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AND MENTAL HEALTH**



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democratic psychiatry, psychology,
and community development

Incorporating the
Newsletter of Psychology
Politics Resistance

the magazine for democratic psychiatry

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asylum magazine is a forum for free debate, open to anyone with an interest in psychiatry or mental health. We especially welcome contributions from service users or ex-users (or survivors), carers, and frontline psychiatric or mental health workers (anonymously, if you wish). The magazine is not-for-profit and run by a collective of unpaid volunteers. Asylum Collective is open to anyone who wants to help produce and develop the magazine, working in a spirit of equality. Please contact us if you want to help.

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**Guest Editors:
Lauren Wroe &
Jane Stratton**

EDITORIAL

'Such high levels of mental illness mean this issue can no longer be brushed under the carpet. Is there any issue which touches nearly everyone's lives yet is so ignored or misunderstood by politics and media?' This is the concluding statement of Michael Richmond's article submitted for this special issue of *Asylum*, in which we explore Anti-capitalism and Mental Health. We share his sentiment, and it has motivated us to bring together these authors and these ideas which we hope will contribute something to what should be a growing field of inquiry into the relationship between crises in economic, social and political life and our mental well-being and autonomy.

We were invited to guest edit this issue after meeting members of the *Asylum* team at their conference last year. We attended as students of psychology and medicine, as members of grass roots anti-capitalist groups, and as individuals who have experienced the pressures of activism and politics on our well-being and the well-being of our friends, comrades and colleagues. However, our interest isn't only in how being involved in anti-capitalist activism puts a strain on our mental health. Andi explores this in the article 'Against Superheroes and Martyrdom' and Elinor illustrates it beautifully in her cartoon on pages 12 and 13. More than this, though, is the impact of capitalism, as a specific form of economic and social relationship, on how we deem what it is to be mentally well or unwell, and consequently how those diagnosed mentally ill are treated. Several articles in this issue explore the particular ways in which capitalism forms and limits our understanding of mental well-being. Writing as activists, survivors, service users, academics and practitioners, they look towards alternative spaces and projects through which we can begin to practise more democratic approaches to our own mental well-being, as well as solidarity with those in crisis.

This was the dual interest of an article we wrote for *Shift Magazine*, 'Possessed or Dispossessed' (*Shift Magazine*, Issue 9). Here we asked of the anti-capitalist Left: 'Where is mental health on your agenda?' Mental health appears low

on the list of priorities of the anti-capitalist Left's activities. We won't be the first to say that there has been a surprising lull in Leftist activity in the face of the crisis, however challenges to health-care reforms have been one arena in which the Left is currently fairly vocal. Why then is the capitalist ideology that underpins the hugely oppressive institution of the psychiatric and mental health services still mostly unchallenged?

We brought these questions to a workshop at the OKasional Cafe in Manchester, a squatted social centre that aims to bring people together to explore radical ideas and alternatives. There was a huge interest in the workshop, titled 'Are we OK?' Discussions ranged from the pressures of activism on our personal and social lives (and a realisation that this is often taken for granted!) to what a re-thinking and re-structuring of mental health services might look like. Attended largely by activists involved in other social justice issues, and marginalised mental health practitioners (including members of the *Asylum* team), this time we were left asking, should 'anti-capitalism' be more of a focus for the movement toward democratic psychiatry?

In our call out we posed these questions, and were overwhelmed by the variety and conviction of the responses. From mental health practitioners who found Occupy, with its challenge to the 1%, an appropriate platform to begin discussions around tackling Big Pharma and the economising and marketising of mental health services, to the stories of those who work in the field, and the challenges they face and pose to mainstream services.

Of course, capitalism is a global system of oppression, and some of our authors have explored the impacts of poverty and climate change on mental health ('Decent Food', 'Climate Change'). Finally Nikki takes a look at those who find themselves at the borderlands of global inequality: crossing borders to seek refuge from the poverty or conflict imposed by the pursuit of capital overseas and the plundering of local resources and exploitation of trade. Some are only

... EDITORIAL continued overleaf

EDITORIAL continued...

seeking some of the very wealth which has been generated by this exploitation. Considering our debt to these countries, does the UK provide a safe haven, nourishing the mental health and well-being of those who migrate or seek asylum?

There is a lot covered in this issue, and at first glance the problems might appear overwhelming: Where do we start? What can I do? All the authors rally against the way capital tends to individualise and pathologise social, cultural and mental variety. Maybe one way forward is to find our communities, to begin to celebrate and tolerate their diversity, and to work together to form networks of support and resistance. With friends and comrades we have the strength to keep moving forward; with open minds we have the courage to question and to resist without the constraints of certainties, answers and 'cures'. As the Zapatistas say: 'Preguntando caminamos' Asking we walk. We'll keep advancing whatever the uncertainties.

Lauren and Jane

POLITICISING THE ANTI-PSYCHIATRY MOVEMENT

Emma Chorlton

I'm a mental health worker, a socialist, an activist, and a firm believer in opposing psychiatry and the medicalisation of emotional distress.

As discussed in Philip Hutchinson's article in the Winter 2011 issue of Asylum (Vol. 18, no. 4), I constantly question the role I play in current mental health services. I have found solace by discovering the anti-psychiatry network - meeting others in a similar position to me, and reading about their experiences.

However, throughout my contacts with the anti-psychiatry network, I have found that many of the critiques of the current mental health system do not pay adequate attention to the political and economic context of mental health theory and services. It is in the interests of the ruling class to medicalise emotional distress because of the enormous profits the pharmaceutical industry (and hence members of the ruling class) are able to make from medication which is supposed to 'fix' people. In my opinion, we will not remove

this source of profit from the pharmaceutical industries until we remove their power and control over society. It seems to me that the obvious conclusion is that to fight the medicalisation of emotional distress we have to fight capitalism. But I think that this idea is often missing from anti-psychiatry critiques.

The anti-psychiatry movement needs to become more politicised. One way it could do this is to show solidarity with campaigns that have goals consistent with the anti-psychiatry movement (for example, improving the lives of people who experience emotional distress). Examples might be opposing the proposed cuts to NHS pensions and services, and the privatisation of the NHS. As more cuts are made to NHS services, this is likely to lead to greater reliance on medication for mental health difficulties, since there will be less provision of psychological and social support. Clearly this will impact significantly upon the well-being of service users. If the Conservatives are able to implement cuts to pensions, this will pave the way for private companies to move health workers across from public sector positions to those within their private companies, allowing further privatisation of the NHS. If governments (whether Conservative or Labour) are successful in the privatisation of the NHS, and people are required to pay for more NHS services, regular users - such as those with mental health difficulties - will find that their economic and social circumstances will deteriorate as they spend more and more money on healthcare. This is currently very much the case where healthcare is privatised, for example, in the USA.

Therefore it is important, in any way they are able, for the anti-psychiatry movement to show solidarity with campaigns that oppose cuts to services and oppose the privatisation of the NHS. For example, by signing petitions, donating to strike funds and becoming involved with anti-cuts campaigns (e.g., Unite the Resistance).

At the same time, I also believe it is important that anti-capitalist groups should engage more with anti-psychiatry networks. We should link up existing groups supporting health worker activism with anti-capitalist networks, and show solidarity to each other with our campaigns.

You can support health worker activism by:
Visiting www.falseeconomy.org.uk/campaigns/item/health-workers-network

Joining the facebook group at www.facebook.com/groups/healthworkersnetwork

Joining a very active discussion list at www.unionlists.org.uk/lists/info/healthactivists

Emma Chorlton has worked in mental health for about six years. due to her anger about public services cuts and her desire to help resist them, she has become more politically active during the last eighteen months.

TOWARDS PSYCHOLOGICAL REVOLT AGAINST THE MACHINES OF SUBJECTION

Bertie Russell

To link 'anti-capitalism' to the issue of mental health is to suggest a direct link between the way capitalist relations organize our life-space and our psychological well-being. It is to imply that capitalism has negative implications for emotional and mental well-being, and so, in the name of improving our lives, coordinated forms 'anti-capitalist' action are necessary. This politicized understanding responds quite clearly to psychiatrist Thomas Szasz's demand that 'mental illnesses' be removed from the category of 'illness' and instead that those kinds of severe personal troubles be reconsidered as 'the expressions of man's struggle with the problem of how he should live'.

The question of 'how man should live' is evidently philosophical and political; it is an interrogation of the nature of freedom, of the construction of the individual, of the meaning of 'the social', and so on. The struggle over the meaning and practice of freedom, or of the individual, should not only be abstract, or the preserve of an intellectual elite. Instead, it goes to the heart of challenging and reorganising how we experience ourselves and our interactions with others.

Crucially, some of the main architects of the dominant contemporary mode of organising capital - such as Friedrich Hayek or Gary Becker - were arguably less economists than prolific philosophers. Indeed, between them and the other economist/philosophers who would later be known as 'neo-liberals', a new idea of what it meant to be 'human' was constructed. In other words, a new answer was proposed to the 'problem of how man should live', and from the late 1970s it came increasingly to underpin the governance of life. Infamously, Thatcher once pulled a copy of Hayek's *the constitution of liberty* from her handbag and announced: "This is what we believe!"

According to the neo-liberal account of conscious behaviour, 'man' operates according to a single form of rationality: that of cost-benefit analysis and the maximisation of returns. From this perspective, 'man' has always striven to process all aspects of life through this logic - from choosing groceries through to producing children - irrespective of whether or not a specific sphere of life is generally recognised as 'a market'. This neo-liberal account of Being - this discourse on rationality and what it means to be human - was recognised as homo oeconomicus by the philosopher-historian Michel Foucault.

Essential to the neo-liberal account of Being is the extension of the logic of 'returns' to every aspect of our lives. Consider the idea of 'work'; rather than

performing a task in return for 'wages', everyone is reconfigured as a sort of little capitalist, choosing to invest their time and effort - configured as 'human capital' - in anticipation of financial return. This account of Being - this way of processing decisions, of valuing oneself and one's relations to others - is considered to apply across every area of life, such that every 'rational' decision is undertaken according to the sole logic of 'increasing one's returns'. As Milton Friedman would argue in *capitalism and freedom*, 'the promotion of freedom' thus becomes possible through the marketization of an ever-increasing proportion of life, in the name of 'enhancing our ability to make accurate return-maximizing decisions'. As the inverse of this logic, the neo-liberal perspective defines as 'despotic' any form of state (or other) intervention that interferes with one's 'liberty' to perform according to this return-maximising rationale.

And so we may interpret the neo-liberal justification for the current acceleration of marketisation - on terrains ranging from the natural environment through to healthcare, housing and education - not as the cynical dispossession and transfer of our commonwealth into certain private hands (although this is arguably the core function), but as the attempt to increase our 'freedom' by submitting ever more of our everyday decision-making to the logic of competition.

For example, a significant outcome of the introduction of university fees in 1998 was to establish higher education as yet another part of life that one needs to 'weigh up' according to potential future returns. The perspective that a university degree 'isn't worth £9000 a year' is no less instructive of this rationale than the argument that 'a degree should only cost £4000 a year'. Either way, the argument is reduced to a question of whether or not a degree is 'a good investment'. The introduction of university fees is thus a perfect example of how neo-liberal rationality is induced: the 'rational' decision-maker must now abandon (or at least relegate) any intrinsic values ascribed to education in favour of assessing the 'investment potential' of any given degree course. In the process, we experience a transformation away from making passionate decisions - now deemed 'irrational' - and towards becoming cold and calculating machines.

To return to the question of capitalism and mental health, the problem we face is that this model of decision-making, grounded in a specific notion of what it means to be free, is psychologically destruc-

tive. As this sort of rationality expands into more and more spheres of life, at the same time we become increasingly anxious about every element of our lives. From our musical tastes and fashion sense through to our dietary decisions or emotional liaisons, we face a permanent existential crisis as our passionate decisions become entirely contingent on their compatibility with 'maximising returns'.

This argument goes beyond naming the psychological effects of 'alienation', in the classic Marxist sense; the divergence between the passionate and the calculating is not the sole issue at stake here. As everyday decision-making becomes increasingly stitched into the regime of capitalist accumulation, the heterogeneity of life becomes increasingly submitted to the rhythms of a single system of Value. This 'rhythm' of capital is inherently one of ever-increasing speed; and through the neo-liberal lens it is no longer only businesses that must be in competition, but more and more of the whole of life. Not only are we induced to act as if every aspect of our lives is subject to the laws of return, life is increasingly hardwired into an economic system that demands that we process it faster, such that we must become psychologically accustomed to a life which is increasingly ephemeral. Franco 'Bifo' Berardi is an autonomist Marxist theo-

rist who diagnoses this arrangement of capitalism, and the associated subjectivity which is induced. He argues that it produces an increasingly accelerated cycle of 'anxiety, panic and depression'.

We can now appreciate Mark Fisher's suggestion (in his book, *capitalist realism*) that we need 'a political movement which will take up where anti-psychiatry left off', as a rallying cry to reconsider the central importance of everyday mental health in the struggle against capitalism. This might begin by interpreting and building a discourse against 'austerity' as the latest stage in a calculated assault on our psychological well-being, as the continued imposition of a toxic and socially degenerative understanding of 'freedom'. Arguably, this will make us return to the question of the concept of 'freedom' itself, understanding that 'man's struggle with the problem of how he should live' is as urgent now as it has ever been.

