



Building a New  
Community Psychology  
of Mental Health

*Spaces, Places, People and Activities*

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Carl Walker, Angie Hart, Paul Hanna



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*To those lost to, or experiencing, distress*

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# 1

## Introduction: Conceptualising Mental Health in the Twenty-First Century

*2016, Beachy Head, East Sussex, England. James, stinking to high heaven, stands on the cliff edge, his eyes fixed on a boat far out to sea. He's about to step out. He can see a bridge that leads to his personal pirate ship. He shouts back to a woman begging him to stay put. 'Don't worry, it's all going to be okay, Mum.'*

*Just down the road, Louise sits in the pub with a shandy to her left, her daughter Jessica to the right. It had been a mistake to bring mum out thinks Jessica. She just can't stop crying.*

*Polegate, not far away at all. The child is in school this time. At the back of the classroom this 12-year-old is not listening to the art teacher tell them about using a colour wheel. She's digging a pencil deep into her arm. Her bag's on the table so nobody else can see.*

Dealing with mental distress often provokes anxiety. Little wonder, the stakes can be high, as the authors of this book know only too well from personal experience. We are all trained in the psych disciplines, and one of us is a practising mental health worker. In our personal lives, we've had more than our fair share of psychiatrists, psychologists and the kind of severe distress with which we began this book. We've sobbed down the phone, begging for psychiatrists to turn up so that people who were a danger to themselves and others could be taken to a place of relative

safety. We've demanded psychiatric medication on behalf of loved ones, knowing that it can have brutal side effects and that the evidence base for many of the medications is weak. We've lain awake at night hoping that people we cared for hadn't killed themselves. We also understand why many people are scared of other human beings who struggle to be in control of themselves and who want definitive action, even though a great deal of ambiguity and uncertainty surrounds us when we think about mental distress.

We understand all of this. But we also hold out for different ways of dealing with distress that are more humane than some of the ways that mental health is currently 'treated'—ways that aren't tied up with professional aggrandisement and the bolstering of practitioner identities, which go beyond conventional psychiatric and psychological responses. Even pausing for a moment to think about some of the history of such responses here, we are struck by the scale of the inhumane drama involved in the history of treating mental distress, and how in many ways, things don't seem to be changing all that much for the better.

And yet, in the last 100 years or so the disciplines of psychiatry and psychology have seen radical change. In only 100 years we have seen institutions characterised by the most profound and disturbing male-dominated incarcerations, where husbands had the abilities to admit wives into asylums that doubled as freak shows for paying customers. Such incarcerations could result from such gross indecencies as suggesting that human beings are not born evil, or because husbands wanted a quick divorce, or because wives protested over a husband's affair with another woman. Reasons for incarceration included infidelity, postnatal depression and being generally disobedient.<sup>1</sup>

We have lived through the 'science' of eugenics where Darwinian thinking was taken to the extreme in the form of many thousands of forced sterilisations to ensure that those considered to be of mentally unsound mind were not able to propagate their 'defective genes'. We have seen the popularity of trans-orbital lobotomies win Nobel prizes—a practice that involved jamming ice picks into the corner of each eye socket and moving it backward and forward to sever connections to the prefrontal cortex. This practice became so mainstream that Walter Freeman could drive around America in his 'lobotomobile' performing lobotomies for \$25 a

pop (and performing as many as 3439 lobotomy surgeries in 23 states, of which 2500 were his ice-pick procedure, despite the fact that he had no formal surgical training). Indeed, Freeman even lobotomised 19 minors, including a four-year-old child, before it was decided that perhaps ice-pick lobotomies were not all that they were cracked up to be.<sup>2</sup>

In the mid-1950s electroconvulsive therapy (ECT) became popular. Formerly known as electroshock, it exists to this day as an inpatient psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric illnesses. Its mechanism of action remains unknown and the guidelines of the National Institute of Clinical Excellence (NICE), the body that regulates what constitutes good medical practice, report that it is beneficial and life-saving for some, and terrifying, shameful and barbaric for others. The antidepressant era began in the 1950s where the predominance of the psychoanalytic model was challenged by the development of a range of new medications, still popular today, which were thought to work on various neurotransmitter pathways in the brain to provide relief from mental distress.

