychiatric Association and many other national psychiatric associations. As minutes from the HRC dialogues suggest that personal or in-person feedback tended to be more friendly towards

the reports than these formal organisational responses, it is also important to note that the submitted, homogenous organisational responses may not reflect the personal views of all individual psychiatrists nor monolithic views of entire organisations. Rather, it is likely that in order for a response to be that of an organisation rather than an individual, to bear the organisation's letterhead, to appear on the organisation's website, there would have been some sort of internal organisational process to decide and agree on the content. Organisations tend to have varying processes for this sort of activity, but often involve some sort of sign-off at a committee level, requiring more than one individual to agree to the contents. Those individuals would normally be acting in their role as organisational role holders and therefore having some degree of responsibility for furthering the aims of the organisation. With this in mind, we would argue that these responses may represent forms of political discourse in the sense that they are discursive acts operating in the interests of the status of biological psychiatry as a professional body rather than individually held opinions.

It is impossible to know certain organisations' reasons for not responding but reasons may include that they, unlike the predominantly biologically orientated organisations that responded, did not feel concerned or threatened by the SR reports; that they did not read them or were not aware of them; or that the reports stimulated internal debates within the organisation but which did not lead to enough consensus to result in any formal written responses. Hence, a limitation of our analysis is that it is restricted to responses from organisations, which had reached internal consensus, and excludes informal or evolving discussions ongoing within other organisations. To capture more informal, evolving responses would require a different methodology in future research, which would seek out informal responses, such as social media dialogs, society meeting transcripts on the topic or published academic papers by (groups of) individuals discussing the report (Dharmawardene & Menkes, 2018; McLaren, 2019b; Menkes & Dharmawardene, 2019).

Lack of formal organisational responses may also be a result of the reports not seeming relevant to some organisations or that the report was written in a formal bureaucratic language using UN jargon, which was comprehensible primarily to Western nations, meaning that some stakeholders and regions may have had less uptake of and discussion of the report. Therefore, our analysis cannot be taken to represent the entire profession of psychiatry across the world and represents only specific segments of psychiatry.

CONCLUSIONS

Antagonistic discourses in mental health were not produced by the SR reports, nor by the responses analysed, nor even by the UN decision to appoint an SR with a known track record of human rights advocacy in mental health practice. Rather, these contesting views of mental health care reflect larger communicative patterns in the field of mental health over the long term. Contesting discourses, also known as the broken dialogue, in the field of mental health could be traced back many centuries in terms of contrasting claims concerning how to understand the mind and how to manage the problem the insane are thought to pose society in shifting political economies (Bentall, 2009; Fee, 2000; Moncrieff, 2022).

The series of SR reports on mental health between 2014 and 2020 do however appear to have provoked the reproduction and intensification of a certain longstanding antagonistic discourse within the mental health field. The reports seem to have been received by medical and psychiatric organisations as a dangerous existential threat to psychiatry such that responses from a small group of medical and psychiatric organisations performed the function of outrage combined with

hostility, defensiveness and counter threats calling for unity with the psychiatric system, under the banner of the biopsychosocial model, against this dangerous threat from anti-psychiatry having captured the UN.

Nevertheless, this conflict-oriented response was not universally adopted beyond this small group of responses and we could also speculate that this initial response may not have had longevity. Nor did the direct requests to modify the recommendations have any impact. The HRC webpage on the right to mental health refers to the 2017 report as 'groundbreaking' and continues to broadly endorse the key observations and recommendations; the UN has not withdrawn or adjusted any of the reports (United Nations, 2023). The counter-critical nature of the medical and psychiatric organisational responses therefore remains in contrast to the broader reception within the UN community.

AUTHOR CONTRIBUTIONS

Jeppe Oute: Conceptualization (lead); data curation (lead); formal analysis (lead); funding acquisition (supporting); investigation (lead); project administration (equal); software (lead); validation (lead); writing - original draft (lead); writing—review & editing (lead). **Susan McPherson**: Conceptualization (equal); data curation (equal); formal analysis (equal); methodology (equal).

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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