Review: Personal Distress, Social Conditions and Mental Health Care

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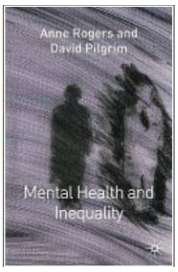
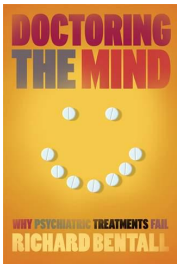
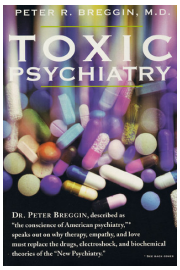


Anne Rogers and David Pilgrim, *Mental Health and Inequality*(2003), Palgrave and MacMillan(Pubs), New York, €28.00



Richard P. Bentall, *Doctoring the Mind, Why psychiatric treatments fail* (2010), Penguin Books, England, €13.85



Peter Breggin, *Toxic Psychiatry, Drugs and Electroconvulsive Therapy: The Truth and the Better Alternatives* (1993) Harper Collins, London, €16.33

In light of the global recession, which the World Health Organisation (WHO) warns will increase the number of people suffering from emotional distress, it is timely to consider the whole question of the relationship between personal distress and social conditions and to explore the appropriateness of the various mental health care treatments available in alleviating or eradicating emotional distress. The three books considered here form a useful starting point for exploring these issues. Throughout this article the preferred term of the Irish based Critical Voices Network, 'emotional distress', is used to designate what is commonly known as 'mental illness'.

The WHO estimates between 20-25% or 450 million of the worlds population suffer from emotional distress, a neurological disorder or a psychosocial problem and the global burden of mental health is set to rise to 15% by 2020[1]. What is commonly called madness is distinguished as a condition separate from the rationality of societal norms and behaviour by manifestations of unintelligible conduct, thought or speech that is expressed by paranoia, hearing voices, elation etc. Symptoms of depression include; low energy, sadness, loss of interest or pleasure and feelings of hopelessness. Figures for Ireland are 1 in 4/5 or about 700,000 people[2] and in 2010 there were nearly 20,000 admissions to psychiatric units and hospitals, of which

[1]World Health Organisation 2001a 23
[2]Mental Health Commission 2003:18

435 were under 18 years[3]. Reported cases of deliberate self harm amount to 12,216[4] and suicide cases account for over 500 deaths[5].Global and Irish studies highlight that the majority of adult sufferers come from socially disadvantaged backgrounds, Currently Irish mental health policy is governed by the policy document *Vision for Change* (2006) where service users in collaboration with health officials devised a plan with a recovery focus for all mental health services. Intervention should be aimed at personal care plans maximising recovery building on personal and community based resources to achieve meaningful integration in society. Special emphasis is given to the need to involve service users, family members and carers at every level of service provision.

Rosen[6] has shown that the source of manifestations of emotional distress has been contested since biblical times. 'Madness' has been variously attributed to divine intervention, evil spirits, fevers, hereditary factors, unbridled passions, strong liquor, the influence of the moon and blows to the head, all of which reflect societal organisation and belief systems therein. It is still disputed area today with frameworks being broadly categorised according to supernatural, societal, interpersonal and individual analysis. In modern society treatment regimes fall between addressing the physiology of a person (psychiatry) or looking to contributing environmental factors (psychology). Since the mid 19th century the biomedical model, as espoused by psychiatry, has dominated in developed countries. This medical model (or, as disability authors see it, individual model with medicalisation as one contributing aspect) views disability or illness as an innate problem of the person directly caused by disease, trauma and other physical conditions which require individual treatment addressing the physical conditions by trained experts[7]. As a result the bulk of resources are distributed to the research and practice of ameliorating or eradicating the physical causes of the illness. In contrast the social model of disability sees disability as a socially created problem resulting from socio-economic and political conditions which exclude people from full participation in society. The remedy is thus economic and political reform[8].