We have also witnessed the growth of the cognitive (behavioural) era, the development of both the antipsychiatry movements and the service user movements as a response to what for many still continue to be disempowering, disengaged and deeply problematic methods of social control dressed up as 'medicine'. At the close of the eighteenth century there were 40 asylums in England and Wales; 60 years later there were over 400. In 1940 there was no 'psychiatrists' bible'; in 2014 we have been through five separate versions of the Diagnostic and Statistical Manual of Mental Disorders (DSMs) with a growth from 16 mental disorders to over 300, spread over 947 pages.

In this book we are going to argue that this field of inquiry is ripe yet again for a radical shift, and show what this new shift might look like. In doing so, we are going to commit the same error that all speculators of the future before us have willingly committed. We're going to ask the reader to suspend their disbelief (a lot) while we posit a version of the UK moving on from 2016 to the year 2050. We're going to do this to provide a framework for new forms of understanding, institutions and practices that could govern how we might look at mental distress after this much-needed shift.

## **An (Admittedly Shaky) Version of the UK in 2050**

Okay, so it's the UK in 2050. And it has to be hot. You can't talk about a future without assuming that global warming is going to continue. We are going to need a few of your standard sci-fi tropes; otherwise before we know it, we're visiting Aunt Mavis after work and the only difference is that we're wearing T-shirts. It's so hot that humans are restricted to leaving the house between 6:00 and 9:30ish at the latest in the morning and then after 5:00 in the evening. The hours of 10:00–5:00 are out of bounds for most people unless you are very wealthy and can afford a solar suit. See what we did there? Boom, a standard sci-fi trope, the solar suits. And of course there is an aging population. The average age of retirement in the UK is now 80 with most of the older workers filling low-paid, service-sector jobs.

And we have personal hovercrafts too. Or at least those who can afford them have personal hovercrafts. So what else is different in this world of 2050? The reader at this point is probably thinking 'where are the robots?' We certainly would be. That's the first thing we'd be thinking and we'd be feeling pretty short-changed without them. Surely there are lots of them, shiny and metal and doing things that we ourselves take for granted? Nope, there are some pretty cool techno gadgets and transport devices, but other than that we still brush our teeth using our hands and a small vibrating plastic brush, still do our own cleaning and still cook our own food. Okay this wasn't the only reason. Since the banning of invisibility cloaks in 2041 (bank robberies soared by 250 % in their first year of public sale), there was a bit of a moratorium on the use of technology, social, medical and otherwise, especially when the online organ gambling craze of the late 20s started to put an almost intolerable strain on local hospitals.

### **The Retirement of 'Mental Health'**

Other than the hovercrafts and T-shirts, things look pretty much as they do now, with alarming inequalities in health and the ever present threat of war and migration crises. However, a few things have changed, and

most specifically, some of the issues that concern us in this book. A social democratic government had been in power for 15 years, and proportional representation is now the order of the day. What in 2016 was once quaintly referred to as ‘mental health’ is no more in 2050. Indeed, the term has as much relevance as other strange descriptors of distress from bygone ages like ‘hysteria’ and ‘schizophrenia’. Misery, which had previously been the remit of health professionals like GPs, psychiatrists and psychologists, was completely deinstitutionalised. The seeds were sown by some academic psychiatrists themselves. Arthur Kleinman in 2012<sup>3</sup> said that for all the efforts in neuroscience, genetic research and neuroimaging, there was no better understanding of what was still referred to as ‘mental illnesses’ and that academic psychiatry still acted like the breakthrough was just round the corner. This failure had already clearly been apprehended by the pharmaceutical industry which had begun to move away from mental disorders, towards treatments for the neurodegenerative diseases so prevalent in an aging population.<sup>3</sup>

Kleinman was a key figure and many listened when he said that ‘if by 2030 we still have no useful biological test for mental disorders and little in way of new therapeutic agents, academic psychiatry will be consigned to irrelevancy’. It turned out that many absorbed this prescient warning. When a year later the National Survivor User Network<sup>4</sup> noted that ‘nearly all of the members who responded to their survey said that the governments’ mental health strategy was failing’, there appeared to develop a small but significant movement towards questioning the psy disciplines (psychiatry and psychology) and how useful they really were. Soon everyone had something to say on the matter.