Bertie Russell is a phd candidate at the University of Leeds. his thesis is focused on subjectivity, knowledge and power within radical climate movements. He is specifically concerned with promoting research which contributes to radical social transformation.

**BRIDGE BEYOND BELIEF:
Exeter, Friday 5th October 2012**

A free event, open to everyone

The Bridge Collective is a community-owned company in Exeter whose members are creating a democratic community where people who have experiences, beliefs, and feelings that have sometimes been labelled as mental illness are welcomed and can talk freely, safely and without judgement. It is somewhere to participate in friendship, support, learning, teaching, discussions, activities, and to make a valid contribution within both the collective and wider community.

A strong element in The Bridge is creative activity, including Underground Sound (music), a Women's Art Group, and the Greenwood Project (environmental arts and crafts and outdoor living).

The Bridge grew from roots in the Hearing Voices Network. Its predecessor, the Joan of Arc project, was closely associated with the publication of the first edition of Tamasin Knight's book *Beyond Belief*. (Now free and available in an expanded e-book edition from Peter Lehmann (www.peter-lehmann-publishing.com/). Tamasin facilitated the first Better Believe It



group at the Joan of Arc project, and that work was an important influence in the development of The Bridge.

This Autumn, The Bridge Collective and the Beyond Belief Network will be putting on an event to tell people more about the book, the collective, and the stories behind them. Included will be:

- A presentation about *Beyond Belief* and a chance to meet Tamasin Knight
- A chance to visit the Bridge Collective in action, hosted by Underground Sound.
- Displays of creative work done at The Bridge.
- Interactive activities, including 'Songs That Saved Our Lives', and a chance to do some green woodworking.
- A participatory workshop in which we will share what we've learnt from five years of building our own community company and offer some tools for you to think about how you could develop your own project.

Find out more at www.bridgecollective.org.uk/links.htm

To receive further information when available, please send your email address to: andrew.bridgecollective@hotmail.co.uk

NOT BROKEN PEOPLE MICHAEL RICHMOND

The writer Dan Hind recently commented in his pamphlet, *commonsense*, that many people with mental health problems who have taken part in occupation movements around the world in recent years have noticed an improvement in their condition. I myself joined the editorial team of *the occupied times of London* just as I was beginning to emerge from a long period of anxiety and depression which had suddenly halted every aspect of my life. The occupation camps were by no means a utopia, and Occupy doesn't have all the answers to the problems of humanity, but I have no doubt that the acceptance of difference and the willingness to listen and be listened to - which are hallmarks of the global Occupy movement - mean that I haven't been the only person with experience of mental illness (or, indeed, substance addiction or homelessness) who has felt the ameliorating effects of collective endeavour and political empowerment.

If there's one conclusion I've come to after five years of suffering from it, it is that mental illness doesn't happen in isolation. We know that one-in-four Britons will suffer from a mental disorder at some time or other. The World Health Organization even predicts that depression will be the second most widespread illness in the developed world by 2020.

But mental illness is not just a matter of statistics or distant 'others', far removed from regular human activity. It is all too human. It is dependent on how we order our own individual worlds and how we relate to other human beings. We evolved as a social species and it was largely thanks to our ability to co-operate, to share tasks in small, mobile, co-dependent groups, that we outlasted other early humans. In recent decades, political, economic and cultural shifts have made society far less community-minded and far more greedy, selfish and acquisitive. But this goes against our collective past. We are not built to go it alone.

Mental illness must not be just a burden for the individual sufferer or their family because it is reflective of our society. The social breakdown, inequalities of health and wealth, celebrity, consumerism and binge culture that we see all around us affects our mental health. These damaging phenomena are a monument to the unfettered market that has ruled our lives. The economic model that the establishment is desperately trying to prop up is premised on exploiting our worst instincts. The sole purpose of advertising is to harvest the feelings of inadequacy that we are all capable of experiencing or, failing that, to create brand new voids which, conveniently, can only be filled through the acquisition of the commodity they are peddling. The economist Tim Jackson best sums up this central plank of our society in his book, *prosperity without growth*: 'We are persuaded to spend money we don't have, on things we don't need, to create impressions that won't last, on people we don't care about.'

The policy of 'Care in the Community,' pursued for the last thirty years, does represent a more humane approach compared to the large Victorian asylums. Those imposing buildings were conceived of more as quarantines where the uncomfortable truth of 'madness', ever-present throughout human history, was sealed-off in an act of segregation. However, despite the recent move towards inclusiveness and a softening of the political language, the reality is still too often one of isolation, stigma and neglect, if not outright abuse. By accepting that sufferers of mental illness are a part of and

not apart from society, we must now accept that aspects of our society are contributing to the dire problems with mental health. It is also crucial that there is widespread acceptance that mental illness is something that can befall anyone, including CEOs of investment banks.

The pervasive neo-liberal mantra of 'private good, public bad' has ring-fenced large swathes of the economy as beyond regulation, but if the supreme aim of every country is to create an amenable business environment then the well-being of its citizens can never be anything more than an afterthought. Instead we're left with reactive government measures in health, crime, education and environmental policy. These become largely thankless struggles to clean up the mess wrought by an economic system that fosters inequality, promotes narcissism and propagates the notion that all human meaning resides in the relentless pursuit of material wealth. Too much of healthcare becomes 'fire-fighting', when much more of it should be about prevention and care.

I prefer the argument for helping people to lead healthy and meaningful lives, but even those with a solely economic view of humanity must deduce that it costs much more to deal with the effects of the problems than it would to begin to tackle them at root. Research by Kate Pickett and Richard Wilkinson for their book, *the spirit level*, reveals that more unequal societies do worse on a number of social indicators - including having much higher rates of mental illness. They write that mental illness is closely related to status anxiety, and so more unequal and callous countries, like ours, leave more people marginalised, more 'losers', and more problems for everyone.

Such high levels of mental illness mean this issue can no longer be brushed under the carpet. Is there any other issue which touches nearly everyone's lives yet is so ignored or misunderstood by politics and the media? The rates of mental illness demand that we re-examine our attitudes and language concerning the concept of 'madness'. Indeed, Mark Fisher, the author of *capitalist realism*, has called for the politicisation of the issue of mental illness to be one of the main rallying points of any new left movement. Occupy is teaching us all how interconnected our lives and our struggles are, and we're learning that the only way to fight the atomising force of neo-liberalism is through solidarity, collective action, mass civil disobedience and the reclamation of public space.

Dan Hind, *Common Sense: Occupation, Assembly and the Future of Liberty*. Kindle Edition: Myriad Editions/New Left Project, 2012.

Tim Jackson, *prosperity without growth? economics for a finite planet*. 2009.

Richard Wilkinson & Kate Pickett, *the spirit level*. Penguin, 2009.

Mark Fisher, *capitalist realism: is there no alternative?* Zero Books, 2009.

Michael Richmond had his first novel, *sisyphusa*, published last year. This is a dystopian allegory for his own experiences of mental illness, but also a polemic of contemporary politics, economics and society. It was praised by respected authors, and recently recommended by Deborah Orr in *the guardian*. Michael is also a member of the editorial team of *the occupied times of London*, the highly regarded newspaper that came out of the Occupy London movement.

RISE UP/ FIGHT BACK

Selected Writings of an Antipsychiatry
Activist by Don Weitz

The author has been a psychiatric survivor and activist for more than thirty-five years.

Organized as a mosaic of personal accounts, essays, and letters to the editor, this book is a devastating critique of psychiatry as a coercive, dehumanizing, stigmatizing system of social control which masquerades as 'medical science' and a 'mental health system'. Don Weitz asserts that these claims, including the diagnostic labels, are fraudulent.

Antipsychiatry is discussed as a political strategy which aims at total abolition. Psychiatry must be abolished because it is coercive, traumatic and frequently a form of torture; in all, it is fundamentally oppressive and disempowering. For millions of citizens world-wide, psychiatric treatment and institutionalization has been, and remains, a daily nightmare of psychiatric wards, lobotomizing drugs, brain-damaging shock treatment, threatening staff, all manner of other traumas, humiliations and permanent stigmatization.

Canadian psychiatric facilities, such as the notorious Centre for Addiction and Mental Health and the Oak Ridge/Penetanguishene Mental Health Centre (both at Toronto), are described as psychoprisons where many citizens are libeled and slandered with unscientific and stigmatizing diagnostic labels such as 'schizophrenic' and 'psychopath'; there they are locked up, intimidated, forcibly drugged, electro-shocked, experimented on, and physically restrained or thrown into solitary confinement ('seclusion').

The longest chapter is on electro-shock (electroconvulsive therapy, or ECT). It documents women and the elderly as the most vulnerable targets of this procedure: women are given electroshock two to three times more often than men. An empowering chronology of resistance against electroshock is provided as an appendix, together with an historic and inspiring Declaration of Principles and a Bibliography on Antipsychiatry.

The tone of this book is passionate - sometimes angry - but it is always informative and constructive. This is

particularly true of the final chapter, A Radical Vision, in which there is a discussion of several humane, survivor-controlled community alternatives.

In the early 1950s, Don Weitz survived 110 insulin shock treatments and fifteen months of incarceration in a Massachusetts mental hospital. With Dr Bonnie Burstow, he is co-editor of *Shrink Resistant: The Struggle Against Psychiatry in Canada*, co-founder of the Coalition Against Psychiatric Assault, and board member of Psychiatric Survivor Archives, Toronto. He has received awards for his human rights advocacy and social justice activism. See:

coalitionagainstoppsychiatricassault.wordpress.com
psychiatricsurvivorarchives.com

Don Weitz's new book is currently accessible as an e-book at:

iTunes (<http://goo.gl/ARzjB>)
Barnes and Noble online (<http://goo.gl/EEpMh>),
Amazon(<http://www.amazon.com/Rise-Fight-Back-Antipsychiatry-ebook/dp/B007EIBK0K>).

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IS 'MENTAL ILLNESS' A BARRIER TO GETTING INVOLVED?

Rose Stambe, David Fryer, Sahra Dauncey & Stephanie Hicks

Each of the authors of this article has been positioned as 'mentally ill', and experienced the consequences. Even though we hold diverse views on psychology and psychiatry, we are united in our dissatisfaction with how we, and people in general, are positioned as 'mentally ill', and have to survive in an Australian society which is, in many respects, violent towards those who are so stigmatised.

We deliberately place 'mental illness' in scare quotes, not to minimise the consequences of such a label but in order to challenge the assumed neutrality of such a term when used by a psychiatrist, or other related professionals, or within related frames of reference (see Butler & Scott, 1992). Indeed, in this article we challenge taken-for-granted ways of thinking, speaking and acting in relation to 'mental illness' more generally, and explore how claims of 'mental illness' function to silence, exclude and 'disappear' people who are talked about and treated as 'mentally ill'.

We face a challenge in this because we don't regard 'mental illness' as either mental or an illness, or even as real, in the everyday sense of 'real', i.e., as existing independently of how we think or talk about or act in relation to it. Instead of thinking in terms of something called 'mental illness', which may or may not exist, we think in terms of processes through which:

- statements about mental illness are given the status of being 'true';
- collections of interconnected statements about mental illness are given the status of 'knowledge';
- forms of surveillance are given the status of 'care';
- forms of assault are given the status of 'treatment';
- the speech and activities of some people is positioned as 'expertise', along with consequent authority to decide whether other people are to be compulsorily detained, have 'treatment' forced upon them, etc.

We are influenced by Michael Foucault (e.g. Foucault, 1997), a trans-disciplinary theorist whose work ranges over and is influential in psychology, sociology, history, philosophy and other disciplines, and also by his English follower, Nicholas Rose (e.g. Rose, 1999, vii). Rose writes about the "psy-complex". This can be thought of as the inter-connected knowledge claims, scientific literatures, diagnostic manuals, techniques, practices, procedures, policies and forms of authority which together make up psychological expertise in neo-liberal capitalist societies like ours, and which is produced by, and deployed not only through psychiatry but also through clinical, health, industrial, community and other psychologies, psychotherapy, counselling, mental health nursing, pop psychology, etc. A component of the psy-complex is any approach to the definition and solution of problems which is fundamentally reductive of whatever is key to the psychological states and processes of individuals.

Once mental illness has been constituted by an element of the psy complex, this becomes 'real', in so far as it has real effects. But it is the social construction which is real, not the mental illness which it has constructed. To give an example, until 1980 the widely used Diagnostic and Statistical Manual II positioned homosexuality as a mental disorder. This meant that the psy-complex was deployed in

relation to homosexuality. And this resulted in real consequences for diagnosed homosexuals, who were treated as if they suffered from a mental disorder. Of course, homosexuality was never a 'real' mental disorder, it was only treated as if it were. For us, this attribution of reality to a social construction applies to all the so-called 'mental disorders'. In this sense, 'mental illness' is not mental but social, not an illness but a manifestation of diversity, and not real except in so far as social policy mandates real consequences.

More than this, whilst the psy-disciplines present themselves within their own frames of reference as accurately describing and rationally explaining who we all are 'objectively', we believe that, for all intents and purposes, the 'psy-complex' actually constructs and regulates not only who and what we are but also who and what we could possibly be. This is achieved by the construction of the mutually exclusive categories of 'normal' and 'abnormal' behaviour; the psy-complex uses devices that are socially constructed as 'scientific' so as to measure, observe and assess people and allocate them to one or the other category (Rose, 1996); in this way, the authority of the psy-complex makes normality and abnormality 'real'. Psychology and the notion of 'mental illness' are central to the deep manufacture of specific, dominant, frames of reference that determine the apparent nature of reality: what an 'individual' is, what is 'normal', what is 'abnormal', how 'abnormality' should be 'treated', and so forth.