These highly informative books address these opposing frameworks, by deploying a rigorous scientifically based method to deconstruct psychiatric premises and practices, the findings of which contest all the tenets held dear by psychiatry. In doing so, they promote and discuss alternative forms of understanding and treatment of emotional distress. Readers may find that the amount of medical terminology and scientific theoretical perspectives is off putting, however it is worth persevering as they are explained very well and the knowledge gained about the effects of the social conditions we live in and the mental health industry makes it worth while.

Breggin takes a psychosocial viewpoint (the integration of the individual and the social) and squarely locates the source of emotional distress in life experiences of socio-economic hardship, stressful life events, and familial relationships. He argues that the solution to these problems is through meaningful therapeutic talk thera-

[3] Daly and Walsh 2011:14
[4]National Deliberate Self Harm 2012:i
[5] National Suicide Research Foundation, July 2012
[6]Rosen 1968
[7]Oliver, 1990:2
[8]Oliver, 1990:2

pies that disregard psychiatric categorisations and symptoms. He identifies initial episodes of emotional distress as a 'psychospiritual overwhelm'. This has no religious connotations, rather it pertains to the self, identity or personality of the individual striving to live a better, more fulfilling life[9]. The author condemns both the historical and the current practice of psychiatry and compares the inmates he met at his initial introduction to the American asylum system in the 1950s to 'concentration camp prisoners' because they endured sexual, physical and emotional abuse and neglect from their carers besides undergoing dehumanising electroshock and insulin coma therapy.

By comparison Bentall takes a clinical psychological viewpoint, maintaining that physiology is an important contributory factor to manifestations of emotional distress. As a result he considers a discretionary usage of medication as appropriate in some cases. He suggests a new approach to understanding emotional distress which brings together the social, psychological and biological. The basis of his professional approach is a belief that the evidence shows that particular manifestations of irrational thoughts, behaviours and beliefs are associated with specific life experiences and it is these life experiences that should be addressed e.g chronic experience of victimisation which seems to associated with the development of paranoid delusions or childhood trauma which seems to be associated with hallucinatory voices. Thus the focus should be on symptoms rather than diagnosis.

In contrast to these professionally focused books, Pilgrim and Rogers is a more academic work. It takes an overview of the mental health field by adopting a critical realist approach (which refers to the investigation of underlying structural enabling and constraining mechanisms of the material world which influence perceptions, values, beliefs and behaviours) to explore the under explored causal relationship between mental health and inequality. In doing so it looks beyond findings from a range of disciplines to expose the three way 'relationship between social divisions, professional knowledge and the role of mental health services'[10]. Thus it investigates professional interests and the societal role of psychiatric practise, knowledge claims about services, including service user perspectives, and the role the continuation of material disadvantage has in creating mental health problems. Similarly to the previous authors, Pilgrim and Rogers view emotional distress as social in origin, however unlike them, they claim that it cannot be considered in isolation from socio- economic and political circumstances and the role mental health services play in creating inequality. They conclude levels of psychological distress are also markers of the extent of relative deprivation in a society and its political health. Thus it counters physiological and psychological claims to be ameliorating or eradicating emotional distress, finding that individualistic models obscure the social causes and consequences of mental health problems and impede specific policy measures to address inequalities.

Despite these varying viewpoints all three authors are connected not only by their critique of psychiatry but also by identifying the importance of socio-economic circumstances in the prevalence of emotional distress, and as a result there are many similarities in content and discussion. All three address the zealousness which psychiatrists employ to perpetuate the notion of the biomedical na-

[9]Breggin 1993:31

[10]Pilgrim and Rogers, 2003:15

ture of emotional distress, in a bid to attain and maintain their professional status. Pilgrim and Rogers demonstrate the association between the knowledge base of mental health professionals and power, and along with Breggin and Bentall show how alternative social analytical models and treatment regimes are continuously derided and undermined in the full knowledge of the high correlation between mental health, personal circumstances and social disadvantage. They all highlight that to many psychiatrists the meaning of patients symptoms and the context in which they occur are seen as irrelevant. Should a patient object to the psychiatric definition of their problems and treatment they are deemed to be 'lacking insight' which psychiatrists believe to be a symptom of 'psychotic illness'. Their perspectives concur with Bentalls main argument that the premises on which psychiatry is based are extremely unscientific and that it has generally failed to help people experiencing emotional distress 'It is not that there is a lack of biological evidence, rather the evidence has been misinterpreted and shoehorned into a biomedical framework that fits it poorly'[11].

