

## The 'C' Word

### Understanding the *Context* of Mental Distress

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Why is context important? Because, without it, we fill in the blanks and arrive at erroneous conclusions. That is precisely what psychiatry has done with our distress. By second-guessing 'scientific evidence' that has so far proved elusive, they have sent us on a wild goose chase, diverting everyone's attention from the causal factors that are right before our eyes. Instinctively we know this but it has suited us, as a society and as individuals, to ignore it and bow instead to the 'expertise' of those whose professional, financial and political motives we neglect to examine. This article attempts to redress the balance by speaking frankly from my experience of coming through the psychiatric system to emerge with a clearer understanding of the damage that is done by medicalising our distress.

I have long succumbed to the comforting allure of mental 'illness' as the reason for my pain. Why wouldn't I? This model has afforded me validation and support, justification for not being able to cope; and relieved me of the guilt and inadequacy I feel. It has also provided me with the means to survive in a harsh, competitive and unforgiving world.

The word 'asylum' is wholly appropriate, therefore, to describe the intervention of psychiatry in my life. I have spent a lot of time in hospital, so understand only too well both the helpful and pejorative connotations of that word. On balance, I am appreciative of the help I have received and I hope my criticisms won't be misconstrued as ingratitude. But the more I have read and observed and reflected, I can't in all honesty continue to harbour under the illusion that my suffering is a product of faulty genes or chemical imbalance; or that it can be neatly reduced to a

diagnosis – because as yet I have seen no credible evidence to support these claims, in spite of the disproportionate investment and attention that has been devoted to finding it. The ‘evidence’ that is put forward is rife with professional bias and funded by pharmaceutical conglomerates so how can anybody in their right mind trust it?

In the absence of a scientific explanation where do we turn? The answer is: within ourselves and all around us. By examining the context of our lives, we can deduce that no thought, feeling or behaviour exists in isolation. There is always a trigger and a consequence – an ever expanding matrix of cause and effect within which our subjective experience resides. We shouldn’t need experts to tell us this because we can observe it for ourselves. But we have been trained to ignore what we can clearly see, hear, taste, smell and feel. By feeding us drugs that dim our consciousness, and furnishing us with the seductive entrapments of madness, psychiatry has replaced the matrix of cause and effect with a toxic web from which it takes great courage and resourcefulness to free ourselves.

What social scientists and community educators *can* do is to provide us with theoretical frameworks through which to conceptualise our experience and understand it better. Broadly, we might use the word *Context* to form an acrostic under which the causal factors, or social determinants that affect our experience, can be grouped as follows:

**C Culture and Connectedness:** the influence of our environment and societal norms and the extent to which we feel an affinity.

**O Orientation:** how we identify; our predisposition or nature, our values, hopes, dreams and objectives.

**N Nurture:** upbringing; in particular the patterns of attachment we formed with our primary caregivers.

**T Trauma:** by this I mean both complex trauma in childhood, including abuse and emotional neglect, as well as isolated incidents or adverse experience as children or adults that has had a serious impact on our psychological wellbeing.

**E Everyday concerns and responsibilities:** these are the things that occupy our current milieu, such as relationships with family and friends; work, study and recreation; finance, housing and health.

**X Existential worries:** this refers to the ‘big questions’ of life/death, aging, meaning and purpose that may cause cognitive dissonance, anxiety and fear, or a sense of being unfulfilled.

**T Transference/Treatment:** the impact of professional intervention and the dynamics of how we relate to caregivers. This is affected by our attachment styles from childhood and the level of our need and whether or not it is met.

This is by no means an exhaustive list; it is simply a framework or map on which the things that affect our mental health can be located. None of these determinants or influences manifests in isolation; they intersect and may compound or alleviate the effects of others. For example, even through adverse experience in childhood, we may have developed coping mechanisms that support our resilience now. Indeed the so-called ‘symptoms’ we experience may be a compensatory means of protecting us that our minds have developed, however much their usefulness is overshadowed by the suffering they cause.

Hallucinations or flights of mania may serve to distract us from underlying memories, or may be a way our mind processes and makes sense of them. Equally, if we have been abused or bullied we might develop what psychiatrists call ‘paranoid ideation’ – a complex pattern of erroneous thoughts about other people plotting against us, or a general sense of mistrust. Surely this is an understandable response – a strategy to protect ourselves from further harm, even if it has outlived its usefulness.

I believe that any distressing experience can be traced and understood, or at least an attempt made to alleviate the intensity and harm it causes, if there is the patience, will and courage to pursue it. Professional rhetoric may pay lip service to psycho-educational, psychotherapeutic and socio-political interventions, but we know that in practice people are much more likely to be given a pill than helped to work through what is troubling them.

