Special issue: the politics of mental health

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Guest Editor's introduction

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As a communication scholar who studies discourse as social action, I take the everyday as highly consequential. As “Hannah Arendt stressed, banality is not synonymous with harmlessness” [1]: our routine, orderly social interaction, narratives, and textual artifacts—as are forms, diagnostic questionnaires, charts—constitute the very (health) institutions that organize us materially. By creating a space for examination of available narratives of mental health and illness, and how these are enmeshed in matrices of political discourses of productivity, biological brain, pharmacological solutions, precarity, function and dysfunction and, indeed, how we measure the value of a human being against the currency of putative diseases of the “mind,” this special issue is for me like revisiting a familiar place, in a novel way. As a doctoral student in Communication, I began to study psychotherapy and psychiatry, chained discourses that realize the “psy-complex,” [2]. This is a term coined by Rose to characterize the institutions that deal with the psyche: psychology, psychiatry, psychoanalysis, psychotherapy, psychiatric nursing, and psychiatric social work, and whose work it is to regulate and diagnose family life, sexuality, mind, and every day actions. In the spring of 2015, ten doctoral students and I met in the seminar *The Politics of Mental*

Health, where we read the blog *Mad in America*, edited by author Robert Whitaker (after a revolutionary book of the same name). I asked students to write a contribution that would speak to the others written for the blog: personal narratives of living with diagnosed conditions, accounts of lives lived in spite of diagnosis or of finding alternatives to bio-psychiatric treatments, painful struggles with social stigma, or news stories, such as, at the time, protests about the proliferation of new diagnostic categories in the DSM-V. The essays that follow are those contributions; they are a testament to the conversations that emerged in the course of the seminar, where we wrestled with ideas of mental illness/health as political and the material and embodied conditions of madness (in America, and therefore, as a cultural construct).

In *The Political Language of the Helping Professions* [3], Edelman writes:

Hospital staff often deny or ignore the requests of angry mental patients because to grant them would be reinforce deviant behavior... Presidents of the United States have declared on occasion that they would pay no attention to peace demonstrators who resort to irritating or allegedly illegal methods. We commonly regard the last as a political act and the first two as therapeutic; but all of them are easily perceived as either political or therapeutic. How they are classified depends upon the assumptions of the observer, not upon the behavior he is judging. The language of reinforcement and help evokes ... a world in which the weak and the wayward need to be controlled for their own good [4].

To enter into a helping relationship, and to engage in it according to the linguistic and relational terms set by the those authorized to control narratives of help within the

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psy-complex, it makes sense, then, that one must become helpless *for their own good*. In my doctoral dissertation, a study of how the dynamic of accountability worked differently and with different consequences for therapists and clients in an inner city family therapy facility, I noticed that clients had to accept diagnoses put forth by therapists as a *sine qua non* of participation in the helping relationship. Though this might make perfect sense if we believe that diagnoses pre-exist conversations, it becomes much more difficult to accept when looking at how these conversations are difficult for therapists and clients to accomplish, and involve considerable convincing on the therapists' part [5]. For the move from being a person consulting a mental health professional to being a mental patient is but one of definitions [4] and definitions are expert-generated and expert-introduced. In my work on therapy, I have argued [6, 7] that clients come in with pain, confusion, narratives that no longer made sense, and left "depressed," "oppositional defiant," "suicidal" and so on, having traded in the old version for a new narrative, a new nosological and etiological identity, patienthood. In more lasting ways, there will also be a treatment plan, a textual record in the form of a case file and new relational and institutional terms of engagement. The essays by Heather Curry, Kristen Blinne and Erin Scheffels are powerful examinations of how mental illness is enmeshed in matrices of Western society's political discourses of human deficit. In her piece on Hollywood producer and filmmaker Tom Shadyac, who is deemed mentally ill and maladjusted because he gives up his wealth, Blinne reminds us that mental illness may be reframed as a coherent maladjustment to unacceptable conditions of the social world: racism, sexism, poverty, famine, injustice. Likewise, in discussing how the canonical narratives of mental health decontextualize and dislocate the individual from the dynamics of relationships and social connections that make him or her an embodied person, Curry and Scheffels approach the political by critiquing how the biopsychiatric model both isolates us and makes bodies a business. Precarious bodies, those that are nonproductive, those that are damaged, homeless, sick, imbalanced, are pushed to the margins, invisible communities that haunt the safety and values of our own narratives of self-actualization.