History of psychiatry

As stated these authors all take a negative view of psychiatry and expose the fallacy of biological or genetic based arguments by looking at the historical development of psychiatric premises, practices and treatments. Bentall gives particular consideration to the subject which he describes as having a 'dark history'. They show how the basic psychiatric classification of mental illness into manic depression and schizophrenia (then called *dementia praecox*) was established by the German psychiatrist, Emil Kraepelin, who believing in the physical nature of mental illness, looked at similarities in case studies and assigned typologies to manifestations of emotional distress. He was also an advocate of eugenics and 'racial hygiene' ie a racist. His work was to provide the foundations of modern psychiatric theory and practice and since then these categories have been revised many times and new conditions added through the Diagnostic and Statistical Manual of Mental Disorders (DSM) which is published by the American Psychiatric Association (who are now in production of the fifth edition) and the International Statistical Classification of Diseases and Related Health Problems produced by the WHO.

Our authors also expose the gruesome and dehumanizing treatment patients had to endure in asylums, such as the belief that 'the bad cells' of the disease could be removed by pulling teeth or removing organs, or that electro convulsive therapy (ECT), prefrontal leucotomies and insulin coma therapies could eradicate the 'disease'. They would agree with Bentall that 'there can be little doubt that the physical therapies were a means by which psychiatry attempted to obtain a place at the high table of medicine'[12].

They find that deinstitutionalisation - so-called 'care in the community' - had more to do with high running costs rather than advances in the pharmacological industry. In so far as what is known as 'the pharmaceutical revolution' is concerned which saw the widespread use of 'antipsychotic' medicines to manage symptoms of emotional distress, a little known fact is, that the drugs were used to manage symptoms before psychiatry had established how they actually affected the brain or indeed how the brain works. Medica-

[11]Bentall 2010:165
[12]Bentall 2010:41

tion is what gave rise to the commonly held myth that people suffering from emotional distress suffer from a chemical imbalance such as the dopamine and serotonin theories (which were based on animal experiments). And again all three highlight the lack of scientific validity and methodological problems in drug testing experiments. Due to expense these are mainly carried out by the pharmaceutical industry, who only study the effects of drugs on people for up to six weeks, where sound medical practise advocates a year.

Side effects

While all three critique psychiatry, Breggin is most powerful in the presentation of overwhelming contradictory evidence regarding psychiatric practices and drugs. Believing that there is no biological basis to manifestations of emotional distress, he is in ardent opposition to the use of pharmaceutical solutions and argues that electroshock and drug treatments are conducive to effectively lobotomising[13] those with mental health difficulties in order to make them docile and more suitable for control[14]. Breggin and Bentall take a detailed look at how the brain works and in particular Bentall looks at neurontransmission, as it is by interfering with this process that psychiatric drugs affect thinking, emotions and behaviour and concludes that this type of explanation serves the interest of psychiatrists and drugs companies very well. He notes that neuroimaging does show abnormalities in the brain, however, so does sex, age, head size, educational achievement, social class, ethnicity, alcohol and medication consumption, water retention and even pregnancy. In studies of first episodes with no medication findings, are generally less consistent and, crucially, no account is taken of life experiences. However there is compelling evidence that traumatic events can alter the structure of the brain and these effects are attributable to environmental stress. Breggin and Pilgrim and Rogers criticise pharmacological treatment on the grounds of its devastating side effects (which were known before their widespread usage) such as *tardive dyskinesia* which is movement disorder effecting eyelids, tongue, larynx and diaphragm, legs arms and torso or *lethargic encephalitis* which is similar to a violent flu virus or *tardive akathisia* which leaves the person with an uncontrollable drive to move the body, dementia, blood disorders etc. The effects of pharmaceutical medication leave little room for doubt about their general bodily toxicity. All three books are also forthright in their condemnation of genetic research that aims to show that particular types of behaviour and experience are related to specific genes (an idea which they point out was linked to Nazism and the Eugenic movement). They highlight methodological faults in experiments and genetic studies and as Bentall states 'indeed down right distortions of facts', and find no convincing evidence of a genetic basis to manifestations of emotional distress.