Crucially, we believe that whilst psychiatry and other psy-disciplines are positioned within their own rhetorics as biomedical/scientific, and therefore politically neutral, psychiatry and the psy-complex actually function to maintain and service a neo-liberal-capitalist status quo. They do this by repositioning what is collective as individual, what is material as psychological, what is political as value-free, what is contingent as necessary, and what is socially constructed as natural.

The function of the psy-complex seems clear enough. On the one hand, it seems clear that the construction of a reserve army of labour is necessary to make neoliberal capitalism function: this takes the form of mass unemployment, socially constructed as 'undesirable'. However, this reserve of labour ensures that the unemployed will compete keenly for jobs; it disciplines those already in employment; it controls inflation by driving down wage-costs; it reduces pressures for improved working conditions. On the other hand, by means of the psy-complex, unemployment is presented as the result of the dysfunctional psychology of individual unemployed people, and the solution is positioned as by means of cognitive behaviour therapy (CBT).

The 'individual' is constructed and legitimated as 'real' by means of the theories, practices, treatments and research of the psy-complex. This is done in such a way that it produces not only the possibility but the inevitability of 'being an individual'. At the same time it functions to blame the individual so constructed for what is socially constructed.

To examine this idea more closely, consider the title of this article. When we think of the barriers to getting

involved, from the standpoint of the psy-complex we tend to list the consequences of being labelled 'mentally ill': we feel powerless; have low-self-esteem; suffer the effects of medication; are exhausted from fighting discrimination, and so on. However, it seems to us that to view things the way the psy-complex views them is to deploy our own agency against ourselves - to govern ourselves on behalf of the status quo, to make ourselves compliant with the agenda of the neo-liberal regime, to re-construct ourselves as the sort of selves needed by 21st century neo-liberal capitalism. But, on the contrary, we refuse to internalise the psy-complex and its production of 'mental illness' as a disease inside us, as the problem or the barrier. Rather, the barriers are not inside us but in the social constructions of the psy-complex of 'individuals' and 'contexts', constructions which make it so hard to get involved in the progressive promotion of one's own interests, since one is excluded, silenced and 'disappeared'.

We came up against such barriers when we tried to conduct our own research. We wanted to use participatory action research to explore the experience of being a patient at the Rozelle Psychiatric Hospital. We used a method called Photovoice (see Lykes, 1997) which is supposed to involve participants as co-researchers: by taking photos, telling stories, analysing text, group-writing conclusions, publishing, and so forth. Unfortunately, the high emphasis on knowledge as a commodity in academia ensured that whilst people with 'mental illness' were permitted to assist in participant recruitment and the initial project development, they were excluded from interviewing, analysis, writing and receiving recognition as co-researchers, due to the university's concerns about the rights to, and ownership of, intellectual work. Further, the ethics process - which is presented as for the protection of participants but actually functions in the interests of the institution - functions as a manifestation of the psy-complex. It does this by positioning people diagnosed with 'a mental illness' as 'vulnerable' and 'at risk', as needing advocates, counselling services, special consideration etc. This would not have happened had the participants not been labelled 'at risk'. The positioning of participants as 'mentally ill' provides a means to exclude them from constructing an alternative knowledge, and by so doing promoting their own interests.

Furthermore, diagnosis of a 'mental illness' is always a significant barrier for people so labelled, preventing them from promoting their own interests, because the particular language and instruments of the psy-complex produce diagnoses in a way which makes it very difficult to refuse. For example, one of the diagnostic features of 'schizophrenia' in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is 'lack of insight' into one's own 'mental disorder'. Hence, any attempt to resist diagnosis will always be considered 'lack of insight' and, as such, characteristic of the disorder. In this way the construction of 'mental illness' serves as a tool for silencing the opinions and concerns of people labelled 'mentally ill'.

Indeed, we find that, through the allocation of a 'mentally ill' label, silencing is used against us as we work to challenge and subvert the psy-complex. Albeit in different ways, we and our colleagues have experienced the consequences of trying to engage in a critique from within psychology. We have had our work closed-down and our standpoints marginalised as "radical" or "ridiculous". Our associates

have been excluded and we ourselves have been subjected to organisational violence; we have been targeted in classrooms, ignored by colleagues, and forced to hide. By being personally positioned as "stressed", "burnt-out" or "depressed", we have experienced the silencing of our opinions and concerns about the psy-complex. We are positioned as requiring 'treatment'. This does not and cannot help because such 'treatment' locates the problem and the solution within individuals rather than within the institutional and systematic violence being done to us. In this manner we and our allies are effectively 'disappeared', and our concerns about a problematic and oppressive psy-complex are dismissed out of hand.

Although we regard 'mental illness' as an oppressive psychiatric construction, we argue that potentially such constructions can be resisted by means of an alternative or counter-knowledge, in a way that is progressive and transformative. By using Foucault's ideas, we can collectively challenge the thinking and practices around 'mental illness' by uncovering the unquestioned, taken-for-granted assumptions of the psy-complex, and by focusing attention on its political and ideological functions. By challenging those taken-for-granted-assumptions, we can collectively make it so that just carrying on treating people positioned as 'mentally ill', as is the case today, is no longer acceptable. Collectively, we can explore the possibilities that emerge when we refuse to accept current practices and theories, just because the dominant way of thinking and acting is in accordance with the neo-liberal-capitalist psy-complex. What has been constructed can just as well be dismantled and reconstructed from a different standpoint. If we acknowledge the oppression and harm that is caused by the psy-complex we can consider alternative ideas that have so far been ignored.

In summary, we argue that the psy-complex constructs 'mental illness' and falsely positions it as 'real'. Instead, we argue that the psy-complex is produced by and reproduces the frame of reference of the neo-liberal-capitalist domain. Furthermore, by silencing, excluding and 'disappearing' diagnosed persons, it is not the 'individual with a mental illness' but the psy-complex itself which puts barriers in the way that prevent people constructed as 'ill' from getting involved to promote their own real interests. Through criticism it is possible to expose the political and ideological nature of 'mental illness', and thereby clear the way towards finding alternative and more progressive ways to theorise and intervene in our embodied oppression and distress.

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NEWS

THREE-QUARTERS OF THOSE IN NEED GET NO MENTAL HEALTH TREATMENT

Research by a team of economists, psychologists, doctors and NHS managers has resulted in a Report by the Mental Health Policy Group (published by the London School of Economics). It declares that 'millions of pounds are wasted' due to a lack of proper mental health treatment, and urges the appointment of special cabinet minister to deal with the issue.

Their studies found that almost half of the ill-health suffered by people of working age has a psychological basis and is profoundly disabling. A third of all families have a member who suffers from a mental disorder. Mental health problems account for almost half of all those on incapacity benefits and nearly half of all absence from work.

And yet in the last quarter of 2011, only one-quarter of those who needed treatment were getting it. And of the 6.1 million people with treatable anxiety or depression in England, only 131,000 (or 2.1%) received talking therapy.

The Report claims that talking therapies such as cognitive behaviour therapy (CBT) relieve anxiety and depression in 40% of those treated, but despite government funding to train more therapists, availability is patchy and some NHS commissioners do not spend the money as intended. More than this, 700,000 children are reckoned to have problem behaviours, anxiety or depression, and yet in some areas children services have been cut.

Lord Layard, the Group's chairman, said that this lack of mental health response is "... The most glaring case of health inequality in the NHS ... Despite the existence of cost-effective treatments, it receives only 13% of NHS expenditure. If local NHS commissioners want to improve their budgets, they should all be expanding their provision of psychological therapy."

Layard maintains that NHS commissioners are wrong "... if they think 'why don't we cut a bit of that [talking therapies]' when they are spending money on infinitely lower priority conditions. Depression is 50% more disabling than conditions like angina, arthritis,

asthma or diabetes." Even including those on medication, treatment only reaches one-quarter of those in need.

In 2008, Layard and others won the argument that treating anxiety and depression saved the NHS money. The program Improving Access to Psychological Therapy (IAPT) was set up to train thousands more therapists.

But there is currently a postcode lottery for talking therapy. Walsall Primary Care Trust did best, with 6.4% of depressed or anxious people in talking therapy; this was followed by Swindon with 5.8% and Northumberland with 5.5%. But Hillingdon, in West London, had only 0.1% in treatment: that is, 17 out of 29,000 eligible patients. Barnet and Enfield, both in North London, had 0.3% and 0.4% respectively.

The Report says that NHS commissioners need to understand that treating people with mental illness saves money. A survey at two London hospitals found that half the patients sent for an appointment with a consultant had inexplicable physical symptoms, such as chest and head pains for which there was no organic explanation. "These are people with somatic symptoms as a result of mental stress," said Layard. In the long term he wants psychologists and therapists to work alongside physical medicine doctors in the acute sector, so as to help determine the real cause of people's apparently inexplicable physical symptoms.

Care services minister, Paul Burstow, responded: "Mental ill-health costs society £105bn per year and I have always been clear that it should be treated as seriously as physical health problems ... The coalition government is investing £400m to make sure talking therapies are available to people of all ages who need them. This investment is already delivering remarkable results."

from S. Boseley: 'Scandal of mental illness: only 25% of people in need get help', *The Guardian*, 18 June, 2012.

Sometimes, talking to my friends, I catch myself channeling some awful 'Voice of Reason' aka 'Voice of the Established Order of Things'.



Why am I arguing with them? I agree with them! I admire them! But they seem so vulnerable, and a bit mad, and I'm uneasy. I don't know how to support them. I'm torn between theoretical radicalism and pragmatic acquiescence.

Thinking this over leads me back to the worst time of my life: working as a Health Care Asst. on a ward with a culture of bullying. I was fresh out of uni with an English degree and a steadily worsening case of depression. You can imagine how well that went...

There were many days I'd be calmly stocking up or running urinalysis on 35 pots of piss or whatever, while inside I was all...
howling black fire...



I self-harmed a lot at work.

People who loved me said 'don't do it, promise me, never again.' I didn't know why I needed it. Never made me feel 'better' or 'in control.' Maybe I needed to do what I'm only beginning to try now, 5 years on: pay attention to my madness, investigate, hear its complex, polyphonic discords, its hints...



Boss Inside My Head

Never got angry if nurses bullied me. Just guilty, ashamed. Deep auto-submission. The anarchist undone by the boss, who holds a blade

Tiger, Tiger

Cuts and scratches, bearing stripes under my uniform, marks of weakness, marks of wear yet it's a fierce weakness, angry, almost proud. A child treasuring her scraped knees.

Let Me Out! Let Me Go!

If I died, I would not have to go to work tomorrow. Escape, change-unimaginable, a jump off the cliff, this world is not my home, what's in the dark?



Take That, Alienated Skin Bag!

Rush of anger, my body refuses name, job, shift patterns, rote motions, empty smiles. Skin unzipped, flayed flesh struggles free, set loose the messy flows. Shiva's dancing on the Minster towers

My madness spoke in screams and groans, incoherent, terrifying. It wrote pain on my skin, marked the cost of that life. I knew of a guy who, every morning before going to work at Deloitte, would vomit. Every day. Capitalism is self harm, tearing apart our bodies from our desires, ourselves from each other, from the earth -and it hurts, it hurts.

The worst thing about capitalism is it's not outside, it's in us, twisting in our guts muscles minds. And we're doing it, weaving the web that ensnares us.

But this is also the best thing about capitalism, our best hope. If we're doing it - maybe - we can learn how to stop. And maybe some hints are in our madnesses?

We can support each other in going out of our minds with a bit of safety. And the pain that another's suffering causes us - there's hope there, too. When we play 'Capitalism' we believe we're set selves, alone, that I am not you not us not the cosmos.

Do you beat your heart?
Do you beat mine?
Do you shine the sun?



THE DOCTOR IGNORANTIA

Bruce Scott

The Docta Ignorantia - the doctrine of learned or wise ignorance, or wise unknowing - was a term coined by the 15th century theologian and philosopher, Nicolas de Cusa.¹ In modern times this wisdom is cultured out by the government's positivistic and capitalistic mental health agenda.

Recognizing this, RD Laing once said: "Is it possible to be a human being anymore? Is it possible to be a person? Do persons even exist?"² On the surface, these might seem like simple questions: people may be described, objectified and pigeonholed from physiological, anthropological or psychological standpoints. However, as echoed by Plato,³ in relation to mental distress, such answers about human existence fall flat. They miss the mark, flailing blindly in the chaos of rational thought. Some people find this failing unacceptable, some crazy, some even terrifying, and consequently they close down this state of being in un-knowingness. And subsequently they try to create over-simplistic and foreclosed ideas about mental distress.

The rise of cognitive behavioural therapy (CBT), Improved Access to Psychological Therapies (IAPT), evidence- or scientifically-based mental health practices, and NICE guidelines all demonstrate quite clearly that such movements are intent on destroying any kind of free thinking. This is clearly a kind of ideological cleansing, however subtle or caring it looks. But are we so imprisoned as to be unable to look into the eyes of the capitalist mental health agenda, recognise it for what it is, and refuse it? Beyond the positivistic codifications and conceptualisations of the mental health industry, there is an urgent need to keep open other possible discourses.