For what does it mean to be *Mad in America* [7]? For one, that "schizophrenics in the United States currently fare worse than patients in the world's poorest countries." [8]. Detailing how the history of psychiatry rests on the semantic substitution of bad to sick, where masters like Rush and Pinel introduced "moral treatment" as a way to rehabilitate deviants the poor, alcoholic, and racially non-white (as well as other deviants and criminals) by first, declaring them mentally ill, and second, introducing "miracle" cures (for the patients' own good!) such as

insulin coma therapy, lobotomy, and electroconvulsive shock therapy, Whitaker's book is a chilling account of the human cost of entrusting our existential pain to psychiatry's medicalization. On the one hand, we (are told to or want to) accept as true that psychiatric diagnoses and drugs are part of the metanarrative of *scientific progress*, where the diagnostic categories will illuminate what is wrong, and the medications will address and cure (the metaphor of diabetes, so popular these days to explain that taking antidepressants is no different than taking insulin, comes to mind). On the other, there is an alternative story, namely, that the proliferation of drugs, diagnoses, and illnesses go hand in hand, and are often the result of skewed studies, to prove erroneous hypotheses, and always enmeshed in various social and political pressures (Big Pharma, interest groups, lobbies, the education system), which make the DSM a moving target. Growing evidence of these studies, as well as Whitaker's [9] painstakingly constructed argument that psychotropic medications actually create the very imbalances they are purported to treat by interfering with the brain's serotonin and other mechanisms are some of the factors which created doubt in psychologist's Amber Gum's everyday practices. Perhaps more frightening was that she could not share this doubt with her colleagues; her beautifully written piece is a testament to the unavailability, as of yet, of scientifically legitimate alternative narratives for practitioners, especially those seeking grants from NIMH; and the more psychiatry enters our lives, the more the number of chronically mentally ill—that is, receiving disability for mental illness—increases in society [9]. Though, as Kinghorn points out, psychiatry might be the best option right now, its limits are well worth questioning.

As a behavioral specialist working with children diagnosed with autism spectrum disorders, DeFreitas' contribution is strikingly different than Barbetta and Valtellina's humanistic view of autistic patients as voices that violate the turn-taking structure of conversation, therefore, violating social norms. Rather, De Freitas essay speaks of autism in terms of behavioral and relational interventions, and how staff should not forget the needs of caretakers, and parents especially. In a similar vein, Anderson, who is a caretaker to her mother, who lives in a home for elderly adults with "mental illnesses," finds support in an unlikely place when she meets Arnene, a gifted artist and art teacher in the community who has lived her life with a diagnosis of bipolar disease. Abraham's essay challenges to see the life of someone that most of us would discount as marginal as an "idol," like Arnene, his idol is *an older woman* who is mentally ill (though Abraham's friend does not admit to it) and thus doubly marginalized. Both Anderson and Abraham find in these women sources of inspiration, mentorship, and understanding. Changing the vocabulary of mental illness, turning the narrative by which we

understand it on its head, can have profound effects on our embodied experiences of it, as well. As narrative therapy has shown us, our stories can be re-storied. As Keller writes in her own lived experience of anxiety, her choice to see anxiety as part of herself, as opposed to an external force that can only prevail against her, allows her to turn its “attacks” into openings for self-discovery. Is it possible that by medicalizing life’s emotions and struggles, diagnoses give many possible and alternative narratives of identity a premature closure?

Mental illness is reconstructed not as deficiency or marginality, but as unconventional experience, like a surrealist painting by Salvador Dalí.¹ This idea is of course not new. Erickson listened closely to the “word salad” of diagnosed schizophrenics that others medicated into silence, and discovered a universe built on metaphor. And Oliver Sacks took his patients’ narratives as starting point for his own meditative writings on the human condition. Monteagut’s first person account of growing up with the legacy of “ghosts” in a Cuban–American family, with ties to Santoria and their country of origin, beautifully connects to work in neuroanthropology, and especially to that of Tanya Luhrmann, a Stanford anthropologist whose studies of “hearing voices” prove that schizophrenia is a disease of the Western World, and that hearing voices, by itself, is not diagnostically salient to inhabitants of Accra or Chennai [10]. By understanding hallucinations as “ghosts” Monteagut is part of a cultural tradition that “chooses” to re-story their lifeworlds and choices “between poverty and institutionalization.” As Chakrabarti poignantly reminds us in writing about Van Gogh, and the almost taken for granted connection between madness and creative genius:

la tristesse durera, durera toujours. Sadness will always be a part of us, part of our life experience. Many of us will endure pain, confusion, uncertainty, and feel very close to that brink that for generations we have politicized and classified as madness. It is how we decide to act with respect to it, how we decide to language it that, the contributors to this special issue say, is the critical move we must take.

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¹ Who is posthumously diagnosed with schizophrenia, though he declared himself the only sane man in a world of mental illness.