Clinical psychologists like Colin Feltham<sup>5</sup> openly noted that ‘Counsellors cannot do much directly about the upstream causes of mental health problems’, and Pat Bracken et al<sup>6</sup> in 2012 warned that psychiatry faced challenges it couldn’t ignore—a need to move beyond its own paradigm and more importantly, the growing evidence of the primary importance of ‘nontechnical aspects of mental healthcare’. There was a growing acceptance that improvements in people’s misery could come from simple human interactions, very often with people who had no training or expertise. These notions gradually gained momentum and a consensus slowly formed, albeit one that many service users had known

for many years—that people were entrained to see themselves as ‘mentally ill’.

That’s not to say that they did not suffer horrendously- it simply meant that understanding this suffering as a biological illness was no longer good enough. Moreover, the consensus grew that receiving alienating ‘treatments’ from remote professionals paid many times their own salaries in environments that were lifeless and completely removed from their own families, friends and communities was not perhaps the best way to address misery. The pain of stigma didn’t come from ignorance or a lack of education in the public but from the diagnostic labours of the psy institutions who had inadvertently worked so hard on a social segregation that enforced ‘mental health’ identity niches that almost demanded that people were stigmatised.<sup>7</sup>

And those were seeds. But they were seeds that soon flourished into discussions about values-based commissioning of services<sup>8</sup> that was underpinned by the realisation that the values and experiences of everyday people could be put at the forefront of helping rather than a reliance on problematic evidence-based medicine (EBM).<sup>9</sup> EBM was an enticing idea in name but one where the technicality of knowledge was irrevocably tied up with professionals’ claims to autonomy and status. EBM had more value in strengthening the authoritative voices of clinical experts than in helping people with their misery. There was a growing acceptance that there needed to be a more nuanced awareness of humanity, one where people were understood not as fixed carriers of disorders but as fluid and plural subjects that couldn’t simply be captured by scientific rational and objective forms of knowledge. That was best left to the physicists working on the memory machines and the invisibility cloaks.

At its worst, at the turn of the century nearly 20 % of British people had consulted a counsellor as counselling had come to be the answer for all manner of personal and social problems<sup>10</sup> —boredom, loneliness, overexcitement, rejection, unattractiveness, workplace change and marital infidelity. There was a growing understanding that antidepressants didn’t treat, they sedated (although such sedation was certainly useful for some in the throes of suffering), and that the evidence base for trials of medications and psychological therapies was so flawed as to leave

little but placebo. And there was a growing acceptance from within the discipline that psychiatry was scientifically bankrupt—it was a collusion of good will, self-interest, inappropriate understanding of people and complex social environments,<sup>10</sup> and more importantly that suffering was social, not personal. The World Health Organization<sup>11</sup> released a report that said as much, stating that what was really needed for mental health was an increase in the number of people with a living wage; that what was needed more than anything was government action on the social determinants of mental health in order to achieve advances in health equity.

The Mental Health Foundation<sup>12</sup> reported that psychiatry needed to be moved into the community for fresh ways of working in mental health. When in 2013 Whately<sup>13</sup> called the publication of DSM-V, previously understood as the ‘psychiatric bible’, an exercise in blatant disease-mongering where normal human behaviours were pathologised and medicalised, even he could little have known DSM-IX would, in 2029, contain ‘leaving your house without locking the door syndrome’ and ‘Bad hovercraft use disorder’. Social prescribing, that is, the prescribing of non-medical community-oriented services for immiserated people visiting their GPs, began to take off under the early century neoliberal governments that saw in this model a way to promote ‘patient choice’ and cut state medical costs in one fell swoop. A financially besieged community and voluntary sector was increasingly ready to be recognised for much of the work that it was already doing.