This reminds me of something the psychoanalyst Jacques Lacan said to a group of revolutionary students, just after the Parisian student uprising in 1968:

... the revolutionary aspiration has only a single outcome - of ending up as the master's discourse. This is what experience has proved. What you aspire to as revolutionaries is a master. You will get one.⁴

This statement is relevant to our predicament today. I am not sure what an 'anti-capitalist' or anti-medical model of mental health stance might entail, but if it is aligned with a demand for better provision of mental health treatment from 'the masters of mental health', i.e., the government and its related institutions, projects and agendas - CBT, IAPT, NICE guidelines, psychiatric drugs, and improved psychiatric diagnosis - then I would be alarmed.

The Philadelphia Association (PA)⁵ is an example of an organisation where questioning medical, biological and other dogmatic ideas about mental distress is encouraged, and where there is scepticism about what 'the masters of mental health' can provide. PA creates spaces within its community households, and provision of individual psychotherapy that allows free questioning of the biological and medical ideology of mental distress. Nothing is foreclosed and other discourses are allowed to flourish. It is clear from the interviews I conducted with ex-residents of PA communities that those community houses uphold a different way of thinking - a discourse

which allows the residents to discover their own discourse or meanings, beyond the dominant oppressive medical, cognitive, and biological discourses of mental distress that circulate in our culture.

I feel that the narratives from the ex-residents of the PA communities show a form of 'learned or wise ignorance'. Residents are led to the houses in mystery and perplexity. This perplexity is not then suffocated by the house therapists by means of a schema or doctrine of knowledge which is supposed to lead people out of their perplexity. Instead, it seems that they are led to arrive at a position to be able to know what is and what is not possible. This is not psycho-scientific knowledge but a path back towards, or the creation of, an increasingly forgotten art of living. This art of living is a very different prospect from that proffered by the mental hygiene movement which, through its psycho-techniques, seems to intend to maintain the status quo in how one sees the world, or at least keep it within pre-ordained boundaries. Things have to be seen through the eyes of the master, i.e., the biopsychiatrist or logical-positivist psychologist.

When a patient disagrees with a neuro-chemical or cognitive theory of depression, this is a valid form of questioning or questing, for it is very questionable that such theories are the truth. (See Healy⁶ or Moncrieff⁷ for a critique of the biological model of mental illness, and Heaton⁸ for a critique of the cognitive model of mental illness.) Fortunately, the masters of mental health do not and cannot have an absolute monopoly of what counts as the truth of mental distress. If such a monopoly is constructed, as it surely is in the UK today, this amounts to a political ploy of attempted social control, the control of permitted discourse.

The paradox par excellence of our times concerns the status of the subject (i.e., persons). A result of the progress of contemporary psycho-science is that a closed definition of the subject is imposed: he or she is supposed to be composed of neuro-chemicals and/or cognitions. But here is the paradox: on the one hand we have 'freedom' and 'the human right' to freedom; on the other hand we have the discourses of power and mastery - discourses of cognitions and/or neuro-chemicals. Guided by the doctrines of cognition and/or neuro-chemicals, subjectivity is banished from those discourses. This creates a landscape with no landmarks.

Science now becomes the big authority on how we feel, think and experience. Since we are pre-determined, subjectivity is written out of the picture. We are supposed to be free, but if people become unhappy that is blamed on their neurons or cognitions. In turn, people demand happiness, and assume that it is a human right which can be achieved via the imaginary ideal of mental health treatment. This is a double-bind, a vicious circle. When 'Science' dominates our perceptions of personal life, we define ourselves by means of an abstract, fictitious scientific posturing, and the subject existing in the here and now is forgotten. We wish to become free but, paradoxically, by defining ourselves 'scientifically' we give up our subjectivity and liberty.

Since the modern subject is increasingly accounted for

in terms of the workings of the brain and cognitive theories of mental illness, activities such as psychoanalysis and psychotherapy, which adopt the approach of the *Docta Ignorantia* and so do not come under the banner of positivism or evidence-based practice, are accused of being useless and redundant. Cognitivism and the neurosciences take away the unity of the individual, or the possibility of knowing oneself as an impossible unity: the *Docta Ignorantia* - to know that we cannot know everything about how to live a human life.

This official cognitive neuro-scientific agenda expands like an empire. As is the case with empires, borders become blurred. As a result, it is difficult to know where one culture starts and another begins. Important aspects disappear under the homogeneity of the empire. The 'benefits' of the empire - unlimited freedom, democracy, health, and happiness - come with a price tag: one's subjectivity. Yes we are a brain, we do have neuro-chemicals, and we do think. But primarily we are subjects. Continuing to hold on to this, to hold on to our suffering (however difficult it may be to accept it), is as much a part of being a subject as it is to live, to be happy, and to die. There are far too many people ready to shore-up, correct and cure so-called mental illness. As prophesied by Nietzsche, we now live by the Religion of Comfort. But if we are really to help ourselves, we must make a concerted effort to hold onto the fast disappearing *Docta Ignorantia*.

Dr Bruce Scott trained as a psychoanalytic psychotherapist with the Philadelphia Association in London and is also a psychologist with a background in research into the cognitive models of depression (which underpin cognitive-behavioural therapy) and the psychological effects of anti-depressants. He currently works in private practice as a psychoanalytic psychotherapist in North London and Amersham, and is an independent writer and researcher.

this article is based on a talk given at occupy the Madness symposium at Trent City University, St Paul's Cathedral, London on 29th January 2012. for the full transcript contact: brucescott@gmx.co.uk, or read it at www.lacanianworks.net/?p=238

Notes

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Call for Papers: "Our Encounters with Self Harm"

Have you experienced self harm?

Would you like to contribute to an important new book?

Maybe you self-harm, or used to self-harm. Maybe you work, or care for, someone who self-harms. Whatever your story – if you'd like to write it – we'd like to hear it. 'Our Encounters with Self Harm' will be edited by Charley Baker, Fran Biley and Clare Shaw. Guided by our own experiences, we want to create a resource which will challenge stigma and misconceptions, by describing the reality of our lives as people who self-harm – our difficulties and strengths, our distress and our determination – alongside the experiences of those who live and work with us. In contrast to more formal accounts, this book (to be published by PCCS books) will reflect a variety of voices, illustrating the richness of our experiences of living with and surviving self harm. We welcome submissions in any style, including stories and poetry. The deadline for submissions is 30th October 2012. Please contact Charlotte.l.baker@nottingham.ac.uk for more details, including publication guidelines and suggested topic areas.

NEWS CONT ...

ASSOCIATION OF SELF-HARM WITH BEING BULLIED AS A CHILD

Children bullied during childhood are at least twice as likely to self-harm as their non-victimised peers. This was found by researchers from King's College London and other institutions in the UK and US, and reported in the *British Medical Journal*.

The study assessed whether children were bullied at several points during childhood, as well as whether they had self-harmed in the months before their 12th birthday. More than 1,000 pairs of twins were followed from the ages of 5 to 12. Interviews with their mothers suggested that 3% of the children (62) had self-harmed by age 12. According to accounts by the children or their mothers, just over half of these (35 children) had experienced frequent bullying. From this, it was calculated that children who were frequently bullied had about double the risk of self-harming as those who had not reported bullying.

The study found that 25% of UK children report being bullied. The researchers wanted to see whether bullying was associated with an increased risk of self-harm during adolescence. To examine the issue, the researchers analysed data from a cohort study, the Environmental Risk (E-Risk) study, which was designed to look at how genetic and environmental factors affect childhood behaviour. This particular analysis of the E-risk looked at the development of 1,116 same-sex twin pairs (2,232 children) born in England between 1994 and 1995. Half of the twin pairs in the study were identical.

A cohort study is the best way to examine whether a particular exposure (in this case bullying) increases an individual's risk of a particular outcome (self-harm). In this study, the mothers were questioned about whether their child had been bullied at ages 7 and 10, but the children were not asked whether they had been bullied until they were 12 years old. Mothers were asked whether their children had self-harmed by the time they were 12. Hence it is difficult to say that bullying (the exposure) definitely preceded self-harm (the outcome). This is particularly the case when looking at how self-harm related to the children's own report of bullying (rather than the mothers'), since both measures were assessed only at age 12. Self-harm could be a sign of low self-esteem or unhappiness, which in turn may make a person a target for bullies. The relationship between bullying and self-harm is likely to be complex and could involve other factors, some of which the researchers attempted to take into account.

The E-Risk study started in 1999-2000, so the first assessment was when the children in the cohort were 5 years

old. They were followed up at the ages of 7, 10 and 12. The follow-up rates were very high for all children in the cohort, at all assessment stages. Bullying was assessed by interviewing mothers when the children were 7 or 10, and interviewing the children themselves at age 12. When bullying was reported, the interviewer asked the mother or child to describe what happened. An independent reviewer verified that the experiences documented related to instances of bullying. When the children were 12 years old, mothers were asked whether each twin had deliberately harmed themselves or attempted suicide in the previous six months. Mothers who responded "yes" to this question were asked to describe what took place. For ethical reasons, the researchers only asked the mothers and not the children.

Other possible confounding factors that were taken into account during the analysis were mothers' reports that their children had been exposed to maltreatment (physical or sexual harm by an adult before age 12), behavioural problems at age 5, and child's IQ at age 5. They also looked at socioeconomic factors.

Of the cohort, 16.5% (350 children) were reported by their mothers to have been "frequently" bullied before age 10, and 11.2% of children (237) reported that they had been bullied "a lot" before age 12. Of the cohort, 2.9% (62 children) were reported by their mothers to have self-harmed in the previous six months by age 12, of which 56% (35) were victims of frequent bullying.

After adjustment for confounding factors, frequent bullying by age 10 (as reported by mothers) was found to be associated with an almost double chance of a mother reporting that her child had self-harmed by age 12. Frequent bullying (as reported by the child) by age 12 was associated with more than twice the likelihood of the mother reporting that the child had self-harmed by age 12.

Looking at children who were bullied, the researchers also found that those who self-harmed were significantly more likely than those who had not self-harmed to have a family history of attempted or completed suicide, to have experienced physical maltreatment by an adult, or to have other mental health problems.

Although the study cannot tell us the exact nature of the relationship between bullying and self-harm, it does highlight the importance of giving victims of bullying care and support to cope with the possible emotional and psychological effects. The researchers concluded that prevention of self-harm in young adolescents "should focus on helping bullied children to cope more appropriately with their distress". They also said that particular focus should be given to children who have additional mental health problems, have a family history of attempted or completed suicide, or have been maltreated by an adult.

from Bazian: 'Bullied children more likely to self-harm', NHS Choices (online), 27 April 2012; BMJ online, 26 April, 2012.

'ILLNESS LIKE ANY OTHER'

What does that really mean?

Hugh Middleton

Years in medical practice have taught me to respect what we don't know better than the false certainties of those who think they do. This is particularly true in psychiatry where so many of our 'treatments' are only partially effective, and yet we wield immense power. Quite often people change in a helpful way not because they have received an evidence-based treatment, but because they have been enabled to grow and develop personally. I am interested in how this can be applied to the provision of mental health services, and in what this can teach us more broadly about what it means to be human.

...

Many of the frustrations and shortcomings people experience when they encounter the mental health services may be due to the misleading and unhelpful notion that 'mental health difficulties are illnesses just like any other'. It is true that this idea might be de-stigmatising; that getting a diagnosis can be a sign of recognition, that it is commonly a necessity if resources are to follow, and that it often provides an explanation for what may have been very confusing and distressing experiences. Nevertheless, defining behaviour as 'an illness' has costs as well as benefits.

More than half a century ago the sociologist, Talcott Parsons described 'the sick role'. He described the way in which healthcare professionals and their patients align their roles in order to permit those activities that make up 'healthcare'. We might tell a healthcare professional something, or even allow them to do something to us that not even a close family member would hear or do. This has to go on in a safe and well-bounded place, such as are provided by the special arrangements of the sick role. Since it provides for situations in which a vulnerable and possibly incapacitated person is expected to benefit from the attention of a skilled and knowledgeable professional, the sick role has the following components, which are only valid for as long as the illness lasts:

- 'The patient' accepts his or her incapacity and submits to the authority of 'the doctor'.
- 'The doctor' exercises professional skills and uses specialised knowledge to which others don't have access.
- 'The patient' is relieved of responsibilities: he or she is given sick leave.
- 'The doctor' acts respectfully and does not use his or her position improperly or for personal gain.

- 'The patient' relinquishes autonomy over other aspects of his or her life: e.g., If you are too ill to go to school, you are too ill to play football.

- 'The doctor', close friends and family, and other elements of healthcare respond unquestioningly to the patient's needs, with resources and emotional support.

- 'The patient' agrees that this is a temporary state of affairs and strives to recover to a state of returned autonomy and responsibilities.

All of this is familiar, but what we probably don't notice is that these arrangements only suit certain circumstances. 'The patient' has to be clearly incapacitated, and all concerned have to agree about this. 'The doctor' actually does have something in his or her bag: skills or knowledge that others don't have, and which will help. 'The patient' is willing to submit to the doctor's authority because he or she feels that doing so will improve the chances of recovery. The condition is considered a temporary one which will result in either recovery or demise. The contract is agreeable to both parties and it tends to work only when all of these conditions hold: when some or many are missing there is scope for frustration and the experience of shortcomings.