Medication can be helpful in managing distress that overwhelms us, but its adverse effects on our health and dire consequences for life expectancy mean that we shouldn't over-rely on it. We should also be aware that psychiatric drugs don't target specific 'symptoms', as we are led to believe, but rather, have a crude sedative or stimulant effect. So the oft used comparison with insulin in the treatment of diabetes really doesn't hold.

Unlike medical conditions where there is evidence of a disease process, mental distress is a subjective experience. That doesn't mean it isn't very real and debilitating, but the hegemony of organic causation that has come to permeate the public consciousness – endorsed by celebrities, mental health charities and the media – is misleading and, as yet, unproven. Even the architects of the diagnostic manual have reluctantly admitted this. It also perpetuates stigma because it locates the problem in a minority of individuals – 'one in four' – who are seen to be defective.

Psychiatry has assumed the power to define what is normal, but is that not simply a colonisation of the truth based on dominant white/male/straight cultural norms? Of course this point has been debated endlessly, but it is worth considering in any discussion of how we understand mental distress. To take someone's experience out of its cultural context seems like a form of madness, but psychiatry does it all the time. Instead of classifying people's pain perhaps we should listen to their stories and recognise the person at the centre of the experience as the person who can shed most light on it.

A contentious issue – one of the most relevant, though difficult to talk about for fear of upsetting people – is the relationship between psychiatric diagnoses, welfare

benefits and capacity/pressure to work. If workplace stress has precipitated a person's breakdown, the prospect of going back after a sickness absence can be terrifying, even cause one to feel suicidal, particularly after a prolonged period off work, which would affect anybody's confidence.

The medical model has been used as a prop to justify why some people shouldn't be expected to work, and others coerced. It has created a class system of deserving and undeserving poor – the genuinely, seriously ill, and the 'worried well' who could do more to push themselves.

That is how the welfare state and its reluctant cousin – psychiatry – are set up to operate. The diagnostic framework is their method of determining who falls into which category, even though it is highly subjective and unscientific. Yet the same rules apply as with other medical conditions – if you are backed up by a hefty axis 1 diagnosis (such as schizophrenia or bipolar disorder) you are less likely to be pressured back to work and your benefit entitlement will be higher; whereas if you are deemed to have depression, or, god forbid, a personality disorder, then you are going to have a much harder job trying to convince the person assessing you of why you ought to be excused from work – even if your level of distress is just as disabling. And of course, equally cruel and unfair, you are going to get much less money if you *are* granted a temporary reprieve.

It is hardly surprising then that so many of us with the most 'serious' diagnoses want to hold on to them. I don't mean to be flippant or divisive in pointing this out, but the fact remains that this is just one of many reasons why service users, as well as professionals, would find it so difficult to relinquish the diagnostic model of mental 'illness'. We have to be honest and realistic in acknowledging that it cannot happen without resistance from almost every quarter. But that does not mean we shouldn't try to propose fairer ways to organise health and welfare systems.

Most people do want and feel able to be in work. If people don't feel they can operate in that domain, for whatever reason, perhaps we should take their word on trust. But this approach might require some radical sacrifices to be made by those on the highest

level of benefit. How can we make the distribution of welfare more equitable and fluid so that people would feel less fearful of coming off benefits if they knew there would be an adequate level of income to support them if they tried but couldn't cope in work? Taxing the highest earners more, improving conditions and reducing the pay gap for those in work, and of course, scrapping Trident, would all go a long way to achieving this.

Clearly then, we cannot review mental health policy and practice in isolation from other factors. In terms of context, it is just as much about politics as personal experience. Not having enough money to live on is a huge cause of stress and contributes to many of our health problems; poverty also correlates with other forms of disadvantage (such as low educational attainment) and adverse experience; all of these compound and impact on each other.

So we need to take a much wider view of the way we organise society and live our lives; to stop treating mental distress as a medical problem and start seeing it as a consequence of life that affects us all. That is not to say it will be equally problematic for everyone, but the ghettos that mental health services create (where some people are so drugged up we can't relate to them) surely mask the fact that this is a very human condition – however it manifests in each of us.

In conclusion, the task for us as individuals and as a society is to be kinder and less judgemental to one another, and to try to understand where people's distress comes from and that they can't just magic it away with a pill, an act of will, or without help and support. But most fundamentally of all, we need to make our world a fairer, safer place where all can live in security, peace and love.

As in all social transformation, critical consciousness among those whose power has been usurped is the key to change. Community education, therefore, has a unique and pivotal role to play in deconstructing people's view of themselves as mentally defective and in supporting them to challenge the structural causes of human distress. That's why I joined the profession – to stop being mad, and get even! Though, of course, I still use the 'C' word - in *Contexts* such as this!