And so things changed—not overnight but slowly and irrevocably. The National Service User Movement’s ‘It’s often bollocks’ campaign drew more and more supporters through the ever-developing social media. That campaign morphed into the ‘Community Options’ movement. It was clumsy at first. Well-being shops opened up on high streets around the country but were often backed by private equity firms. These largely virtual environments scored a bit of an own goal. But eventually and slowly they got there. ‘Options in the Community’ programmes developed around the country to help support people who were experiencing what was no longer referred to as mental health problems. Psychologists and psychotherapists who had always been keen to differentiate themselves from the biomedical psychiatrists, yet often who

had reproduced and benefitted from the conceptual tools of psychiatry (DSM, disorders, illnesses, treatments), were quick to respond and rebrand themselves as ‘community psych workers’ and then eventually ‘community supporters’.

People like James and company, introduced at the beginning of this chapter, who were experiencing embodied suffering, and often as very clear and understandable responses to life histories, losses, abuses, dislocations, humiliations and pressures, were no longer seen as ‘abnormal’ or ‘different’. They were just people going through a period of change (albeit a period which felt excruciating) much like other periods of life change. Many people continued to experience distress as a result of coming to terms with difficult things that they had experienced, such as housing, benefits and legal issues, with work difficulties and debt. These people were no longer automatically sucked into the institutions of medicine to be sedated or inappropriately counselled when in many cases they just needed help with the specific life circumstances that were causing their distress. Instead, an ‘Options in the Community’ programme, staffed by volunteers who did a fixed term in the programme to avoid the building of professional enclaves and interests, pointed them to a vastly expanded array of networks of community organisations whose incredible distress work, often carried out by non-trained staff and volunteers, was finally recognised with funding by parliament of the Community Options Programme nationwide in 2050. People still had facility to talk to the rebranded psychologists who had become ‘community friends’, many of whom had come through the volunteer ranks and had never had any psychological or medical training. However, that wasn’t deemed important.

For some of those whose acute distress took the form of hearing voices, a vastly expanded series of Soteria houses were integrated with the ‘Community Options Programme’ and served as community spaces for people experiencing mental distress or crisis. The Soteria approach included non-medical staffing and worked by preserving residents’ personal power, social networks and communal responsibilities; finding meaning in the subjective experience of hearing voices by ‘being with’ clients; and involving no or very little use of antipsychotic medication. Staff



members at the house were encouraged to treat residents as peers and to share household chores. The programme was designed to create a quiet, calming environment that respected and tolerated individual differences and autonomy. They were initially heavily criticised as irresponsible or ineffective by what had become the Nike College of Psychiatrists, but came to be widely established across the country.

And for those whose period of acute crisis meant that they were considered to be in danger of taking their own lives or harming others, the institutional baby wasn't completely thrown out with the psy bathwater. Safe zones, shorn of the biomedical and diagnostic pretensions that had engulfed the old inpatient hospitals, were used to hold people in these forms of crisis. As with Soteria houses, non-medical staffing and a focus on preserving residents' personal power, social networks and communal responsibilities were emphasised. The sedatives that had previously laboured under the guise of treatments were sometimes used here. And as with the old inpatient hospitals, they failed in the eyes of many to hold the uneasy tension between crisis and liberty.

## **Back to 2016: This Book**

The world outlined above may look naive/silly/hideous/odd/irresponsible depending on your positioning, but you don't have to buy into the notion of hovercrafts to know that there is, and always has been, something quite fundamentally wrong with the institutions that have coalesced around people's misery over the years. This book won't chart a path to some form of mental distress utopia, but what it will provide is an unashamed and much-needed celebration of the precious and often invisible non-professional, non-technical mental distress work happening in communities up and down the country on any given day. We want to tease out, and articulate in some detail, the very texture of the kinds of things that are happening in this arena.