How well do most, if not all 'mental health difficulties' fit this template? The answer has to be: 'Not very well'.

Since the overriding social convention which shapes roles and responsibilities throughout healthcare is the classic 'sick role', this is a problem. This idea of the sick role may be seen as a legacy from when most serious life-threatening illnesses took the form of fevers caused by bacterial infection - such as gangrene, pneumonia or internal sepsis. Before we had antibiotics such patients would become very ill and would need others to keep them clean, fed and hydrated. And they would either recover or die. It is only since the beginning of the 20th century that this general representation of serious illness has changed to include physically disabled people who are still capable, i.e., people with a need for continuing professional attention but who are otherwise well and autonomous - such as those with diabetes or controlled blood pressure - and those under threat of serious incapacity but who are currently well - such as people with cancer in remission. Many adjustments have had to be made so as to accommodate these more recent social implications of illness, and relations between 'patients' and 'professionals' have been reformulated.

It is even more recently that we have chosen to regard 'mental health difficulties' as 'illnesses like any other'. And, so far, 'like any other' actually seems to mean 'an acute debilitating condition that fits the template required of the classic sick role and will respond to a professional intervention'. When we say 'illness like any other', what we commonly mean is 'qualifies for the particular social contract of the classic sick role'. And of course, when that doesn't comfortably suit both sides, problems result. There is an obvious need to develop more sophisticated ways of accommodating 'mental health difficulties'. This might begin by recognising how the currently unsatisfactory commitment to an illness model came about, and continues.

Wherever you look, from the medieval priest who casts out demons, to current fashions in diagnostic labelling, medical treatment and cognitive behaviour therapy, you will always find some kind of arrangement to deal with 'the problem' of those who are distressed, confused, anxious and in despair - and who provoke anxiety in everyone else. Sadly, tragedies happen and people are left traumatised. Abuse and childhood neglect happen, and as a result some people grow up limited in their ability to relate to others comfortably and reliably. Not everyone is equipped to negotiate all the complexities of life and relationships. There is, there always has been, and there probably always will be, a small sector of any community who at some time or another find life unbearably difficult, confusing and distressing.

In *Madness and civilisation*, Michel Foucault outlined the history of the different ways in which society has responded to this 'problem'. It is not a very edifying story, and it can be read as an account of the various ways in which society has chosen to keep itself from contamination by those who are irrational and emotionally unruly. For Foucault, the introduction of 'illness like any other' was but a further step on that road. The classic sick role insists that 'illness like any other' means that 'there is something wrong with me and I have to submit to the authority of experts who will correct it'.

Delegation of the management of all 'mental health difficulties' to doctors 'for treatment' was fully achieved by the first half of the 20th century. This provided all sorts of opportunities for interests as diverse as the pharmaceutical industry and authors of self-help manuals. One example of how these interests have defended their territory is the way in which NHS guidance has been shaped to present 'mental health difficulties' as 'illnesses to be treated'.

In effect, NHS clinical guidance is provided by the NICE Guidelines, which often feature in the media. Doctors hold their authority on the basis of privileged access to specialised knowledge, and decisions about what can and cannot be expected from the healthcare system are based on interpretations of the relevant

scientific knowledge. This is called 'evidence-based practice'. NICE Guidelines are official NHS policy, and are seemingly drawn from careful academic review of the scientific evidence.

One of the most influential mental health NICE Guidelines is that concerning depression. The 2009 NICE Guidelines for Depression is based on the usual exhaustive review of the scientific literature. This particular Guidelines is voluminous, with over 700 pages and many technical appendices. If you like that sort of thing, it is a definitive resumé of the scientific consensus on the topic.

But very few GPs and NHS managers have the inclination, time or patience to work through such a weighty tome. NICE is aware of this, and uses academic reviews as the basis for much shorter and more digestible documents. In the case of depression, NICE issued a twenty-seven page Quick Reference Guide which was sent to every NHS practitioner and to relevant managers.

Now you can't take a technical document with more than 700 pages and numerous appendices and turn it into a Quick Reference Guide without cutting a few corners. By looking at how those corners have been cut we can see how NHS staff are led to understand what depression is and how it might be treated, and that the science actually implies something quite different.

Here are three examples, comparing the Full Guideline (FG) and the Quick Reference Guide (QRG). Both are available at <http://www.nice.org.uk/CG90> where many more examples can be found if you care to look.

1. The QRG presents the management of depression as a series of steps based upon differing degrees of severity, as if it is truly realistic to clearly identify and distinguish between mild, moderate and severe depression. The FG (page 13) states "Depression refers to a wide range of mental health problems characterised by the absence of a positive affect (a loss of interest and enjoyment in ordinary things and experiences), low mood and a range of associated emotional, cognitive, physical and behavioural symptoms. Distinguishing the mood changes between clinically significant degrees of depression (for example, major depression) and those occurring 'normally' remains problematic and it is best to consider the symptoms of depression as occurring on a continuum of severity."

2. The QRG recommends a number of psychosocial and psychological interventions, as if they are clearly identifiable, discrete and effective treatments. The scientific evidence reviewed in the FG concludes that there is nothing to choose between them, and that what makes all of them effective, when they are, is probably the fact that they are credible ways of providing an understanding and supportive relationship.

3. Seven of the 27 pages (more than one-quarter) of The QRG are given over to medical advice about the use of antidepressant medication. The QRG also says, more than once, that antidepressants should only be used in cases of moderate to severe depression. The FG concludes (page 411) "... that antidepressants have largely equal efficacy and that choice should largely depend on side-effect profile, patient preference and previous experience of treatments, propensity to cause discontinuation symptoms and safety in overdose ...". This is hardly the ringing endorsement suggested by coverage which occupies more than three-quarters of the QRG.

It is pretty clear that The QRG is not a faithful representation of the scientific facts. It obviously spins them in a way that consolidates a view of depression as 'illness to be treated'. This may be attractive from some points of view, but against the background of the social contract that is the classic sick role, perhaps less so than it first appears. And, of course, the same is substantially true for most if not all other 'mental illnesses'.

The 'problem' is that distress, despair, anxiety or confusion in others is disturbing to witnesses; it is very difficult to tolerate and drives a need to do something. Over the centuries we have adopted one after another largely oppressive reactions, and currently the facts are twisted in order to label such conditions 'illness-

es' which must be fixed by professionals. In the long run, this is no more helpful than earlier approaches, although many people are seduced into thinking that it is.

Who actually benefits, and in whose interests do we continue to follow this line? One thing it does is reify the otherwise complex, threatening and inchoate phenomenon of human distress - to make it seem like a governable and transactable commodity, available for professional and commercial exploitation.

What the alternatives might be makes interesting speculation. If I was in a bad emotional or psychological way I would probably rather take Prozac than be tortured by the Spanish Inquisition or incarcerated in a madhouse. But I would far rather be understood and cared for by supportive and understanding people.

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THE POLITICS OF PSYCHOTHERAPY

Jean-Francois Jacques

First of all, it is important to recognise that therapeutic practice cannot be separated from the ideological context in which it takes place. The dominant Western discourse gives a particularly high value to individualism. For instance, the rights and prerogatives of individuals are more highly regarded than the development of meaningful relationships between the members of a community. This ideological discourse reflects the demands of a neo-liberal economy which protects 'the free market' and 'free will'. So how much does therapeutic practice reflect the dominant discourse or how much does it help create an alternative discourse based on different values? And how far do people see things in a privatised manner, for example by viewing mental disturbances or disorders as private matters, disconnected from the social realities in which they originate?

Secondly, it seems equally important to consider the relationship between social or cultural dynamics and individual or psychological dynamics. I believe that they mutually influence one another. Yet this total dynamic is very often masked and overlooked, and for an obvious ideological reason: it is not in the interest of the existing social order (and the dominant class) to make the link visible. Although there are actually plenty of signs of the link, there are both conscious and unconscious efforts to mask it. This is not surprising, since the social order develops and supports a discourse that guarantees the reproduction and survival of that order. As a defence against the anxiety of not having any order at all, any opposition will be attacked.

So, what is the system trying to hide? And what sort of myths has the system produced? As regards persons, there is the myth of 'the isolated self' - as if the self could be conceived and understood apart from the context in which it exists and develops. This myth, claiming the autonomy of the subject from social context, is to an extent expressed in early psychoanalytic views on human motivations as arising from within the person, not from without. The general social and cultural conditions in which individuals develop their difficulties have largely remained overlooked. This de-contextualisation of the individual from his environment and his relationships with others gives us a false picture: 'Dominant theories too often isolate psychological processes from the concrete sociopolitical context that first produced them and that continues to shape them' (Martín-Baró, 1996, p. 95).²

What we have here is the privatisation of the mind. There are three different strands to this. The first is the privatisation of psychological disturbances and disorders, disconnected from the social reality in which they occur. The second is the atomisation and isolation of the person, who becomes the object of social stigma and has to receive treatment. The third is the commodification of the psyche.

Self-sufficiency is the proclaimed aim, not relationship or connection. Social structures and the psychological understanding of human development converge in the interest of the social status quo. And so much emphasis on the individual - as the market economy demands - results in endemic solitude and isolation. There has been an erosion of the aptitude of individuals to connect with each other. The social fabric has been torn apart. Dissociation, fragmentation, alienation, paranoia and aggression are not simply psychological processes or defences; they also reflect social dynamics - from the immediate family to the wider context and history.

When we talk about the politics of mental health, these are the questions that we need to ask ourselves: What are the social implications of mental health care? What are the assumptions on which it is based? And what are its relations to the dominant ideology?

A shift is needed, whereby we start to think about the relations between how we feel and how we operate socially, or to put it differently, between individual structure and social structure.

This brings me to the relationship between psychic space and social space, or between internal and external structures of oppression. The way we develop individually is influenced by the environment we are brought into. That environment (the family, and the wider community) is not fully responsive to our basic or more complex needs. For example, our needs for interaction and relationship are not adequately met. From birth onwards we internalise ways of being and develop a kind of internal 'working model' that influences our subsequent experiences with others, our reactions, behaviours, and the way we move through life. This model is very often oppressive since it makes us conform to patterns that may not be at all helpful to us. It also limits our ability to experience and understand the unfamiliar. Due to the anxiety that it may crumble and disappear, this model is easily upset.

External structures of oppression derive from the way the social structure is organised. This includes the social relations, distributions of power, social hierarchy, the production and distribution of wealth, norms, culture, etc. These structures of oppression are distributed variously, depending on the group to which we belong and on our position within that group. External structures of oppression permeate the entire fabric of the social relations and are experienced continuously by the individual, thereby leaving a profound imprint.

Understanding ourselves is as important as understanding the world. Changing ourselves is as important as changing the world. The internal and external structures of oppression exert a very powerful force for conserving the status

quo, making any change very difficult. But no progress will ever be made unless we recognise that individual transformation and social transformation are simply two sides of the same coin. The problem is that for too long each has been conceptualised in isolation from the other, and viewed as an entirely separate process.

Jean-Francois Jacques is a drama therapist who works in private practice. He is director of Out-Side-In: Centre for Dramatherapy and Therapeutic Theatre. He was involved in the welfare tent of the Occupy movement at St Paul's in London.

Notes

1. This is an extract of a paper presented at the Tent City University on the Occupy London site at St Paul's, London, 29 January, 2012. It was one of a number of presentations on psychopolitics and the politics of psychotherapy.
2. Martín-Baró I. (1996). *Writings for a Liberation Psychology*. Cambridge: Harvard University Press.

A THERAPIST IN SECURE SERVICES

Julia K Horn

In my office I had two postcards where I could always see them. Edmund Burke reminded me that "All that is necessary for evil to triumph is for good men and women to do nothing".¹ And Eugene Debs said "Years ago I recognized my kinship with living things, and I made up my mind that I was not one bit better than the meanest on the earth. I said then, and I say now, that while there is a lower class, I am in it; while there is a criminal element, I am of it; while there is a soul in prison, I am not free." In stark black and white, the picture showed a man behind bars.²

Those sentiments define my choice to work as a psychological therapist in secure services. I suggest that there may be better ways to care for people who are risky. Prison and hospital make people less able to cope as they become older and institutionalised. All employees who work in these environments are as 'imprisoned' as those who are detained.

The community of a Medium Secure Unit consists of about 120 patients and around 320 staff. It is akin to a 'total institution' or similar to a small village. Secure Units look after people with some of the most complex mental health problems. These units are spread across the sectors - private, independent/not for profit, and National Health Service.

There has been a massive increase in the number of these small units throughout the UK. They often exist within a larger trust, occupying a privileged position and having access to increasing budgets. Often quite small, the units have high ratios of staff to patients and high quality resources. Social work and occupational therapy support, as well as clinical psychologists and psychological therapists are routinely incorporated into the care team. There may also be art therapists, rehabilitation psychiatrists and nursing specialists.

Secure Units have some specialist primary tasks: they are designed to keep the public safe by looking after people who are often designated as violent offenders with serious mental health problems. In England there are also three High Security Hospitals,

bound by the strictest rules. I worked as a psychological therapist in both sectors for eight years, predominantly in women's services. As part of my high secure role, I also worked as a therapist in a women's prison for eighteen months.