Big business

Besides advocating individualised psychotherapy and psychology for healing emotional distress Breggin and Bentall both highlight that mental health care is a multi billion business and lambast the powerful network of association between

[13]Lobotomy usually refers to the surgical cutting of nerve connections between the frontal lobes and the remainder of the brain where the frontal lobes are the seat of higher human functions such as emotions, concentration and abstract thinking.

[14]Breggin 1993:66

the pharmaceutical industry, psychiatry, government regulatory agencies, academia and parent organisations in support of the biomedical model, as controlling influences on the mental health industry. Breggin compares it to 'a giant combine similar to the military industrial complex'[15]. They emphasise that it is important to recognise that the pharmaceutical industrys aim is to make profits for its shareholders. They place a particular emphasis on the close relationship between psychiatry and the pharmaceutical industry and portray how the mental health industry is big business. Bentall believes that powerful financial forces have ensured that medical remedies for human misery have been promoted even in the face of evidence that they do not work. He claims that organised psychiatry is willing to use any and every method to promote their products to consumers, who have been taught to look to the medical profession for the relief of emotional distress. He identifies cases where it tries to increase not only its share of the market, but also the size of the whole market through the medicalisation of social problems by building relationships with PR firms, the media, publicising its products, lobbying on behalf of its interests and issuing 'scientific' reports in order to convince the government , society and individual citizens that its services are needed. These efforts are then backed up by the pharmaceutical industry, who also contribute to medical schools, academic journals, psychiatric conferences and psychiatric research.

As discussed many of these issues are addressed by Pilgrim and Rogers, however their overall stance is fundamentally different from the exposition of the mental health work as outlined by Breggin and Bentall. They build their case for revealing the social origin of emotional distress by a thorough investigation of theory and evidence based studies examining the social divisions of class, race gender, age and sexuality including negative neighbourhood effects and longitudinal studies in relation to the patterning of mental health problems, They argue that social class is the main determining agent of inequality. However, similar to the above accounts they do highlight that negative childhood experiences is associated with poor mental health in later life.

While the other two authors do consider the role mental health services play in the coercive and social control of deviance, Pilgrim and Rogers see it as a central to the management of poverty. Powers given by the State to psychiatry allow it to implement therapeutic law which a enables them to detain people without trial and impose physical intrusions on their bodies against their will, while those in the community are forever threatened with confinement. Thus in marked contrast to medical health problems that have a degree of voluntarism, mental health services are routinely involved in involuntary surveillance and control and this fact alone distinguishes them from other health services. They traces this authoritarian role back to the States regulation of the poor in mid-19th century, when the numbers of 'paupers' reduced in direct correlation to increases in asylum inmates, who were then subjected to surveillance, containment and management. They highlight how people diagnosed with mental illness were feared and distrusted (as they still are today). Beliefs about the medical origin of their condition, rooted in eugenics (which assumes a 'tainted' gene pool) and biodeterminism, perpetuated the myth that they were 'different' from 'normal' people, resulting in, 'social rejection, stigmatisation and even demonisation'. It believes ser-

[15]Breggin 1993:451

vices today still perpetuate these attitudes.

Interestingly their discussion regarding the common attribution of 'dangerousness' and 'violence' to those with mental health 'problems', not only addresses studies investigating this phenomenon but locates it within a wider discussion about the level of violence in society and its effect on mental health, in order to establish the victimhood of expressions of emotional distress. Thus it looks at: State sanctioned warfare and its effects on combatants, civilians and refugees, regime oppression, how social divisions and unequal power relationships are imposed and maintained by violence, how rape, child abuse, domestic violence, racism, sexism and poor locality, all influence mental health. Set in this context they question why individual psychopathology has greater importance for the media. For their studies show that when one removes drug and alcohol addicts and those with personality disorders, who are also treated by psychiatric services, and concentrates on those only diagnosed with emotional distress the link with violence 'is so small that it is contested' (Pilgrim and Rogers 2003:151).They find that the perpetuation of the notion of 'dangerousness' serves the interests of the state in social control of the poor.