We will get to that in due course. But first we will provide an account of some of the fundamental misunderstandings which underpin much of the theory and practice of mainstream psychiatry and psychology, outline

some of the implicit and explicit problems with any institution that has an impulse to reward professional expertise and in so doing highlight the profound need for a banality of misery, not one which privileges the notion that misery is somehow exotic, distant and irrelevant to most people's lives. Psychological misery is largely a social phenomenon and its potential lies within every single living person. Moreover, despite esoteric enclaves of expertise often anointing themselves as the only sources of authority on misery, there is a perfectly good lay vocabulary on misery that is reproduced all over the country by people with no mental health training and in all manner of institutions and settlements around the country. And it's often happening with barely a psy person in sight. It works because people and distress are fundamentally social in nature.

After outlining some of the difficulties with psych institutions and the social character of misery, this book will set out case studies that show what is already happening for many people experiencing misery, albeit sidelined and marginalised in the dominant story of biomedicine. There are 161,000 active voluntary organisations in the UK, 2.5 voluntary organisations for every 1000 people doing immensely valuable work.<sup>14</sup> This book is a celebration of the non-technical, but it is far from a celebration of anti-intellectualism and the two should not be conflated. It marks a movement from one set of dominant conceptual and institutionalised ideas of biomedicine, to one which explores the knowledge and capabilities inherent in many of the informal community settings and spaces around the country. We hope to reinforce the understanding that important mental distress work occurs in a great variety of lay social settings: in arts centres, schools and libraries; along river paths; and in sports clubs, community groups and support groups.

## The Chapters in This Book

Chapter 2 in this book takes some of our critical thinking highlighted in this chapter and provides a theoretical framing for this. We utilise a Martian friend to explore the ways in which we might think differently about mental health and indeed models of the 'self'. Towards the end of

the chapter we start to suggest that the self can be seen as a social, rather than individual, being. While in itself this argument has been made in a variety of places, it enables this book to move on to Chap. 3 in which we explore some of the implications for mental health practice if this alternative understanding of the self and mental health is adopted.

The book then moves on to our research-based chapters. From Chaps. 5 to 9, we draw on a range of empirical material (interviews, focus groups, participant observation) we have collected over the past four years in a range of settings. Such settings include community singing groups, an unemployed family centre project, a fishing project, a support group for parents of children with disabilities and complex needs, a cycling group for people with mental health problems, and organisations taking a positive view on the practice of sex. Whilst all of these settings are clearly very different, and as you will see, our accounts of them are also very different; we hope these empirical chapters will offer an assemblage of the core social fabric that underlies each setting and which we feel can deeply benefit the individuals that use them.

Finally, our conclusion chapter attempts to offer a summary of the data we offer up in this book to provide some hint at the ways in which we feel mental health practice might be more usefully understood in the future.

Firstly, let's get to our Martian friend...

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# 2

## The Flawed Assumptions of Psychology and Psychiatry: A Martian Analysis

*After what seemed like an eternity of watching David's moods shifting to such radical extremes, it had become more difficult to recognize him than it was to recognize his mood state. He had levelled out for a while. He had been profoundly low, desperate, demented and crawling with the agony of an ever present anxiety for too many months to remember. He was now back on the up. Nobody knows why. He didn't know why. From experience I gave him about 2 or 3 weeks before the mania really took hold. Before the abuse, the anger, the incoherence, the wild spending, the voices, the discussions about how to counter the people who were following him in order to train him into the secret services, the newly discovered superpowers, the false texts telling me our dad had died, and the repeated threats of suicide. Then the promises that all of these would stop. Then more abuse, anger, rogue secret service agents and dead dads. Our dad must have died more times than Freddy Krueger over the years. Sure enough it was about 2 or 3 weeks. I got a call to tell me that he had gone AWOL leaving a message that he was going to drown himself in the sea. After driving around for 2 hours looking for David I finally found him on the beach staring at the sea. He said he wanted to be left alone so that he could throw himself in. I told him that as he wasn't on a platform it would probably be easier to walk in. If he threw himself, he'd bang his face on the*