My job was to listen to people who were in hospital who had committed criminal acts, often very serious offences. I worked with people who had killed another human being or abused adults or children, people who had robbed to support their use of drugs or alcohol, and those who had set fire to buildings. Some of those I worked with had not committed any offences. They simply had such serious levels of distress that they were considered too risky for ordinary psychiatric wards. Patients came from very deprived backgrounds, had not done well at school, had never had the chance to work, and were physically very disadvantaged.

A better way to avoid institutionalisation might be smaller hospitals, therapeutic prisons and the same standards of care in prison as that available to patients who are 'free' in the community. In all, around 87,000 people are incarcerated. Prison may be their one chance to receive health care and therapy, dentistry and nutrition. Many of these people have serious mental health problems before they enter prison, and inside they get worse very quickly. Keeping 'bad' company, lack of physical and mental occupation, boredom and a power-hungry hierarchy are the foundations of prison life. When these people are sent back to their communities they are isolated, sometimes unable to reintegrate or get work. The only people they can associate with are offenders. Their family, partners, friends and ex-work colleagues may be unable to support them and there is nowhere for them to go but back into prison. This process can be changed by workers who support patients by challenging negative decisions as they are being made.

Most of my colleagues had legitimate professional priorities. Additionally, they wanted to fit in at work, be liked, be promoted and keep getting paid. Some went

to work only because it gave them money and status. They were not always clear about the meaning of their work. Rather than helping people to change, personal agendas seemed more important to some of my colleagues. Some considered work a place to meet potential partners, for others it was somewhere to show off their clothes or car, for status or to exercise power. Some workers seemed to use work as an environment to socialise and preen. The patient, client or prisoner was not the focus of their time at work. Others systematically avoided work, avoided patients and lied to their boss. Others again were too unwell to work consistently but seemed afraid to go off sick or take time out in case they were removed - they often seemed to be good people who had burned out, and who disappeared year by year. Those who appeared successful within the system seemed the most disinterested in mental health, recovery or hope.

The NHS, the Prison Service and all services working with people need to change. We can bring about this change.

I did not let decisions go by without raising concerns. I challenged many of the pejorative decisions regarding the people I worked with. I made inmates' well-being my priority. I listened to their concerns with an open mind. I came to recognise that abuses of power, exploitation and unfairness were endemic within the system. I spoke out to powerful people and groups, even those who I considered as colleagues. And I was afraid.

Recently I became a Quaker. I feel sad this took me so long. Had I been able to draw support from a group of 'Friends' I might have done more to change the system. I might have lasted longer before being spotted as an alien, and spat out. I might have kept my health, courage, and strength.

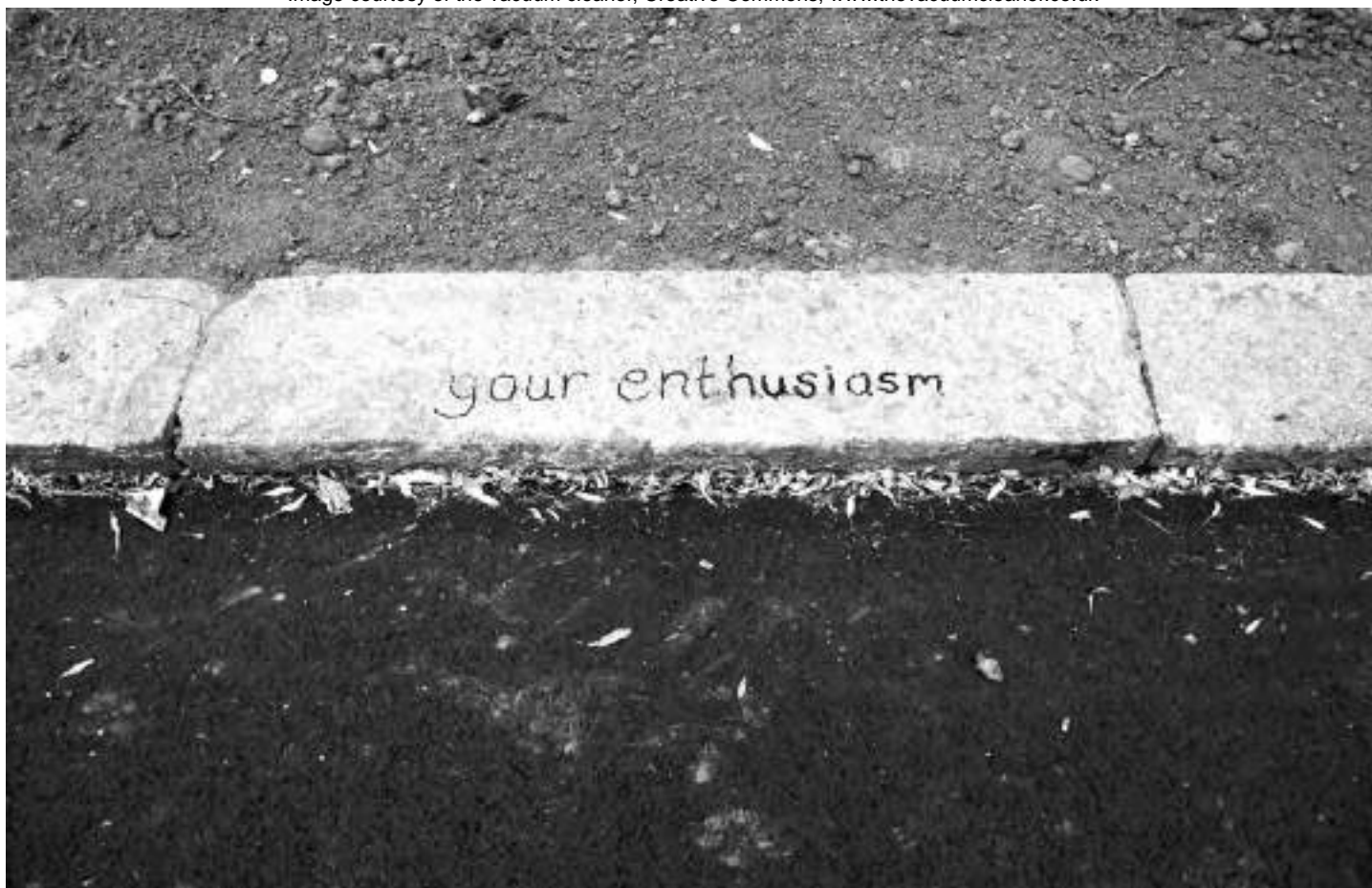
Workers in such systems face moral compromises and ethical dilemmas that seem irresolvable. Such decisions can be soul destroying. In such toxic spaces we need each other to keep safe. We need to accept that we will be inconvenienced by work in order to fulfil our responsibilities. Our work is to help people recover, become safer, and gain their freedom. Otherwise, we all remain incarcerated.

Dr Julia K Horn is a person-centred psychological therapist who currently works independently and is studying law. previously she studied sociology, psychology and forensic psychology. she is a lifelong feminist, and hopes to change the systems in which so many people suffer needlessly. in refusing to accept the subjugation of woman, she came to reject the view that any person deserved to be punished.

Notes

1. Edmund Burke (1729-1797) was an Irish conservative and liberal politician and writer.
2. Eugene Debs (1855-1926) was an American Socialist. Quote, (1918) Statement to the Court Upon Being Convicted of Violating the Sedition Act.

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IT'S YOUR PROBLEM BUT YOU NEED US TO HELP YOU TO FIX IT

The paradox at the heart of the Improving Access to Psychological Therapies agenda

Ewen Speed and Danny Taggart

Improving Access to Psychological Therapies (IAPT) was an agenda conceived in 2005 as a way to increase access to psychological treatments by increasing the numbers of psychological therapists available to treat 'common mental health problems' such as anxiety and depression, mainly by means of Cognitive Behavioural Therapy (CBT). Much of the thinking behind the project was - and still is - about money. IAPT was designed to treat people who received Incapacity Benefit because of their mental health problems. A clear goal of the IAPT programme is to enable people without paid employment, because they feel depressed or anxious, to receive a talking therapy. People on these courses are supposed to use CBT to 'think' their problems away, and then to be able to return to the workforce, 'fitter, happier and more contented'. In turn, this reduces the welfare benefit 'burden' on the state. (Meanwhile, Incapacity Benefit has now been abolished and is replaced by the Employment Support Allowance, which is much more restrictive in terms of eligibility conditions.)

A key force behind the IAPT programme is Lord Layard. He is an economist from the London School of Economics who has been influential in directing both New Labour and Coalition government policy. He is also a key figure in the 'Action for Happiness' movement (<http://bit.ly/l4Pz2C>). He talks of seven causes of happiness. These are: family relationships, financial situation, work, community and friends, health, personal freedom and personal values.

Layard uses survey data collected across a range of countries to 'prove the truth' of this normalising framework for happiness. However, it seems absurd to try to reduce something as abstract as 'happiness' down to a number of quantifiable 'causes', and then to argue that these causes point to a universal definition of happiness. Furthermore, this process ignores many of the very real social and political causes of unhappiness. For example, a government report published in 2010 estimated that more than 5 million people in the UK suffer from multiple disadvantages, with 3.7 million of them doing so persistently. Poor mental health, poor housing, unemployment and income poverty are all indicators of multiple disadvantage, and can be seen as the flip-side to Layard's indicators of happiness.

In the context of 'happiness', then, issues that are clearly social problems come to be seen as individual ones. The effect of high unemployment in a community comes to be seen in terms of the impact of individual unemployment upon that person's level of happiness. This individualising of social issues also makes people feel responsible for addressing 'the problem' themselves: rather than addressing wider issues of social inequality and injustice, it prioritises individual solutions based on normative measures of happiness.

Consider healthcare, in which individual responsibility is reflected in an emphasis on consumer choice. Health outcomes are regarded as issues of lifestyle choice rather than

responses to the unequal distribution of resources. This is in spite of a range of evidence that points to a direct and very strong relation between levels of social inequality and health inequalities. The focus on individual responsibility means that options for mental health treatment are increasingly focused on psychological interventions that are presented as pre-packaged commodities to be consumed by individual service users.

Now consider low-intensity IAPT interventions, specifically 'guided self-help'. These interventions are part of a stepped-care model designed to be accessed by people with 'common mental health problems'. In this model, psychological practitioners offer a limited number of contacts to service users, either face to face or by telephone, emphasising psycho-education or 'socialisation' to the CBT model. Service users are provided with a range of educational materials that explain to them that the reason they feel the way they do is because of a 'negative' relationship between their thoughts, feelings and behaviour. They are asked to address their 'problems of thinking' via a manual of interventions which are directly or remotely guided by a psychological practitioner.

From a healthcare consumer-choice perspective, 'guided self-help' positions service-users as active subjects who are to manage their distress. However, there is a paradox here, and one that actively undermines people's struggles to address their problems. The pseudo-scientific, 'technical' language enshrined within these guided self-help manuals describes people's 'Negative Automatic Thoughts', 'Thinking Errors' and 'Safety Behaviours' as ways of explaining how an individual's internal processes are to blame. And it is suggested that individuals can become more psychologically minded (or robust) by carrying out tasks such as completing 'Thought Diaries' and 'Evidence Recording Forms', before finally addressing their difficulties by means of psychological techniques such as 'Cognitive Restructuring', 'Behavioural Activation' and 'Exposure Therapy'.

However, this language and this way of understanding human distress is not the way that service users would normally make sense of their problems; IAPT imposes a model of human suffering upon people that is often alien to them. Importantly, it is also one that they are powerless to address without 'professional' assistance. To us, this insistence on professional assistance seems to clash with the responsibility that service users are supposed to take for their own situation. This way of characterising distress also diverts attention away from social injustices, allowing much of it to continue unchallenged. Most worryingly, the risk is that people suffer alone and in silence, blaming themselves for their misery, rather than collectively arguing for social change.

As we have already outlined, these psychological practices serve the purpose of cloaking the real, social causes of many people's distress. It does so in language that inter-

nalises and individualises the person's experience of emotional pain. Furthermore, and paradoxically, we argue that when they try to understand their problems it makes people over-reliant on psy-professions and technologies. 'Guided self-help' places responsibility on individuals for their distress (i.e. for the situation they find themselves in) but it does not genuinely give them the tools to get themselves out of the situation.

In conclusion, IAPT, and the individualising ideology that it embodies, actively undermines our capacity to find solutions to the social problems which we face, and the misery they cause us. The implication that individuals are to be held to account for what are, in fact, social inequalities and social injustice, is a worrying trend that must be addressed. The idea that so many people need professional help from corporate, self-interested mental health services needs to be contested, and the hypocrisies at the heart of this paradox must be challenged and resisted. It is through resisting this paradox that new solutions can emerge. The current focus on those who access benefits, coupled to claims that CBT will enable them to return to work, makes the IAPT agenda an explicitly political one which seeks to make individuals take responsibility for improving the social and economic conditions in which they find themselves. In itself this is not a problem, so long as it does not excuse the government its obligation also to address inequality. But if programmes such as IAPT become the principal government response to that obligation, then there is clearly cause for concern.

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BLUR THE BOUNDARIES, BUT GET ORGANISED

Anon

As distinctions between service workers and users shifts, and Peer Support roles are created, more than ever workers and users need to be organised.