However violence against the self in the form of suicide is associated with those diagnosed with emotional distress but it is not clear if this is associated with individual life circumstances or a function of irrational decision making. Most completed suicides are not by those with a recent diagnosis of mental health 'problems' but there is a correlation with past mental health contact. However a focus on the medical condition and individualised behaviour disallows the links between social and personal implications. Sociology (as an academic discipline) was firmly established by Durkheims study of suicide which found that poor social integration and social stress were common place in suicidal deaths. Findings show that a sense of helplessness, entrapment, poor self image, poor problem solving, a sense of perfectionism, and a propensity to blame oneself for life difficulties are mediators in suicidal attempts which are connected to life experiences and social conditions.

Alternatives

As outlined the omnipresence of psychiatry as the authority on mental health and treatments is supported and enforced by the State. However it has also been shown that this is highly contested and no discussion about mental health would be complete without reference to the dissenting voices within psychiatry and sociology that emerged as 'the anti-psychiatry movement' in the 1960s and still resonates today, as seen in the above discussion. All three works under review outline how this movement questioned the origin of 'madness', the nature of service provision and psychiatric treatments. This is a critique that is most commonly associated with the works of psychiatrists R.D.Laing, David Cooper and Thomas Szasz and the sociologist Erving Goffman. As psychiatrists they promoted the development of services based on voluntary psychological approaches and rejected the coercive nature of the health services. A key argument was that behaviours and experiences deemed symptomatic of 'mental illness' are often more understandable when their context is taken into account. The movement not only contributed to a shift away from institutions but also led to the movement known as Psichiatria Democratica in Italy which identified mental health with social divisions. Consisting of trade unionists, students and psychiatrists they brought about legislative change in 1978 that made it ille-

gal to detain people in institutions. This in turn led to the development of local community services and an emphasis on social inclusion in mental health policy.

The anti-psychiatry movement also led to the establishment of the Philadelphia Association who initiated specific therapeutic communities for 'schizophrenics'[16] and others where treatment was non-coercive and based on psychoanalysis. The most famous of these was developed by Laing at Kingsley Hall in Londons East End. This template was later adopted by others such as Loren Mosher in who established the Soteria community in California, where residents were offered little medication and were cared for by untrained staff.

Breggin gives particular attention to 'survivors' or service users, in America who have been very proactively engaged in providing alternative experientially based understandings, treatments and care, acting not only as support and self help groups but as political entities engaged in promoting the rights of those diagnosed with emotional distress. Such movements have been slowly contributing to political change as evidenced in the recovery focus in *Vision For Change* 2006.

In summary we can say that these three books provide varying insights into the field of mental health, demonstrating that the concept of 'mental illness' is socially constructed and that the violence of an unequal social system which creates deep class divisions, perpetuates a state sanctioned coercive mental health care system that is founded on a deeply flawed scientific basis and whose treatment regimes are questionable in the extreme. . **NB** None of this article is intended as advice. If you are taking psychiatric prescription drugs, you may risk serious and irreversible harm should you decide to stop taking these potent drugs 'cold turkey', and/or without the supervision of a licensed, skilled, caring professional. Never stop taking these drugs without understanding the serious adverse effects of incorrectly doing so. For more information on this please visit the Icarius project. Each body is unique and responds differently. This is why it is recommended for a skilled professional to monitor your blood levels and other homeostatic processes should you decide to withdraw from psychiatric drugs; and to introduce you to social support networks to assist you through this major change.

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WORLD HEALTH ORGANISATION (2001) The world health report 2001. *Mental health: new understanding, new hope.* Geneva. World Health Organisation.

[16] One of Laing's central arguments was that 'schizophrenia' did not exist as a 'disease entity', but is merely a label attached by psychiatrists to various symptoms of distress. Therefore people do not **have** schizophrenia nor can they be said to **be** schizophrenics.