For most of my career as a mental health nurse I have been conscious that I earn a living out of mental (ill) health, rather than suffer from it, and that my 'expertise' is not always of great value to those who do suffer. It did not take me long to become mistrustful of the technologies we professionals implement, both bio-medical and psychological. Not that either technique is entirely without merit, but they are given such primacy and resources, when plainly they fail people, and even damage them.

Really, I am an expert in mental health services as much as mental health itself. I have quite a lot of complex knowledge about therapies, drugs, the Mental Health Act, benefits, admission procedures, duty cover, etc. But this is all about our systems and not about the human beings caught up in them, and not about what these people might have been dealing with which led them into their contact with the services.

Sometimes my knowledge of the system is useful. Often, it is outside of working hours that this becomes apparent. I'll get a phone call when a friend has had a brush with the Mental Health Act, or when an elderly relative is given neuroleptics. I wish everyone had a friend to call when they were in those circumstances. But it shouldn't be like that. Society's system for helping people shouldn't leave them needing advice and advocacy to deal with the service itself - as so often they do.

At present there is little else for people to turn to, apart from the mental health services. And, quite rightly, people expect their public services to be useful. It's no surprise, then, that there is always a strong demand for statutory mental health services. So what should workers like me offer?

I console myself that it isn't usually any supposed 'ex-

pertise' that makes the difference between a helpful contact with services and a traumatising one. The mundane human activities of respecting, listening, and trying to understand go a long way, and usually they trump any therapeutic technique or theory.

The distinction between workers and users is now evolving further, with new NHS posts being created for Peer Support Workers (PSWs). A PSW is someone employed to work in the mental health service specifically because he or she has lived the experience of mental ill-health and recovery. This is supposed to enable them to guide and inspire others on that journey. PSWs were trialed in Scotland, and during the last few years programmes to recruit and train them have been developed in some parts of England. This is not a new idea: I think we have always known that many service users find it easier to identify with peers than professionals, and that friendships made between patients on wards often matter more to them than the professional help on offer.

I have been working alongside PSWs in my community team, and it has really moved things on. Suddenly, in our midst, we have genuine voices from outside the professional cliques: a mirror on the inside. This is another potential benefit of PSWs: to criticise and help reform the rest of us.

Together with a PSW, I have been running a group on 'recovery' themes. (We are not uncritical of the idea of 'recovery'.) We brought in various guest speakers, with an emphasis on service user voices. It surprised me to find just how many people there are with lived experience who can deliver their expertise to a very high standard, with a passion that is so often lacking amongst jaded professionals.

However, my inner sceptic also knows that PSWs are mainly viewed by management as a much cheaper option than nurses, doctors, or social workers. (Whereas experienced nurses are generally on NHS pay Band 6 or 7, a PSW is on the considerably lower Band 2 or 3.) And I know that the 'recovery' ethos is fairly superficial in most big organisations. For the same organisations you see trumpeting their recovery strategies are also involved in the increasing securitisation of services, with bed closures in open units, and fences going up around some hospitals. And people continue to take second place to policies and targets. Sometimes those admitted under the Mental Health Act are made to wait days on end before they are able to smoke a cigarette: policy on smoking and patient leave win out over an individual's needs. Other examples abound. Some are sinister, such as the introduction of iris scanners at the entrance to one mental health unit. Thankfully, that idea was abandoned.

On a national level, in actual practice, the increasing use of compulsion in the community, and the greater orientation towards psychiatric diagnosis, and 'clusters' of diagnostic types, further diminish the recovery ethos. Besides this, some service user activists may view the integrity of PSWs

as weakened and politically neutered by their having been co-opted into the system.

What is needed is a strong counterweight to these pressures. Sadly there still doesn't seem to be a coherent and well known 'service user movement'. There have been various attempts to establish such a thing, or networks of smaller groups, but little is in evidence on the ground, at least where I live and work. Service users are by and large not aware of anything to join or identify with. Perhaps 'users' or 'survivors' only emerged from deeper levels of oppression and inarticulacy just when the habit of solidarity and organisation went into decline.

But now, more than ever, there is surely a need for such organisations. Closing day centres, tightening funding criteria, withdrawal of welfare benefits, and a host of other threats sorely need defending. Instead, much of the ground that should be occupied by a service user movement is left to the charities that claim to speak for them. As 'third sector providers' they are compromised by tendering for services, and still rattle tins rather than sabers. Mind, Rethink, and the rest are often notably absent from any real struggles to defend services or welfare rights.

At least one established group of health workers - nurses - is relatively well organised. This has been the case since the early 20th century, when the National Asylum Workers Union was formed. Our unions may be slow and bureaucratic, but they are a great safeguard to individual members, as well as having some collective bite.

The common interests of workers and service users are outweigh their differences. I believe that the public provision of services is worth defending. Even though the present mental health system is often oppressive, and the NHS hands over massive resources to big pharma and PFI cronies who pour concrete, we should be re-appropriating and democratising those resources rather than abandoning them. Perhaps the PSW role represents an early glimpse of what this might look like.

Service users need to be organised just as much as health workers. This cannot be imposed by outsiders, though others should support service user organisations wherever they can. We need to try and bring together the threads of workers organisations and service user activism so as to thrash out our differences and support our common interests.

Maybe it is in this synthesis that an agenda for a more democratic and humane provision can emerge.

The author is a Community Mental Health Nurse and a UNISON activist.

AGAINST SUPERHEROES & MARTYRDOM: REFLECTIONS ON BURNOUT

Andi Sidwell

This article is aimed at both myself and others. I started writing it in response to a friend's Facebook request for tips on burnout, when I thought I'd try and write down what I've been trying to do to avoid it. The important word is trying – this stuff is difficult and I'm only slowly getting better at it.

Burnout

This is when you get really attached to what you're doing and you can't stop. Even when not stopping is hurting you and others around you. It's when you stop doing things for fun or because you want to, but when you feel you have to, when you feel you should. Burnout is insidious; it gets under your skin and it damages you.

Often you don't even notice burnout, but when you do, you can still ignore it. It's when you feel tired, when your body starts complaining that you're pushing it too hard, when you're worrying about something much or all of the time, when you've lost enthusiasm but you have to continue the fight.

Burnout is where the pressure you feel is too much for you to bear, and its implications for your health, both bodily and mentally, can be terrible. Some people who burn out fade away and never come back. A crushing sense of obligation is not healthy for anyone.

Struggle and sustainability

Given that just existing in one's own body can be a struggle, trying to face and fight the injustice in the world was always going to be difficult. But while we're not fighting for social change because it's easy, there's no point in exploding in a fiery ball of incandescent activity. The world rarely needs more martyrs; it needs more people in it for the long haul. And if you want to be in it for the long haul, then you need to think about sustainability.

Social struggle happens over years. While I hope I will still be part of a movement in ten years' time, I realised that I won't be if I wear down my mind and my body with constant activity. I've found it's actually really important to look after myself – and it's important for you to look after yourself, too. Sometimes this can be really difficult. I've had to make some really hard decisions for my own health – including leaving an organisation I helped to set up, even though I thought my leaving would precipitate its collapse.

I don't really feel I can lecture anyone about learning your personal limits and coming to accept them. I'm not that great at it, though I'm getting better. All I can offer is my own experience and some rules of thumb I found or worked out on my journey.

The classic cause of burnout is taking on too much. You can't physically do everything because there are too many fights to fight. If you're involved in workplace struggle, that might take all your energy. But what about animal rights, anti-capitalist struggle more generally, liberation struggle or the fight for housing or health? I feel overwhelmed, just

thinking about it.

My solution to this has been to focus. You can choose to spread yourself thin over many projects or thicker over fewer. Each project you're involved in takes up a certain amount of headspace, regardless of the size of the project. It's like you keep a folder of tracking information for each

project: events coming up, the things you said you'd do, ideas for what to do in the future, the general sense of how well or badly things are going, etc. You need all that information whether you are running a smallish one-off event or part of co-ordinating a large group on an ongoing basis.

Now imagine you only have a limited amount of space in the filing cabinet of your brain. The more projects you have, the more of your brain will be used up as overheads – just tracking what you

are doing, without actually doing anything. The fewer the projects, the more space you have for thinking really deeply and creatively about them.

A match needs a certain amount of head regardless of how long it is. And a matchbox only has so much space. That's a bit like how it is with projects and your brain. This isn't an exact analogy, because some projects do have less overhead than others, but hopefully it's illustrative!



I've read that one of the keys to a fulfilled life is being really good at something. You can't get really good at something without long-term sustained effort and dedication, and I've found it disap-

pointing that you can't apply that effort and dedication to everything, all the time. I've had to choose. However, I've found that getting really good at a few skills is a reward in itself. That reward, and the knowledge that I'm doing a good job, has helped me through the troughs.

Finding a long-term project has been really important for me, too. I'm involved in the Green & Black Cross, and it's not going away anytime soon. A long-term project gives you the potential to think about strategy and to build lasting social links with others. Strategy is important because it can help to alleviate the worry that you're not achieving anything. And long-term links with other people are incredibly important. Personally, I also find that organising support work matches my personality and style better than confrontational campaigning. So all I can suggest is that you find a project that matches your politics, personality and skills. And stick at it.

I've also found it really useful to recognise that meaningful social struggle is always collective. Individually we are atomised, and in 2012 the working classes are in a historically weak position. It can be easy to respond to this by piling the pressure on ourselves to achieve, individu-



ally. Can one superhero make up for the absence of a mass movement? I don't think so. I sometimes feel like we're on an automatic walkway and we have to run in the opposite direction just to stay still. However, if our numbers are limited and we all sprint, we're all going to collapse well before the end of the marathon.

Taking a break

A quick and seemingly easy solution to burnout is to take a break. This can be a short-term sabbatical where you know you're coming back, or it could simply be leaving with no firm plans to return. I say 'seemingly easy' because I've found that breaks can mask the reasons I burn out instead of helping me to address them. Those reasons took me quite a lot of time to work out.

For me, they revolve around not being honest with myself about what I am or am not coping with, and the number of projects I am entertaining commitment to. The good news is that I've spent years avoiding these issues but now I'm increasingly turning to face them, and I'm a lot happier and a lot less stressed out.

Taking a break can be great for clearing your head but if you are feeling the need to take one be careful you don't

just rush back into the same old issues afterward! And make sure you take a complete break. Otherwise it's not really a break at all.

I hope that some of these reflections have been useful. I've written about my experience in the hope that others can recognise some of it in their own lives, and may be encouraged to think differently about their relation to activism or working for social justice. That can often feel like a burden, but there's nothing wrong with putting down your share of it every now and again. And remember, you're not on this journey alone! Rest by the roadside when you need to. If you build up a habit of doing this, then when a time comes when you can't rest - when you must work all out at a sustained and frenzied pace - then you will be so much better prepared. As the old fable goes: 'Slow and steady wins the race', said the tortoise.

Andi Sidwell is a genderqueer activist-on-a-break, surprised at how much easier life is without having multiple long-term and time-intensive projects on the go. they enjoy applying theory to practice, collecting and analysing data, and making things.

MENTAL HEALTH: THE STRUGGLE FOR DECENT FOOD

Shaun Whittaker

Mainstream psychology and psychiatry appear to deliberately ignore ground-breaking research about links between mental health and nutrition. Reasons for this lamentable state of affairs may be found in the tremendous influence of the pharmaceutical companies and the persistent effects of the eugenics movement.

It benefits profit-driven pharmaceutical companies to assume that every mental disorder is due to genetics or chemical imbalances. It seems to follow logically from such assertions that it is best to intervene with psychiatric drugs. However, it is too easily forgotten that the correct use of prescription drugs is a leading cause of death, all over the world. There is also sufficient evidence that companies often suppress negative data concerning the effectiveness of their psychiatric drugs.

The alleged genetic origin of psychological conditions limits the understanding of mental health, and of the available options. Yet there is simply no convincing evidence of genetic cause and no proof of the so-said chemical imbalance.

The obsession with a genetic basis to severe mental and emotional distress indicates a kind of lingering racism amongst many mental health 'experts'. For instance, despite all the evidence against racial differences provided by the human genome project, in the year 2000 the diagnostic manual of the American Psychiatric Association still wonders whether the discriminatory treatment given to people diagnosed with schizophrenia could be legitimated by "true differences among racial groups".¹ This certainly seems to be the APA trying to justify the fact that relatively more black people in the USA are diagnosed with schizophrenia (and learning difficulties).

To affirm the specific role of nutrition in mental health is

to counter such racism. Broadly, the nutritional approach also highlights the impact of social class on the incidence of mental disorders. It represents nothing less than a revolutionary approach to mental health.^{2,3}

ATTENTION DIFFICULTIES This is the most common learning difficulty. Without the ability to direct one's attention, learning becomes tricky or even impossible.

The brain is the most sensitive organ in the body. It consists of 60% fat. Consequently, so as to function optimally, it requires very specific nutrients. The essential fatty acids are found in higher quantities in the brain than elsewhere in the body, and they assist in the transmission of nerve impulses. A lack of essential fatty acids undoubtedly gives rise to impaired learning ability.

It is well-documented that the diet of most children is not good. Besides the possibility of a lack of essential fatty acids, considering what kind of food children eat before they go to school, it is hardly surprising that so many of them wrestle with attention problems. Blood-sugar level is usually low by morning: since fluctuations in blood-sugar level result in detrimental changes to energy, mood and concentration, it is crucial for students to eat a diet which can balance this level. The issue of blood-sugar level demonstrates the tremendous educational disadvantage of undernourished or malnourished children.

MENTALLY CHALLENGED 85% of mentally challenged cases are usually of a mild nature. Ultimately, the nutritional status of the pregnant mother determines the development of the brain in the foetus, but the infant's nutrition is also crucial to further growth.

In mainstream mental health, Down Syndrome is re-

garded as the most frequent genetic cause of someone being mentally challenged. However, since there is only a 1% chance of a mother producing more than one Down's child, it is questionable that this syndrome is a simple matter of genetic transmission.

DEPRESSION Depression is like the common cold of the mental health field. It is a leading cause of the global disability burden. However, chemical intervention with psychotropics does not make a lot of sense.

On the other hand, we know that neurons are located not only in the brain but also in the gut, which seems to function as a kind of 'second brain'. For example, 90% of the 'feel-good' hormone Serotonin is produced in the gut, which is also where other functions such as blood-sugar level are located. This might explain the success of a low-glucose diet, for instance, in countering depression.

SCHIZOPHRENIA Significant resources are channelled into dealing with these patients, often over many years. However, the Canadian psychiatrist, Abram Hoffer, reported a 90% recovery rate with a nutritional approach to the treatment of schizophrenia. In his opinion:

"If you were to make sure that every child in Canada started eating flour that contained enough vitamin B-3, I suspect that schizophrenia would disappear... The main reason is Big Pharma. They're pushing drugs. They certainly don't want to sell vitamins, when there's no patent on them... It's absolutely terrible. I connect it to the fact that the medical schools don't teach nutrition. Also, they've been taken over by Big Pharma."⁴

It should be noted that the remaining 10%, the unrecovered patients in Hoffer's sample, had not usually received a nutritional intervention within two years of the onset of the disorder.

If the symptoms of schizophrenia can best be improved by means of good nutrition, then it is most likely that, to an important extent, 'racial' differences are due to nutritional differences.

DECENT FOOD From the foregoing, it follows that a good way to prevent mental illness is to provide people with decent food. During the last half-century, the never-ending denaturing of food so as to boost profits has resulted in a marked decline in much of its nutritional quality.⁵ Now, due to the unemployment crisis and the rising food prices of neo-liberal capitalism, most care givers cannot access or afford nutritious food. With the disaster of badly regulated genetically modified (GM) foods in our midst, the worsening of the mental health situation should probably be expected.

In the short term, one solution would be to make nutritious foods available free of charge to those most in need, such as pregnant mothers and psychiatric patients.

Mental health is also about the right to decent food!

Shaun Whittaker is a mental health worker in Windhoek, Namibia.

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The psychological impact of the British asylum and immigration system on female victims of torture Niki Taylor

Women who come to seek asylum experience a number of hardships when arriving in the UK. For example, the lack of expertise and communication within the Home Office causes further anguish and increased health needs. Here I discuss how the asylum system is motivated and shaped by capitalist economics: profit, competition, and the old eugenic ideology impacts particularly on the mental health of women seeking asylum.

These women are assessed purely on their country of origin, using out-of-date and incorrect data. Home Office Country of Origin reports should provide information on the political, legal, cultural, and social and human right conditions in the countries generating asylum seekers. However, arbitrary measures and policy changes are continually made, and they bear no relation to what is happening in many countries. For instance, the Home Office might deem some countries to be dangerous one year and then safe the next when in fact there has been no change in the country's social or political situation. The list of countries deemed safe comes under S.94 of the Nationality Immigration and Asylum Act (2002). Further evidence of these discrepancies are revealed when we consider the huge inconsistency within countries of successful asylum

applications from one year to the next, even when circumstances in that country have not changed. The arbitrary and irrational nature of the asylum system means that the rights of immigrants who have experienced torture and persecution, resulting in serious psychological damage, could easily be overlooked.

This is particularly problematic for female victims of torture because although some of their male counterparts might experience sexual torture, women are more likely to have suffered due to their gender (a socially constructed role expected to be fulfilled because of their biological sex). Socially constructed gender has very real and varying cultural norms and expectations attached to it; for instance persecution in the form of rape, sexual violence, honour crimes, forced sterilisation, sex trafficking, female genital mutilation (FGM) and domestic violence. These crimes happen because women do not conform to the expectations of their gender. Missing information on gender-related persecution might be for the very reason of severe gender inequalities, where persecution is covert and women have very little or no knowledge of their rights. If women do assert their rights they are deemed to be dishonourable troublemakers and will suffer extreme stigma and ostracism.

cism within their communities. Understandably, this creates fear amongst such women about speaking about their experiences. Country of Origin reports and human rights information focus on the male experience to illustrate the human rights situation; women's human rights only constitute a small part of this picture, although the UK is thought to be one of the most progressive in incorporating gender-related issues into its asylum policy.

Once these women are here they are dispersed into asylum housing throughout the UK. The government has a 'no choice scheme', which means that asylum seekers are not given preference and may be housed in areas where there are no existing immigrant communities and are at risk of racist attacks. One woman who had been raped and burned with acid for belonging to an opposition group in her own country tells what happened when she was dispersed to the North East of England:

On buses people would refuse to sit next to me and shout out "monkey" and "asylum seeker" ... A big strong man struck me on my back with his fists ... Boys spit at me and throw stones when I walk down the street. (K Nygothi: Every moment is a fear; as an asylum seeker, I discovered what racism really meant when I was dispersed. *the guardian*, 8th July, 2004)

Ironically, a 2006 Home Office report states that women are four times more likely than men to feel unsafe walking alone after dark. So why is this not considered when relocating and housing women seeking asylum? Why is nothing done about it? If they have already experienced persecution in their country of origin, we can surmise that this treatment must surely worsen any psychological problems these women already experience.

Indeed, research finds that 26% of women are diagnosed with psychological problems after their dispersal, compared to 3% so diagnosed prior to coming to the UK. It is believed that women who have suffered gender-specific persecution will suffer severe psychological injuries including depression, anxiety, post-traumatic stress, trauma and stress. This suggests that inaccurate data in Country of Origin reports (which directly impacts the outcome of asylum claims) and the inappropriate dispersal system combine to increase psychological problems amongst the female victims of torture.

Another harrowing experience for the female asylum seeker is the detention procedure. They are detained when officials believe they can make a quick decision and thus place the women in the fast-track system, or in other cases of a 'quick removal', particularly if they are ill-equipped to obtain the correct information on the woman's country of origin. Other reasons for detention include exhausting one's right to appeal or where 'leave to remain' has run out and the person has not been granted indefinite leave to remain (full refugee status). The government's policy on detention was set up purely as a deterrent and said to be a short-term measure, yet many women remain in detention centres for months, even years. Many asylum seekers are so afraid of returning to their own country they resist removal. One woman who made her claim too late suffered brain damage as a result of malpractice by a member of staff when she was incorrectly fed after a series of break-

downs and hunger strikes.

Such maltreatment would understandably have devastating effects on women's mental health, reinforcing their feelings of fear and terror. Attempted suicide and self-harming is common amongst female victims of torture. An Inspectorate report in March 2007 found that women were five times more likely than male detainees to self-harm to the extent of requiring medical attention.

Ironically, it is against the law to detain anyone regarded as unsuitable on the basis of having a medical condition (as outlined in the Immigration and Asylum Act, 2006). What is absurd is that of course many of these women have a medical condition; they are extremely psychologically traumatised due to persecution, made worse by the asylum system. The treatment of these people is inhumane. Women who have travelled to a place where they thought they would find protection and safety are faced with interrogation, torment, detention and racism. One assumes that these are women intellectually sound enough to recognise the corrupt nature of the regime of their country of origin and who, at their peril, made attempts to do something about it.

So what is the root of this obvious racism and unfair treatment? It was bourgeois reformists who recognised that immigrant labour was vital to the capitalist economy. On the one hand, immigration control is designed to obtain cheap foreign labour when the domestic economy requires it, and on the other it allows for better population control. Capitalism requires a flow of goods, services, capital and labour across national borders. However, most countries have less restrictions on the movement of goods and services and rather more on labour, as we can witness here in the UK. Immigration is not an accident, and controls are required to meet the needs of capital. By selling their labour, people produce things to sell, and in return they are paid and go on to become consumers, by spending their pay in the goods and services market. Herein lies the problem: people with no skills and also no money are essentially economically useless.

The immigration system, and increasingly the asylum system, seems to be run according to that logic. The asylum system is not driven by generosity or so as to help those suffering in countries of unrest and poverty; it is shaped by the requirements of capitalism. People are reduced to statistics and games of number-crunching and party political posturing.

This impersonal system neglects the specific circumstances and needs of individual women who seek asylum. It leads to their poor treatment, and has a severe impact on their mental health. One can only imagine, if they are unfortunate enough to be deported, in what condition they return to their countries of origin. We can only assume that they return in a far worse mental condition than when they made their escape.

Niki Taylor lived and studied in Manchester for eleven years, and studied politics, psychology and social work. she worked as a social worker with asylum seekers, and with people with mental health and learning disabilities. she will soon be moving to guatemala to work with indig - enous women.

CLIMATE CHANGE Its impact on physical and psychological dislocation and on the incidence of alcohol and drug use disorders

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Authors and social activists have already addressed the negative impacts on physical and mental health by climate change, and the consequent dislocations of populations. The idea of social and psychological 'dislocation' goes back to the sociological concept 'anomie', proposed by Emile Durkheim. It is more recently explored in the work of the Canadian scholar, Bruce Alexander. He views dislocation as physical, psychological, social and cultural breakdown in the continuity of individual experience, and as the major root of addiction problems.

'Dislocation' includes both physical and psychological uprooting. Although mainstream science has focused mainly on the possible biological, psychological, and micro-social aspects of addiction, neither research nor clinical applications have yet yielded much convincing evidence for clear causative factors and specific treatments. However, physical and psychological dislocation seem to constitute clear contributing factors to the incidence of mental illness and substance-abuse disorders.

Alexander's work indicates that the concept of dislocation is applicable to individuals and populations who or which experience misplacement, both physical and cultural, due to the effects of globalisation and the intensification of uncontrolled capitalist practices under the free market economy. Climate changes, related to those factors, have substantial effects on physical and psychological well-being.

Alexander uses sound data to argue that damaging addictions follow on the heels of social and economic changes which disrupt the social fabric. He identifies the free market economy as the main basis for this dislocation. Having been deprived of their essential senses of identity and continuity, affected individuals look for substitutes and new coping mechanisms, even if they are unhealthy: alcohol and drugs are among these substitutes.

Community dislocation and a high incidence of drinking problems is well documented for a number of indigenous communities. If we look at the history of the physical dislocation of indigenous peoples caused by US, Canadian and Australian policies - which almost annihilated those cultures - the link with the emergence of alcohol or substance abuse is undeniable. Rather than intervening with discrete individuals, communal approaches aimed at re-

building dislocated cultures have achieved much better results in dealing with problems of behaviour and addiction. There is an extensive literature on such historical traumas.

But there are other examples, involving many different cultures. Several scholars have elucidated the deleterious effects of neo-liberal economic policies in recent times. These effects have appeared since World War II, but especially since the conscious efforts at globalisation during the last thirty years or so. These have brought on an increase in the problems of addiction in countries such as the USA, China and Russia.

It is easy to find studies on the social and personal effects of climate change. For example, an increase in droughts can lead to increased stresses as the economic structures of communities are forced to change: drought causes migration, with major effects on social support networks and substantial psychological stress.

Another example of the effects of dislocation is the 2005 tsunami, which caused a huge loss of life and massive economic and social damage. In affected areas, more than 30% of the locals reported symptoms of substantial psychological distress, whilst more than another 20% showed multiple signs of mild distress. Again, Sheila Watt-Cloutier, an Inuit activist and 2007 Nobel Peace Prize nominee for her work on climate change and human rights, has spoken about the threats to Inuit physical and mental health associated with the changes in the sea ice, with consequently diminished access to traditional foods; this has undermined the social and cultural structure of the population. Data indicates that the suicide rate for the Inuvialuit Settlement Region is eleven times higher than that for the rest of Canada.

Climate change will predominantly affect communities which are vulnerable because they are highly dependent on their local resources and social and cultural networks. The resulting socioeconomic difficulties are linked to reduced personal autonomy, negative self-perception, stress, insecurity and social isolation, with a major impact on mental well-being. Psychological trauma is one of the most common and better studied of the negative mental health consequences of climate changes and natural disasters, but grief, anxiety and substance abuse are also listed as consequences. These mental health outcomes are to a large extent attributable to population displacement, consequent poor housing, lack of access to services and employment, and loss of a connection to place.

It is likely that climate change will displace increasing numbers of people, contributing to a keener sense of dislocation and an increased adoption of dysfunctional coping mechanisms such as alcohol and drug abuse. On the bright side, there is evidence that communities do tend to cope

with natural disasters by applying their traditional views and wisdom in attempts to regain their senses of belonging and identity, and may be able to oppose threats of climate change by resisting experiences of physical and psychological dislocation. One essential step in dealing with the sense of dislocation will be the rebuilding of a worldwide socioeconomic and cultural context which enhances a sense of belonging to a community, something which has been profoundly undermined by the widespread adoption of extreme neo-capitalistic policies.

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